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

Maternal and Child Health Bureau

Emergency Medical Services for Children (EMSC)
State Partnership Grant Program

Announcement Type: (New and Competing Continuation)
Announcement Number: HRSA-13-201

Catalog of Federal Domestic Assistance (CFDA) No. 93.127

FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2013

Application Due Date: September 26, 2012

Ensure your Grants.gov registration and passwords are current immediately!
Deadline extensions are not granted for lack of registration.
Registration may take up to one month to complete.

Release Date: June 27, 2012

Issuance Date: June 27, 2012

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Authority: Public Health Service Act, Title XIX, §1910 (42 U.S.C. 300w-9), as amended by the Patient Protection and Affordable Care Act, §5603 (P.L 111-148)

EXECUTIVE SUMMARY

Emergency Medical Services for Children (EMSC) State Partnership Grant Program

The Health Resources and Services Administration (HRSA) is pleased to release the Emergency Medical Services for Children (EMSC) funding opportunity announcement for the State Partnership Grant Program. The Program is administered by the U.S. Department of Health and Human Services (HHS), HRSA, through the Maternal and Child Health Bureau, Division of Child, Adolescent and Family Health (DCAFH), EMSC and Injury Prevention Branch.

The HRSA vision is "Healthy Communities, Healthy People" with a mission "to improve health and achieve health equity through access to quality services, a skilled health workforce and innovative programs." This is the framework that supports a health care system that assures access to comprehensive, culturally competent, quality care. In concert with the vision and mission of HRSA, the Emergency Medical Services for Children Program is soliciting applications from States and accredited schools of medicine in States, to support projects focused on integrating the unique healthcare needs of children into the pre-hospital and hospital healthcare system.

The EMSC State Partnership Program provides funding to support a program of demonstration projects for the expansion and improvement of emergency medical services for children who need treatment for trauma or critical care (Section 1910 of the PHS Act). Long-term success is measured by assessing the quality of pediatric emergency care provided in the pre-hospital and hospital setting, and institutionalizing pediatric emergency care within the larger Emergency Medical Services (EMS) System. Hence, the Program instituted performance measure standards. These standards have guided national efforts to assure that nationally-recommended pediatric equipment are readily available in ambulances; pre-hospital providers receive pediatric-focused training regularly and frequently to assure they are prepared to manage pediatric medical and traumatic emergencies; pre-hospital providers have access to pediatric medical direction whenever needed to assure the right care at the right time; hospitals are equipped to medically-manage pediatric medical and traumatic emergencies; healthcare facilities have well-defined guidelines and clearly understood processes that assure the immediate transfer of children to the most appropriate facility when medically-necessary; and that emergency medical services for children are institutionalized within the State EMS system.

The Program encourages a multifaceted approach to healthcare in project planning, development and implementation that incorporates the full-spectrum; from injury prevention, intervention, tertiary care, rehabilitation and return to the community. This requires community engagement and involvement of key stakeholders. Stakeholders may include a data manager and family representative, as well as representatives from the hospital association, Maternal and Child Health, Rural Health, Highway Safety, EMS, and others responsible for the continuum of care for children in the State.

As key stakeholders at the national level, State family representatives serve as members of the EMSC Program's Family Advisory Network (FAN). FAN representatives help to foster partnerships within their communities to address potential barriers in the delivery of care and support efforts at the national level to assure family- and patient- centered activities are fully

integrated in all EMSC activities. Thus, the inclusion of FAN representatives in project planning, development and implementation supports the Program's global effort to assure community engagement and involvement at all levels.

EMSC partnership grants further opportunities to improve the pediatric readiness of emergency departments and pre-hospital provider systems, as well as assure the alignment of State Partnership collaboratives with the American Indian/Native American and rural communities supported by the EMSC State Partnership Regionalization of Care Demonstration Program.

EMSC investments are synergistic to other HRSA efforts in the Office of Rural Health Policy with increasing pediatric access in rural communities and developing innovative approaches to regionalization of care. EMSC initiatives are integrated with HHS/ASPR efforts in the area of disaster preparedness, and the Office of EMS/DOT to ensure that the EMSC State Partnership grantees are integrated into the overall EMS system of care.

Qualified Applicants: Applications may be submitted by State governments and accredited schools of medicine in States. See Eligibility in section III for additional details.

Number of Grants:	59
Categories:	Three funding categories – Planning, Implementation and Partnership
Funds per year:	Category I - up to $40,000 per year for years 1 and 2, and up to $130,000 per year for years 3 and 4 Categories II and III - up to $130,000 per year for four (4) years
Deadline:	September 26, 2012, 8pm eastern time. Please submit your application early. Applications submitted after the application deadline will not be accepted.
Award Date:	On or prior to March 1, 2013
Project Period:	March 1, 2013 – February 28, 2017

Applicants may obtain information regarding business, administrative, or fiscal issues related to this funding opportunity announcement by contacting the Division of Grants Management Operations, Grants Management Specialist. The Grants Management Specialist assigned to each State may be found in Section VII. Agency Contacts.

Additional information related to the Program may be obtained by contacting the EMSC and Injury Prevention Branch, State Project Officer. The State Project Officer assigned to each State may be found in Section VII. Agency Contacts.

Technical Assistance Call

The Program has scheduled a Technical Assistance Conference Call on Monday, July 16, 2012 at 4:00 pm ET to answer questions related to this funding opportunity announcement. Please dial 866-823-9065 and enter Pass code 1346468#.

Table of Contents

I. Funding Opportunity Description

1. Purpose

This announcement solicits applications for *the Emergency Medical Services for Children State Partnership Grant Program* in one of three categories, Planning, Implementation and Partnership.

The overall mission of the Emergency Medical Services for Children (EMSC) Program is to reduce the prevalence of pediatric morbidity and mortality that may occur as a result of acute illness and severe injury. To accomplish this mission, the EMSC Program works to institutionalize pediatric-centered healthcare programs within States, and promotes the value and importance of Integration. Integrating the pediatric population's emergency healthcare needs and resources will improve the process, access, and delivery of the emergency medical services system to respond, provide intervention, and transport to the most appropriate healthcare facility; and the pediatric-readiness of health institutions to medically manage and adequately treat children in emergency situations all across the country.

The purpose of the EMSC State Partnership Program is to assist States in expanding and improving their capacity to reduce and ameliorate pediatric emergencies, taking special care to include children with special health needs, culturally distinct populations and historically underrepresented groups, including the U.S. Territories, the Freely Associated States, and American Indian/Native Americans. This will be accomplished using existing research-based knowledge, state-of-the-art systems development approaches, and the experience and products of previous EMSC grantees. State Partnership grants are intended to solidify the integration of a pediatric focus within state EMS systems. States are guided by Standards of Achievement through Program-defined Performance Measures. The Performance Measures are the primary goals, objectives and priorities of the EMSC State Partnership Program.

2. Background

This Program is authorized by the Public Health Service Act, Title XIX, §1910 (42 U.S.C. 300w-9), as amended by the Patient Protection and Affordable Care Act, §5603 (P.L 111-148)

The Emergency Medical Services for Children (EMSC) program evolved out of a growing recognition that children have unique needs in emergency situations due to physiological, developmental and psychological differences between adults and children. Central to all Program project activities is assuring that any child, no matter where they live or travel has access to optimal pediatric emergency care; ultimately demonstrated by a reduction in the prevalence of pediatric morbidity and mortality as a result of acute illness or severe injury.

Over the last 28 years, the program has expanded State Partnership funding from demonstration projects to providing funding to 56 States and Territories. The Program anticipates expanding State Partnership funding further in the Freely Associated States and through regionalization efforts in American Indian/Native American and rural communities across the nation.

Grantees have been assessing the quality of pediatric care and recently launched one of the most comprehensive assessments of pediatric emergency care. In 2011, the aggregate grantee data from more than 6,000 EMS agencies demonstrated that approximately 90% of EMS agencies had access to medical direction when treating a pediatric patient; and 4,887 EMS agencies

(representing 22,067 transporting ground vehicles) reported that their BLS/ALS vehicles carried at least 90% of the nationally-recommended pediatric equipment. In the hospital setting, 2,644 hospitals completed an Assessment; 59% reported that they had inter- facility transfer agreements for transfer to a higher level of care and 38% had written transfer guidelines that assured the safe transfer of a pediatric patient.

Applications must be guided by the goals, objectives and priorities of the EMSC StatePartnership Performance Measure Standards which can be found at http://www.childrensnational.org/files/PDF/EMSC/ForGrantees/Performance_Measure_Fact_Sheet_2009.pdf.

II. Award Information

1. Type of Award

Funding will be provided in the form of a grant.

2. Summary of Funding

This program anticipates funding projects beginning in Federal fiscal years 2013 to 2016. Approximately $7,400,000 is expected to be available annually to fund 59 grantees, which includes the 50 States, 6 U.S. Territories and the Freely Associated States.

There are three funding categories – **Planning, Implementation and Partnership**

States may apply for **only one** of the categories and must apply for the most appropriate phase of program development. Please see the categories and corresponding criteria for each phase of development.

Category I Applications will be funded up to $40,000 per year for years 1 and 2, and up to $130,000 per year for years 3 and 4. Category II and Category III Applications will be funded up to $130,000 per year for four (4) years.

Category I: State Planning (New)

Planning grants are intended for States that have never received an EMSC grant and are not at a stage of readiness to initiate a full-scale implementation project. States (or medical schools within those States) that have not received prior EMSC implementation grants are the only applicants eligible for this category. Planning grants are designed to enable a State to assess needs and evaluate pre-hospital and hospital level of readiness specific to the 10 EMSC Performance Measures (later defined in the FOA). Applicants may apply for a ceiling amount of up to $40,000 per year for the first two years of the project, and up to $130,000 per year for the last two years of the project. The project period is four (4) years. Funding beyond the first year is dependent on the availability of appropriated funds for "EMSC" in subsequent fiscal years, grantee satisfactory performance, and a decision that continued funding is in the best interest of the Federal Government.

Category II: State Implementation (New)

Implementation grants are intended for States that have received an EMSC Planning Grant and are ready to initiate a full-scale implementation project to improve the capacity of a State's Emergency Medical Services system to address the particular needs of children. Implementation grants are used to assist States in integrating research-based knowledge and state-of-the-art systems development approaches into the existing State systems. The program components of these grants should reflect the goals set by the EMSC State Partnership Performance Measure Standards found at http://www.childrensnational.org/files/PDF/EMSC/ForGrantees/Performance_Measure_Fact_Sheet_2009.pdf. Depending upon the appropriation of funds, project periods are up to four (4) years. Applicants may apply for a ceiling amount of up to $130,000 per year. The project period is four (4) years. Funding beyond the first year is dependent on the availability of appropriated funds for "EMSC" in subsequent fiscal years, grantee satisfactory performance, and a decision that continued funding is in the best interest of the Federal Government.

Category III: State Partnership (Competing Continuation)

State Partnership grants are intended to improve the capacity of a State's Emergency Medical Services system to address the particular needs of children. State Partnership grants are used to assist States in integrating research-based knowledge and state-of-the- art systems into existing State healthcare systems. The program components of these grants should reflect the goals set by the MCHB Discretionary Grant and EMSC State Partnership Performance Measure Standards found at http://www.childrensnational.org/files/PDF/EMSC/ForGrantees/Performance_Measure_Fact_Sheet_2009.pdf. Depending upon the appropriation of funds, project periods are up to four (4) years. Applicants may apply for a ceiling amount of up to $130,000 per year. The project period is four (4) years. Funding beyond the first year is dependent on the availability of appropriated funds for "EMSC" in subsequent fiscal years, grantee satisfactory performance, and a decision that continued funding is in the best interest of the Federal Government.

III. Eligibility Information

1. Eligible Applicants

State governments and accredited schools of medicine in states are the only eligible applicants for funding under the EMSC Program.

The Emergency Medical Services for Children statute establishes a program for States through a State-designated agency, or to accredited medical schools within States, to support a program of demonstration projects for the expansion and improvement of emergency medical services for children who need treatment for trauma or critical care (Section 1910 of the PHS Act). For purposes of this grant program, the term ``State'' includes the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Northern Mariana Islands, Guam, American Samoa, the Republic of Palau, the Republic of the Marshall Islands, and the Federated States of Micronesia. The term ``school of medicine'' is defined as having the same meaning as set forth in Section 799B of the PHS Act (42 U.S.C. 295p(1)(A)). "Accredited" in this context has the same meaning as set forth in section 799B (1)(E) of the PHS Act (42 U.S.C. 295p(1)(E)).

It is the intent of this grant program to stimulate further development or expansion of ongoing efforts in the States to reduce the problems of life-threatening pediatric trauma and critical illness. It is anticipated that applications will be submitted by the organization responsible for EMS for children, which may be the State Emergency Medical Services (EMS) office. The involvement of the State MCH program in all grant categories is strongly encouraged. Linking EMSC activities with the system of care for children is essentially a key step to successfully integrating the pediatric needs into the entire continuum of care. Such involvement could be demonstrated by a letter of support. If the applicant is a school of medicine or the state MCH program, the application must be endorsed by the State EMS office. The State's endorsement must acknowledge that the applicant has consulted with the State and that the State has been assured that the applicant will work with the State on the proposed project. This endorsement must accompany the application. **Without the endorsement, the application will not be considered for funding.**

Eligible States by Category:

Category I State Planning (New):
Freely Associated States (Republic of Palau, Republic of the Marshall Islands, and the Federated States of Micronesia)

Category II State Implementation (New):
State of Maine

Category III State Partnership (Competing Continuation):
All other States and U.S. Territories not mentioned in categories I and II

2. Cost Sharing/Matching

Cost Sharing/Matching is not required for this program.

3. Other

Applications that exceed the ceiling amount will be considered non-responsive and will not be considered for funding under this announcement.

Any application that fails to satisfy the deadline requirements referenced in *Section IV.3* will be considered non-responsive and will not be considered for funding under this announcement.

NOTE: Multiple applications from an organization **are not** allowable.

IV. Application and Submission Information

1. Address to Request Application Package

Application Materials and Required Electronic Submission Information
HRSA ***requires*** applicants for this funding opportunity announcement to apply electronically through Grants.gov. The registration and application process protects applicants against fraud and ensures that only authorized representatives from an organization can submit an application. Applicants are responsible for maintaining these registrations, which should be completed well in

advance of submitting an application. All applicants ***must*** submit in this manner unless they obtain a written exemption from this requirement in advance by the Director of HRSA's Division of Grants Policy. Applicants must request an exemption in writing from **DGPWaivers@hrsa.gov**, and provide details as to why they are technologically unable to submit electronically through the Grants.gov portal. If requesting a waiver, include the following in the e-mail request: the HRSA announcement number for which the organization is seeking relief, the organization's DUNS number, the name, address, and telephone number of the organization and the name and telephone number of the Project Director as well as the Grants.gov Tracking Number (GRANTXXXX) assigned to the submission along with a copy of the "Rejected with Errors" notification as received from Grants.gov. **HRSA and its Digital Services Operation (DSO) will only accept paper applications from applicants that received prior written approval.** However, the application must still be submitted by the deadline. Suggestion: submit application to **Grants.gov at least two days before the deadline to allow for any unforeseen circumstances.**

IMPORTANT NOTICE: CCR to be moved to SAM at the end of July 2012

The General Services Administration (GSA) is moving the implementation date of the System for Award Management (SAM) from May 29, 2012 to the end of July 2012. The additional sixty days will allow Federal agencies to continue preparing their staff, give agencies and commercial system providers even more time to test their data transfer connections, and will ensure SAM contains the critical, documented capabilities users need from the system.

This first phase of SAM will include the capabilities of Central Contractor Registration (CCR)/Federal Agency Registration (FedReg), Online Representations and Certifications Application (ORCA), and the Excluded Parties List System (EPLS). In preparation for the launch, GSA conducted extensive testing internally and in coordination with Federal agencies using the data from these systems in their own contracting, grants, finance, and other departments. The testing was very valuable and will focus the efforts of the next sixty days.

SAM will reduce the burden on those seeking to do business with the government. Vendors will be able to log into one system to manage their entity information in one record, with one expiration date, through one streamlined business process. Federal agencies will be able to look in one place for entity pre-award information. Everyone will have fewer passwords to remember and see the benefits of data reuse as information is entered into SAM once and reused throughout the system.

Active CCR registration is a pre-requisite to the successful submission of grant applications!

Grants.gov strongly suggests visiting CCR prior to this change and checking the account status. Some things to consider are:

- When does the account expire?
- Does the organization need to complete the annual renewal of registration?
- Who is the eBiz POC? Is this person still with the organization?
- Does anything need to be updated?

To learn more about the switch from CCR to SAM, more information is available at https://www.bpn.gov/ccr/NewsDetail.aspx?id=2012&type=N. To learn more about SAM, please visit https://www.sam.gov.

Note: CCR or SAM information must be updated at least every 12 months to remain active (for both grantees and sub-recipients). As of August 9, 2011, Grants.gov began rejecting submissions from applicants with expired CCR registrations. This systematic enforcement will likely catch some applicants off guard. According to: the CCR Website it can take 24 hours or more for updates to take effect; or SAM Quick Guide for Grantees (https://www.sam.gov/sam/transcript/SAM_Quick_Guide_Grants_Registrations-v1.6.pdf), an entity's registration will become active after 3-5 days Therefore, ***check for active registration well before the grant deadline.***

An applicant can view their CCR Registration Status by visiting http://www.bpn.gov/CCRSearch/Search.aspx and searching by their organization's DUNS number. The CCR Website provides user guides, renewal screen shots, FAQs and other resources.

Applicants that fail to allow ample time to complete registration with CCR (prior to late July 2012) / SAM (starting late July 2012) and/or Grants.gov will not be eligible for a deadline extension or waiver of the electronic submission requirement.

All applicants are responsible for reading the instructions included in HRSA's *Electronic Submission User Guide,* available online at http://www.hrsa.gov/grants/apply/userguide.pdf. This Guide includes detailed application and submission instructions for both Grants.gov and HRSA's Electronic Handbooks. Pay particular attention to **Sections 2 and 5** that provide detailed information on the competitive application and submission process.

Applicants are also responsible for reading the Grants.gov Applicant User Guide, available online at http://www.grants.gov/assets/ApplicantUserGuide.pdf. This Guide includes detailed information about using the Grants.gov system and contains helpful hints for successful submission.

Applicants must submit proposals according to the instructions in the Guide and in this funding opportunity announcement in conjunction with Application Form SF-424. The forms contain additional general information and instructions for applications, proposal narratives, and budgets. The forms and instructions may be obtained by:

- Downloading from http://www.grants.gov, or
- Contacting the HRSA Digital Services Operation (DSO) at: HRSADSO@hrsa.gov

Each funding opportunity contains a unique set of forms and only the specific forms package posted with an opportunity will be accepted. Specific instructions for preparing portions of the application that must accompany Application Form SF-424 appear in the "Application Format Requirements" section.

2. Content and Form of Application Submission

Application Format Requirements

The total size of all uploaded files may not exceed the equivalent of 80 pages when printed by HRSA. The total file size may not exceed 10 MB. The 80-page limit includes the abstract, project and budget narratives, attachments, and letters of commitment and support. Standard forms are NOT included in the page limit. **HRSA strongly urges applicants to print their application to ensure it does not exceed the 80-page limit. Do not reduce the size of the fonts or margins to**

save space. See the formatting instructions in Section 5 of the Electronic Submission User Guide referenced above.

Applications must be complete, within the 80-page limit, within the 10 MB limit, and submitted prior to the deadline to be considered under this announcement.

Application Format
Applications for funding must consist of the following documents in the following order:

SF-424 Non-Construction – Table of Contents

- It is mandatory to follow the instructions provided in this section to ensure that the application can be printed efficiently and consistently for review.
- Failure to follow the instructions may make the application non-responsive. Non-responsive applications will not be considered under this funding opportunity announcement.
- For electronic submissions, applicants only have to number the electronic attachment pages sequentially, resetting the numbering for each attachment, i.e., start at page 1 for each attachment. Do not attempt to number standard OMB approved form pages.
- For electronic submissions, no Table of Contents is required for the entire application. HRSA will construct an electronic table of contents in the order specified.

Application Section	Form Type	Instruction	HRSA/Program Guidelines
Application for Federal Assistance (SF-424)	Form	Pages 1, 2 & 3 of the SF-424 face page.	Not counted in the page limit
Project Summary/Abstract	Attachment	Can be uploaded on page 2 of SF-424 - Box 15	Required attachment. Counted in the page limit. Refer to the funding opportunity announcement for detailed instructions.
Additional Congressional District	Attachment	Can be uploaded on page 3 of SF-424 - Box 16	As applicable to HRSA; Counted in the page limit.
Project Narrative Attachment Form	Form	Supports the upload of Project Narrative document	Not counted in the page limit.
Project Narrative	Attachment	Can be uploaded in Project Narrative Attachment form.	Required attachment. Counted in the page limit. Refer to the funding opportunity announcement for detailed instructions. Provide table of contents specific to this document only as the first page.
SF-424A Budget Information - Non-Construction Programs	Form	Pages 1–2 to support structured budget for the request of Non-construction related funds.	Not counted in the page limit.
Budget Narrative Attachment Form	Form	Supports the upload of Project Narrative document.	Not counted in the page limit.
Budget Narrative	Attachment	Can be uploaded in Budget Narrative Attachment form.	Required attachment. Counted in the page limit. Refer to the funding opportunity announcement for detailed instructions.
SF-424B Assurances - Non-Construction Programs	Form	Supports assurances for non-construction programs.	Not counted in the page limit.
Project/Performance Site Location(s)	Form	Supports primary and 29 additional sites in structured form.	Not counted in the page limit.
Grants.gov Lobbying Form	Form	Complete this form online per the instructions embedded in the form.	Not counted in the page limit

Additional Performance Site Location(s)	Attachment	Can be uploaded in the SF-424 Performance Site Location(s) form. Single document with	Counted in the page limit.
Disclosure of Lobbying Activities (SF-LLL)	Form	Supports structured data for lobbying activities.	Not counted in the page limit.
Attachments Form	Form	Supports up to 15 numbered attachments. This form only contains the attachment list.	Not counted in the page limit.
Attachment 1-15	Attachment	Can be uploaded in Other Attachments form 1-15.	Refer to the attachment table provided below for **specific** sequence. Counted in the page limit.

- To ensure that attachments are organized and printed in a consistent manner, follow the order provided below. Note that these instructions may vary across programs.
- Evidence of Non-Profit status and invention related documents, if applicable, must be provided in the other attachment form.
- Additional supporting documents, if applicable, can be provided using the available rows. Do not use the rows assigned to a specific purpose in the program funding opportunity announcement.
- Merge similar documents into a single document. Where several documents are expected in the attachment, ensure that a table of contents cover page is included specific to the attachment. The Table of Contents page will not be counted in the page limit.
- Limit the file attachment name to under 50 characters. Do not use any special characters (e.g., %, /, #) or spacing in the file name or word separation. (The exception is the underscore (_) character.) Attachments will be rejected by Grants.gov if special characters are included or attachment names exceed 50 characters.

Attachment Number	Attachment Description (Program Guidelines)
Attachment 1	Staffing Plan and Job Descriptions for Key Personnel
Attachment 2	Biographical Sketches of Key Personnel
Attachment 3	Letters of Agreement and/or Descriptions(s) of Proposed/Existing Contracts
Attachment 4	Project Organizational Chart
Attachment 5	Summary Progress Report (applicable to Category III Applicants only)
Attachment 6	Letters of Support from Key Stakeholders
Attachment 7	Letter of Endorsement/Designation (if applicable)
Attachment 8	EMSC Performance Report 2011 (applicable to Category III Applicants only)
Attachments 9-15	Other attachments, as necessary

Application Format

i. Application Face Page

Complete Application Form SF-424 provided with the application package. Prepare according to instructions provided in the form itself. Important note: enter the name of the **Project Director** in 8. f. "Name and contact information of person to be contacted on matters involving this application." If, for any reason, the Project Director will be out of the office, please ensure the email Out of Office Assistant is set so HRSA will be aware if any issues arise with the application and a timely response is required. For information pertaining to the Catalog of Federal Domestic Assistance, the CFDA Number is 93.127.

DUNS Number

All applicant organizations (and subrecipients of HRSA award funds) are required to have a Data Universal Numbering System (DUNS) number in order to apply for a grant or cooperative agreement from the Federal Government. The DUNS number is a unique nine-character identification number provided by the commercial company, Dun and Bradstreet. There is no charge to obtain a DUNS number. Information about obtaining a DUNS number can be found at http://fedgov.dnb.com/webform or call 1-866-705-5711. Please include the DUNS number in form SF-424 - item 8c on the application face page. Applications ***will not*** be reviewed without a DUNS number. Note: A missing or incorrect DUNS number is the number one reason for applications being "Rejected for Errors" by Grants.gov. HRSA will not extend the deadline for applications with a missing or incorrect DUNS number. Applicants should take care in entering the DUNS number in the application.

Additionally, the applicant organization (and any subrecipient of HRSA award funds) is required to register annually with the Central Contractor Registration (CCR) (soon to be SAM) in order to conduct electronic business with the Federal Government. CCR (or SAM) registration must be maintained with current, accurate information at all times during which an entity has an active award or an application or plan under consideration by HRSA. It is extremely important to verify that the applicant organization's CCR registration is active and the Marketing Partner ID Number (MPIN) is current. Information about registering with the CCR can be found at http://www.ccr.gov. Please see Section IV of this funding opportunity announcement for IMPORTANT NOTICE: CCR to be moved to SAM at the end of July 2012.

ii. Table of Contents

The application should be presented in the order of the Table of Contents provided earlier. Again, for electronic applications no table of contents is necessary as it will be generated by the system. (Note: the Table of Contents will not be counted in the page limit.)

iii. Budget

Complete Application Form SF-424A Budget Information – Non-Construction Programs form provided with the application package. Please complete Sections A, B, E, and F included with the application kit **for each year** of the project period, and then provide a line item budget using Section B Object Class Categories of the SF-424A.

In Section A use rows 1 - 4 to provide the budget amounts for the first four years of the project. Please enter the amounts in the "New or Revised Budget" column- not the "Estimated Unobligated Funds" column. In Section B Object Class Categories of the SF-424A, provide the object class category breakdown for the annual amounts specified in Section A. In Section B, use column (1) to provide category amounts for Year 1 and use columns (2) through (4) for subsequent budget years (up to four years). Be very careful about showing how each item in the "other" category is justified. For subsequent budget years, the justification narrative should highlight the changes from year one or clearly indicate that there are no substantive budget changes during the project period. The budget justification MUST be concise. Do NOT use the justification to expand the project narrative.

Salary Limitation:
The Consolidated Appropriations Act, 2012 (P.L. 112-74) enacted December 23, 2011, limits the salary amount that may be awarded and charged to HRSA grants and cooperative agreements. Award funds may not be used to pay the salary of an individual at a rate in excess of Executive Level II. The Executive Level II salary of the Federal Executive Pay scale is $179,700. This amount reflects an individual's base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to the applicant organization. This salary limitation also applies to subawards/subcontracts under a HRSA grant or cooperative agreement.

As an example of the application of this limitation: If an individual's base salary is $350,000 per year plus fringe benefits of 25% ($87,500) and that individual is devoting 50% of their time to this award, their base salary should be adjusted to $179,700 plus fringe of 25% ($44,925) and a total of $112,312.50 may be included in the project budget and charged to the award in salary/fringe benefits for that individual. See the breakdown below:

Individual's *actual* base full time salary: $350,000 50% of time will be devoted to project	
Direct salary	$175,000
Fringe (25% of salary)	$43,750
Total	$218,750
Amount that may be claimed on the application budget due to the legislative salary limitation: Individual's base full time salary *adjusted* to Executive Level II: $179,700	
50% of time will be devoted to the project	
Direct salary	**$89,850**
Fringe (25% of salary)	**$22,462.50**
Total amount	**$112,312.50**

iv. Budget Justification

Budget Justification requirements apply to all Application Categories (I, II and III), unless noted otherwise. Specific requirements that may apply to each Application category, I, II or III, are included within each budget item section.

Budget for Multi-Year Award

This announcement is inviting applications for project periods up to four (4) years for all categories. Awards, on a competitive basis, will be for a one-year budget period; although the project period may be up to four (4) years. Submission and HRSA approval of the Progress Report(s) and any other required submission or reports is the basis for the budget period renewal and release of subsequent year funds. Funding beyond the one-year budget period but within the four (4) year project period is subject to availability of funds, satisfactory progress of the awardee, and a determination that continued funding would be in the best interest of the Federal Government.

The budget justification should clearly describe how each item will support the achievement of proposed objectives. Each budget period is for twelve months. The project period is from March 1, 2013 to February 28, 2017.

Use the budget periods and corresponding fiscal years when preparing your budgets.

Year 1	March 1, 2013 to February 28, 2014	Fiscal Year 2013
Year 2	March 1, 2014 to February 28, 2015	Fiscal Year 2014
Year 3	March 1, 2015 to February 28, 2016	Fiscal Year 2015
Year 4	March 1, 2016 to February 28, 2017	Fiscal Year 2016

All application categories, I, II and III, are encouraged to show that the proposed activities and associated costs **clearly demonstrate the active engagement of a Family Advisory Network (FAN) representative** in project development and implementation (reference MCHB DGIS Performance Measures 7 and 10). Thus, related activities and cost associated with the proposed activities that assure the engagement of a FAN representative may be included. A FAN representative must be named and a description of the person's background must be provided in the Project Narrative, Organizational Information section.

Category I State Planning (New) - Applicants **must** submit four (4) twelve month budgets, each totaling up to $40,000 per year for Years 1 and 2, and each totaling up to $130,000 per year for Years 3 and 4, at the time of application. In the first year, Category I Applicants will be required to conduct a Needs Assessment. The purpose of the Needs Assessment is to evaluate the degree to which the Applicant's healthcare system has established the components of the EMSC State Partnership Performance Measure Standards to understand baseline needs. Applicants will be required to consult with their State's NEDARC representative regarding the process and timeline to conduct the Needs Assessment. In the second year, Category I Applicants will be required to develop a Strategic Plan to address the gaps identified in the Needs Assessment. In years 3 and 4, Category I Applicants should be moving toward implementation activities. The proposed budget narrative must clearly account for these required activities.

Categories II State Implementation (New) - Applicants **must** submit four (4) twelve month budgets, each totaling up to $130,000 per year for Years 1, 2, 3 and 4 at the time of application. Category II Applicants will be required to conduct a Needs Assessment and Reassessment. The purpose of Assessment and Reassessment is to evaluate the degree to which the Applicant's healthcare system has established the components of the EMSC State Partnership Performance Measure Standards found at http://www.childrensnational.org/files/PDF/EMSC/ForGrantees/Performance_Measure_Fact_Sheet_2009.pdf to understand baseline needs and to measure progress. Applicants will be required to consult with their State's NEDARC representative regarding the process and timeline to conduct the Needs Assessment and Reassessment. In addition, Applicants will be required to focus activities toward the achievement of the EMSC Performance Measures. Proposed project activities and sufficient resources must be directed toward efforts to achieve the Program Performance Measures. The proposed budget narrative must clearly account for the required activities.

Subject to the Program review and approval: Other activities may be proposed, provided efforts and sufficient resources have been directed to the Program Performance Measures first and foremost. Other project activities may be included but must relate to a pediatric topic. The pediatric topic may be in the field of Injury Prevention, Disaster Preparedness, and others that impact the quality of pre-hospital and hospital care for children. Funds of up to 10% may be allocated for other project activities. Please ensure that the proposed activity is clearly explained in the project narrative within the required sections (Introduction, Needs Assessment, Methodology, Work Plan, Resolution of Challenges, Evaluation and Technical Support Capacity).

Note: Pediatric Education, Pediatric Emergency Department Readiness and Pediatric Regionalization project activities are directly related to PM 74, 75 and 78 and are not considered Other Activities.

Category III State Partnership (Competing Continuations) - Applicants **must** submit four (4) twelve month budgets, each totaling up to $130,000 per year for Years 1, 2, 3 and 4 at the time of application. The budget justification and activities proposed must be consistent with the EMSC Program Performance Measures. Applicants must clearly demonstrate progress toward achieving each of the Program Performance Measures (71-80). Category III Applicants will be required to conduct a Reassessment to evaluate progress. The purpose of the Reassessment is to evaluate the degree to which the Applicant's healthcare system has established the components of the EMSC State Partnership Performance Measure Standards and measure progress. Applicants will be required to consult with their State's NEDARC representative regarding the process and timeline to conduct the Needs Assessment. In addition, Applicants will be required to focus activities toward the achievement of the EMSC Performance Measures. Proposed project activities and sufficient resources must be directed toward efforts to achieve the Program Performance Measures. The proposed budget narrative must clearly account for the required activities.

Subject to the Program review and approval: Other activities may be proposed, provided efforts and sufficient resources have been directed to the Program Performance

Measures first and foremost. Other project activities may be included but must relate to a pediatric topic. The pediatric topic may be in the field of Injury Prevention, Disaster Preparedness, and others that impact the quality of pre-hospital and hospital care for children. Funds of up to 10% may be allocated for other project activities. Please ensure that the proposed activity is clearly explained in the project narrative within the required sections (Introduction, Needs Assessment, Methodology, Work Plan, Resolution of Challenges, Evaluation and Technical Support Capacity).

Note: Pediatric Education, Pediatric Emergency Department Readiness and Pediatric Regionalization project activities are directly related to PM 74, 75 and 78 and are not considered Other Activities.

Include a Budget Spreadsheet and Narrative organized by the following budget categories: Personnel Costs, Fringe Benefits, Travel, Equipment, Supplies, Contractual, Other, and Indirect Costs.

***Personnel Costs**:* Personnel costs should be explained by listing each staff member who will be supported from funds, name (if possible), position title, percentage of full-time equivalency, and annual salary. Reminder: Award funds may not be used to pay the salary of an individual at a rate in excess of Executive Level II or $179,700. An individual's base salary, per se, is NOT constrained by the legislative provision for a limitation of salary. The rate limitation simply limits the amount that may be awarded and charged to HRSA grants and cooperative agreements. A Key Personnel and Biographical Sketch must be completed for all key personnel. Both forms may be found on the EMSC National Resource Center's Grant Writing Resources page; here is a direct link to the forms: Grant Writing Resources at http://www.childrensnational.org/EMSC/ForGrantees/GrantsManagement/Grant-Writing-Resources.aspx. Please provide an individual's actual base salary if it exceeds the cap.

See the sample below:

Sample:

Name	Position Title	% of FTE	Annual Salary	Amount Requested
J. Smith	Chief Executive Officer	50	$179,700*	$89,850
R. Doe	Nurse Practitioner	100	$75,950	$75,950
D. Jones	Data/AP Specialist	25	$33,000	$8,250

*Actual annual salary = $350,000

Category I – State Planning (New)
Funds may be used to hire staff to assist in the Needs Assessment; obtain technical assistance from national, State, regional or local resources; help formulate a State plan for the integration of EMSC services into the existing State EMS plan; and plan a more comprehensive grant proposal based upon a Needs Assessment performed during the planning grant project period. A comprehensive approach, addressing physical, psychological, and social aspects of EMSC along the

continuum of care, should be reflected. An ongoing working relationship with Federal EMSC program staff and resource center staff, beginning with the initiation of a planning grant application, is desirable.

Category II and III – State Implementation (New) and State Partnership (Competing Continuation)
Applicants must budget for a **full-time program manager** to oversee the program. **EMSC Federal funds do not need to be the primary source of funding for an EMSC program manager position**. However, a full-time (40 hours per week) program manager must be designated/assigned to the EMSC program. Please indicate the full salary of the EMSC program manager position, the name of the program manager, the percent of time and salary that will be paid by EMSC Federal funds, as well as the percent of time and salary that will be paid by other sources to support a 100% full-time equivalent program manager. Include all funding sources and a detailed scope of work for the program manager. If a program manager position is dependent upon successful grant award of the EMSC Grant Program, please include a plan for hire, proposed budget for the position (pro-rated), and the job description (reference performance measure 79).
Applicants may also budget for a **part-time FAN representative** to assure that patient-centered and culturally-competent approaches in the delivery of care remain central in planning, development and implementation of EMSC projects. A few examples of Program-related FAN activities may be found in the EMSC Toolkit for FAN Representatives.

Here is an example:
Jane Doe, EMSC Program Manager, $55,000 per annum, full time. Ms. Doe is dedicated 100% to the EMSC Program. The position is supported 50% through the State's local general fund and 50% by the EMSC Federal grant program **($27,500).**

Fringe Benefits*:* List the components that comprise the fringe benefit rate, for example health insurance, taxes, unemployment insurance, life insurance, retirement plans, and tuition reimbursement. The fringe benefits should be directly proportionate to that portion of personnel costs that are allocated for the project. (If an individual's base salary exceeds the legislative salary cap, please adjust fringe accordingly.)

Travel*:* Funds may be used for travel to meetings, workshops, or other activities that would support efforts to improve the quality of pediatric EMS care in your State. List costs by local and out-of-state travel. For local travel, the mileage rate, number of miles, reason/purpose for travel and staff member/advisory member/FAN representative completing the travel should be outlined. For out-of-state, the budget should reflect the travel expenses (such as airfare, per diem, transportation, etc.), the role of the individual(s) traveling, the reason/purpose of attending, and the expected impact as a result of attending.

Category I State Planning (New) Applicants - The applicant is required to budget for attendance at Program-sponsored meetings, specifically the EMSC Program Manager and EMSC Program meetings; both held biennially.

- **The EMSC Program Managers Meeting**. EMSC State Partnership grant award recipients are required to attend the biennial EMSC Program Manager's Meeting in Year 1 and 3. Applicants must budget for at least one program representative (preferably the program manager) to attend the meeting for technical assistance. The intent of the EMSC Program Manager meeting is to share knowledge, engage in regional collaborative learning exchanges to support State efforts to implement EMSC Performance Measures, and for knowledge translation and dissemination in all fields that may impact the delivery of pediatric healthcare in the States. Budget estimates should include travel costs to the Washington, D.C. area for at least 4 nights/5 days

- **The EMSC Program Meeting.** EMSC State Partnership grant award recipients are required to attend the EMSC Program Meeting in Year 2 and 4. The purpose of the EMSC Program Meeting is to assure new developments related to pediatrics is disseminated, grantees are trained on grants and program management requirements, full participation in mentorship sessions and in-person consultations, an active engagement in methodical discussions on pediatric regionalization activities and processes, and an increased knowledge and skill related to the EMSC performance measures, as well as other healthcare related educational sessions to support grantees efforts to achieve positive outcomes. Applicants must budget for the anticipated costs for at least one Program representatives (preferably the program manager) to attend the meeting. Include anticipated costs for travel to the Washington, D.C. area for at least 4 nights/5 days. The Program anticipates holding the biennial meeting in conjunction with one of the partnering national organizations. Approximate hotel rates for the Washington, D.C. area are $250 per night.

- Category I Applicants may also budget for attendance at a Program-sponsored Technical Assistance workshop, specifically the **National EMSC Data Analysis Resource Center (NEDARC) Technical Assistance workshop.** Category I Applicants have the option to attend at least one NEDARC technical assistance workshop in Years 1 and 2, but are required to attend at least one NEDARC workshop in Years 3 and 4. It is critical that each State or Territory improve its capacity to collect and analyze data. Applicants have the option to budget sufficient funds to cover travel expenses for at least one person to attend a two-day workshop hosted by the National EMSC Data Analysis Resource Center (NEDARC); this is optional in Years 1 and 2, but required in Years 3 and 4. These workshops emphasize the use of EMS data to drive quality improvement, data collection and analysis to support informed public policy decisions, and integration and linkage of EMS data with other state health data sources. Three to four NEDARC workshops will be available in selected sites around the United

States each fiscal year, and grantees or a designated representative may plan to participate in a workshop best suited to meet their needs. NEDARC will provide upcoming workshop information through the EMSC website at http://www.nedarc.org as it becomes available.

Category II State Implementation and Category III State Partnership Applicants - The applicant is **required** to budget for and attend Program-sponsored meetings and at least one Technical Assistance Workshop. Specifically:

- **The EMSC Program Managers Meeting**. EMSC State Partnership grant award recipients are required to attend the biennial EMSC Program Manager's Meeting in Years 1 and 3. The intent of the EMSC Program Manager meeting is to share knowledge, engage in regional collaborative learning exchanges that support State efforts to implement EMSC Performance Measures, and for knowledge translation and dissemination in all fields that may impact the delivery and impact of pediatric healthcare in the States. Applicants must budget for at least two program representatives (the program manager and FAN representative) to attend the meeting. Estimated costs should include travel to the Washington, D.C. area for at least 4 nights/5 days.

- **The EMSC Program Meeting.** EMSC State Partnership grant award recipients are required to attend the biennial EMSC Program Meeting in Years 2 and 4 of the Project Period. The purpose of the EMSC Program Meeting is to assure new developments related to pediatrics is disseminated, grantees are trained on grants and program management requirements, full participation in mentorship sessions and in-person consultations, an active engagement in methodical discussions on pediatric regionalization activities and processes, and an increased knowledge and skill related to the EMSC performance measures, as well as other healthcare related educational sessions to support grantees efforts to achieve positive outcomes. Applicants must budget for the anticipated costs of at least three Program representatives (preferably the project director or EMSC medical director, program manager and FAN representative) to attend the meeting for technical assistance. Should any of the representatives be unable to attend, an **active** member of the State's EMSC Advisory Committee is recommended. Include anticipated costs for travel to the Washington, D.C. area for at least 4 nights/5 days. The Program anticipates holding the biennial meeting in conjunction with one of the partnering national organizations. Approximate hotel rates for the Washington, D.C. area are $250 per night.

- **A National EMSC Data Analysis Resource Center (NEDARC) Technical Assistance workshop.** EMSC State Partnership grant award recipients are required to budget for and attend at least one NEDARC technical assistance workshop **each year** during the Project Period. It is critical that each State or Territory improve its

capacity to collect and analyze data about EMS/EMSC outcomes. With this aim in mind, Partnership grants must budget sufficient funds to cover travel expenses for at least one person to attend a two-day workshop hosted by the National EMSC Data Analysis Resource Center (NEDARC). Applicants are encouraged to budget approximately $1,500 per person per year. These workshops will emphasize the use of EMS data to drive quality improvement, data collection and analysis to support informed public policy decisions, and integration and linkage of EMS data with other state health data sources. Three to four NEDARC workshops will be available in selected sites around the United States each fiscal year, and grantees or a designated representative should plan to participate in a workshop they feel is best suited for their needs. NEDARC will provide upcoming workshop information through the EMSC website as it becomes available.

State EMSC Advisory Committee meetings. **All Applicant categories** should budget for costs associated with conducting EMSC Advisory Committee meetings each year. The Federal EMSC Program requires grantees to meet with their EMSC Advisory Committees at least four times per year, with at least one of the meetings in-person (reference performance measure 79). Cost should be budgeted for at least one in-person EMSC Advisory Committee meeting.

Equipment: List equipment costs and provide justification for the need of the equipment to carry out the program's goals. Extensive justification and a detailed status of current equipment must be provided when requesting funds for the purchase of computers and furniture items that meet the definition of equipment (a unit cost of $5,000 or more and a useful life of one or more years). Equipment items must be described in clear detail and include the purpose and how it will contribute to the overall goal of the project. Per HHS Policy statement, prior approval is required for equipment items that exceed $25,000.

Examples of equipment to support the activities of this grant may include items related to the development and creation of medical facilities to address telemedicine options or items to improve pediatric transport systems. Some equipment items may include electronics to support telemedicine consulting, equipment to support webinars or internet live communication systems similar to Skype or office communicator for educational seminars or to create communication systems to reach the entire State, pediatric equipment bags or supplies for clinics or transport vehicles, and other items directly related to improving communication and access to quality pediatric healthcare services.

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

may be needed to support the activities of this grant may include electronics (below $5000 per unit cost) to support medical direction and educational consulting, items to support training webinars or internet live communication systems similar to Skype or office communicator for educational seminars or to create communication systems to reach the entire State, pediatric equipment bags or supplies for clinics or transport vehicles, and other items directly related to improving communication and access to quality pediatric healthcare services. **No promotional items may be included**.

Contractual: Applicants are responsible for ensuring that their organization or institution has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring all contracts. Examples of contractual costs could include contractual services for a **FAN representative** and **pediatric medical director**. **FAN representatives** help to foster partnerships and community engagement; and a **pediatric medical director** provides pediatric-focused medical oversight and quality assurance. See the Project Narrative, Work Plan section for examples of FAN-related activities. A few other examples of Program-related activities may be found in the EMSC Toolkit for FAN Representatives. Applicants must provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. Reminder: recipients must notify potential subrecipients that entities receiving subawards must be registered in CCR (or SAM starting in late July 2012 – see Section IV of this document for more SAM details) and provide the recipient with their DUNS number. **No promotional items may be included**.

Other: Put all costs that do not fit into any other category into this category and provide an explanation of each cost in this category. In some cases, rent, utilities and insurance fall under this category if they are not included in an approved indirect cost rate. Other examples include: Stipend funds to reimburse **FAN representatives** for attendance at meetings, travel expenses, cell phone usage at EMSC related, community-based activities, parking, etc.

Applicants may include the cost of access accommodations as part of their project's budget, including sign interpreters, plain language and health literate print materials in alternate formats (including Braille, large print, etc.); and cultural/linguistic competence modifications such as use of **FAN representatives**, translation or interpretation services at meetings, services for review of materials for dissemination, clinical encounters, and conferences, etc.

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

offices which negotiate them. **This program is not a research project in and of itself; therefore, it is not eligible for research indirect rates.** The indirect cost rate refers to the "Other Sponsored Program/Activities" rate and to neither the research rate, nor the education/training program rate. Those applicants without an established indirect cost rate for "other sponsored programs" may only request 10% of salaries and wages, and must request an "other sponsored programs" rate from DCA. Direct cost amounts for equipment (capital expenditures), tuition and fees, and contracts in excess of $25,000 are excluded from the actual direct cost base for purposes of this calculation.

v. Staffing Plan and Personnel Requirements

Applicants must present a staffing plan and provide a justification for the plan that includes education and experience qualifications and rationale for the amount of time being requested for each staff position. Position descriptions that include the roles, responsibilities, and qualifications of proposed project staff must be included in Attachment 1. Biographical sketches for any key employed personnel that will be assigned to work on the proposed project must be included in Attachment 2. When applicable, biographical sketches should include training, language fluency and experience working with the cultural and linguistically diverse populations that are served by their programs.

vi. Assurances

Complete Application Form SF-424B Assurances – Non-Construction Programs provided with the application package.

vii. Certifications

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

viii. Project Abstract

The project abstract must be single-spaced and limited to one page in length**.** Provide a summary of the application. Because the abstract is often distributed to provide information to the public and Congress, please prepare this so that it is clear, accurate, concise, and without reference to other parts of the application. It must include a brief description of the proposed project including the needs to be addressed, the proposed services, and the population group(s) to be served.

Please place the following at the top of the abstract:

- Project Title
- Applicant Organization Name
- Address
- Project Director Name
- Contact Phone Numbers (Voice, Fax)
- E-Mail Address
- Web Site Address, if applicable

Abstract content:

PROBLEM: Briefly (in one or two paragraphs) state the principal needs and problems which are addressed by the project.

GOAL(S) AND OBJECTIVES: Identify the major goal(s) and objectives for the project period. Typically, the goal is stated in a sentence or paragraph, and the objectives are presented in a numbered list.

METHODOLOGY: Describe the programs and activities used to attain the objectives and comment on innovation, cost, and other characteristics of the methodology. This section is usually several paragraphs long and describes the activities which have been proposed or are being implemented to achieve the stated objectives. Lists with numbered items are sometimes used in this section as well.

COORDINATION: Describe the coordination planned with appropriate national, regional, State and/or local health agencies and/or organizations in the area(s) served by the project.

EVALUATION: Briefly describe the evaluation methods used to assess program outcomes and the effectiveness and efficiency of the project in attaining goals and objectives. This section is usually one or two paragraphs in length.

ANNOTATION: Provide a three- to - five-sentence description of your project that identifies the project's purpose, the needs and problems, which are addressed, the goals and objectives of the project, the activities, which will be used to attain the goals and the materials which will be developed.

ix. Project Narrative

This section provides a comprehensive framework and description of all aspects of the proposed project. It should be succinct, self-explanatory and well organized so that reviewers can understand the proposed project.

Category I State Planning - Category I Applicants will be required to conduct a Needs Assessment in partnership with NEDARC to evaluate the degree to which the Applicant's healthcare system has established the components of the EMSC State Partnership Performance Measure Standards to understand baseline needs. Applicants will be required to consult with their State's NEDARC representative regarding the process and timeline anticipated to conduct the Needs Assessment. In the second year, Applicants will be required to develop a Strategic Plan in partnership with the HRSA Project Officer and State key stakeholders to address the gaps identified in the Needs Assessment. Please ensure that these activities are included in the project narrative within the appropriate sections.

Category II State Implementation and Category III State Partnership Applicants will be required to conduct a Reassessment in partnership with NEDARC to evaluate progress. The purpose of the Reassessment is to evaluate the degree to which the Applicant's healthcare system has established the components of the EMSC State Partnership Performance Measure Standards. Applicants will be required to consult with their State NEDARC representative regarding the process and timeline anticipated to conduct the Reassessment. Please ensure that these activities are included in the project narrative within the appropriate sections.

Applicants will be required to focus activities toward the achievement of the EMSC Performance Measures. Proposed project activities and sufficient resources must be directed toward efforts to achieve the Program Performance Measures.

Subject to Program review and approval: Other activities may be proposed by Category II and III Applicants, provided efforts and sufficient resources have been directed to the EMSC State Partnership Performance Measure Standards first and foremost. Other project activities must relate to a pediatric topic. The pediatric topic may be in the field of Injury Prevention, Disaster Preparedness, and others that impact the quality of pre-hospital and hospital care for children. The proposed activity must be clearly explained in the project narrative, specifically the introduction, needs assessment, methodology, work plan, resolution of challenges, and the evaluation and technical support capacity sections. *Note: Pediatric Education, Pediatric Emergency Department Readiness and Pediatric Regionalization project activities are directly related to PM 74, 75 and 78 and are not considered Other Activities.*

Use the **section headers** for the Project Narrative in the following order:

I. Introduction
II. Needs Assessment
III. Methodology
IV. Work Plan
V. Resolution of Challenges
VI. Evaluation and Technical Support Capacity
VII. Organization Information

ADDITIONAL NARRATIVE GUIDANCE This table provides a bridge between the narrative language and where each section falls within the review criteria.	
Narrative Section	**Review Criteria**
Introduction	(1) Need
Needs Assessment	(1) Need
Methodology	(2) Response
Work Plan	(2) Response & (4) Impact

Resolution of Challenges	(2) Response
Evaluation and Technical Support Capacity	(3) Evaluative Measures & (5) Resources/Capabilities
Organizational Information	(5) Resources/Capabilities
Budget Narrative	(6) Support Requested – the budget section should include sufficient justification to allow reviewers to determine the reasonableness of the support requested.

▪***INTRODUCTION***

This section should briefly describe the State's healthcare system and purpose of the proposed project. Key information may include the number of hospitals (to include critical access hospitals) and EMS agencies in the State; number of EMS patient transports per year and of those transports how many were pediatric patients up to 18 years of age; the five most common types of severe injury and acute illnesses within the pediatric population (up to 18 years of age) category; the number of Emergency Department (ED) visits and of those visits, how many were pediatric patients up to 18 years of age; and any other information that may help to describe the State's healthcare system and the prevalence of pediatric illness and injury in the State. If this information is not known at this time, please include details that are available to help describe the healthcare system in the State.

▪***NEEDS ASSESSMENT***

This section outlines the healthcare needs of the State, as well as the needs related to the EMSC State Partnership Performance Measure Standards. This section should help reviewers understand the gaps in care identified by the EMSC performance measures, the current state of your system and any relevant barriers in the service areas that the project hopes to overcome.

Category I and II Applicants, include the current needs of your pre-hospital and hospital healthcare system, such as whether or not pediatric medical direction is accessible when needed, pediatric equipment is carried on the ambulances, EMS and hospital healthcare professionals receive pediatric-focused training frequently or the lack thereof, hospitals are prepared to treat pediatric medical emergencies and trauma, and hospitals have agreements and guidelines that assure the immediate transfer of a child when medically necessary. If this information is not known at this time, please include details that are available to help describe the healthcare needs of your State.

Category III Applicants, include the current needs of your pre-hospital and hospital healthcare system. When discussing the gaps in care related to the EMSC State Partnership Performance Measure Standards, please make

reference to the EMSC Program Performance Report for 2011 (provided by HRSA in 2012). Also include the 2011 Performance Report as Attachment 8. As a reminder, the EMSC Program Performance Report for 2011 was sent to each State Partnership grantee. The Report was based on the data grantees entered into the HRSA Electronic Handbook on or around July 2011 and includes the 2011 national data for each of the EMSC Performance Measure Standards listed below:

PM71 The percent of pre-hospital provider agencies in the State/Territory thathave on-line pediatric medical direction available from dispatch through patient transport to a definitive care facility.

PM72 The percent of pre-hospital provider agencies in the State/Territory that have pediatric off-line medical direction available from dispatch through patient transport to a definitive care facility.

PM73 The percent of patient care units in the State/Territory that have the essential pediatric equipment and supplies as outlined in national guidelines.

PM74 The percent of hospitals recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies.

PM75 The percent of hospitals recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric traumatic emergencies.

PM76 The percentage of hospitals in the State/Territory that have written inter-facility transfer guidelines that cover pediatric patients and the required components of transfer.

PM77 The percentage of hospitals in the State/Territory that have written inter-facility transfer agreements that cover pediatric patients.

PM78 The adoption of requirements by the State/Territory for pediatric emergency education for the license/certification renewal of basic life support (BLS) and advanced life support (ALS) providers.

PM79 The degree to which States/Territories have established permanence of EMSC in the State/Territorial EMS system.

PM80 The degree to which the State/Territory has established permanence of EMSC in the State/Territorial EMS system by integrating EMSC priorities into statutes/regulations.

Additional information and details pertaining to the EMSC performance measures may be found at the EMSC NRC (http://www.childrensnational.org/emsc) and NEDARC (http://www.nedarc.org) websites.

Here is a direct hyperlink to the Performance Measures Manual – EMSC Performance Measures Manual

The nationally recommended pediatric equipment may also be helpful. Here is a direct hyperlink to the site – Nationally Recommended Equipment

- ***METHODOLOGY***

  Propose methods that will be used to address the stated needs and meet each of the previously-described program requirements (EMSC Performance Measures) and expectations in this funding opportunity announcement. As appropriate, include development of effective tools and strategies with the involvement of patients, FAN representatives, and communities of culturally, linguistically, socio-economically and geographically diverse backgrounds, if applicable. Include proposed methods that will be used to complete the Needs Assessment and Strategic Plan (for Category I Applicants), Needs Assessment (Category II Applicants), or the Reassessment (Category III Applicants).

  Applicants must assure that the proposed methods demonstrate the active engagement of a FAN representative in project development and implementation (reference MCHB DGIS Performance Measure 7). Some examples of FAN activities include outreach and education, participating in planning, implementation and evaluation of Program activities at all levels, to include strategic planning, program planning, materials development, program activities, and supporting projects aimed to achieve a specific EMSC performance measure standard.

- ***WORK PLAN***

  Describe the activities or steps that will be used to achieve the EMSC State Partnership Performance Measure Standards and any other activities proposed during the entire project period in the Methodology section. Use a time line that includes each activity and identifies responsible staff. As appropriate, identify meaningful support and collaboration with the EMSC Advisory Committee, FAN representatives and other key stakeholders in planning, designing and implementing all activities, including development of the application and, further, the extent to which these contributors reflect the cultural, racial, linguistic and geographic diversity of the populations and communities served. MCHB and the EMSC Program value the involvement of FAN representatives and strongly encourage their active engagement in State and FAN national activities. The national activities assure their inclusion in the development of family- and patient-centered, as well as cultural competence EMSC projects. In the Work Plan, please delineate the degree to which FAN representatives will be engaged in project activities.

  Include activities planned to complete the Needs Assessment and Strategic Plan (for Category I Applicants); Needs Assessment (Category II Applicants); or the Reassessment (Category III Applicants). Also include a data dissemination plan to assure the results of the Assessment and Reassessment reach a variety of key audiences. The data dissemination plan should include activities related to the Peds Ready[1] Assessment and the EMSC Performance Measure Assessments, and may include other sources related to improving pediatric care in the State.

[1] www.pedsready.org

Category III State Partnership (Competing Continuation) Applicants must also include an Accomplishment Summary. A well-planned accomplishment summary can be of great value by providing a record of accomplishments. It is an important source of material for HRSA in preparing annual reports, planning programs, and communicating program specific accomplishments. The accomplishments of competing continuation applicants are carefully considered during the review process; therefore, applicants are advised to include previously stated goals and objectives (EMSC State Partnership Performance Measure Standards and Other Activities, if any) in their application and emphasize the progress made in attaining these goals and objectives. The guidelines for the Accomplishment Summary are found in Section XI Attachment 5 and must be uploaded as Attachment 5. *Note: If the 2011 Non-Competing Continuation Progress Report recently submitted in December 2011 contains the details requested in this section, you may update the Report and submit as Attachment 5 to satisfy this request. Please re-title to "Accomplishment Summary", update to assure key items requested in this section are included. This document counts toward the 80-page limit.*

▪***RESOLUTION OF CHALLENGES***

Discuss challenges that are likely to be encountered in designing and implementing the activities described in the Work Plan, and approaches that will be used to resolve such challenges. Include anticipated delays due to local legislative processes; limited EMS authority; change in Advisory members; delivery systems of care that are primarily volunteer or privately-run; no pediatric specialty hospitals in the State or a specific region; lack of resources to support pediatric educational opportunities; lack of funding for pediatric equipment; and next steps/plans to overcome the challenges.

▪***EVALUATION AND TECHNICAL SUPPORT CAPACITY***

This section of the project narrative serves to illustrate the applicant's process for evaluating the project's current status. This section must include a carefully designed and well-planned evaluation plan capable of demonstrating and documenting measureable progress toward reaching the project's stated goals through achievement of the project's measureable objectives. Details in this section should include current experience, skills, and knowledge, including individuals on staff, materials published, and previous work with the key stakeholders; an Evaluation Plan that describes the data collection strategy to be used to collect, analyze and track data, measure process and impact/outcomes with key stakeholders, and explain how the data will be used to inform program development and service delivery (to include data collection related to the EMSC Performance Measures and the Emergency Department Readiness Assessment)[2]; and a clear process that will be followed to consistently monitor the progress of the project as it moves toward completion.

[2] www.pedsready.org

▪***ORGANIZATIONAL INFORMATION***

Provide information on the applicant organization's current mission and structure, scope of current activities, an organizational chart[3] (to be uploaded as Attachment 4), and describe how key stakeholders, to include the EMSC Advisory Committee, contribute to the ability of the organization to conduct the program requirements and meet program expectations.

Provide information on the program's resources and capabilities to support provision of culturally and linguistically competent and health literate services. Describe how the unique needs of target populations of the communities served are routinely assessed and improved. **A program manager and FAN representative must be named and a description of the person's background must be provided.**

x. Program Specific Forms

1) Performance Standards for Special Projects of Regional or National Significance (SPRANS) and Other MCHB Discretionary Projects

The Health Resources and Services Administration (HRSA) has modified its reporting requirements for SPRANS projects, CISS projects, and other grant programs administered by the Maternal and Child Health Bureau (MCHB) to include national performance measures that were developed in accordance with the requirements of the Government Performance and Results Act (GPRA) of 1993 (Public Law 103-62). This Act requires the establishment of measurable goals for Federal programs that can be reported as part of the budgetary process, thus linking funding decisions with performance. Performance measures for States have also been established under the Block Grant provisions of Title V of the Social Security Act, the MCHB's authorizing legislation. Performance measures for other MCHB- funded grant programs have been approved by the Office of Management and Budget and are primarily based on existing or administrative data that projects should easily be able to access or collect. An electronic system for reporting these data elements has been developed and is now available.

*2) Performance Measures for the **EMSC State Partnership Program** and Submission of Administrative Data*

To prepare successful applicants of their reporting requirements, the administrative forms and performance measures are presented in Appendix A of this funding opportunity announcement. In summary, the forms and performance measures for this program are:

- Form 1, MCHB Project Budget Details

[3] A one-page figure that depicts the organizational structure of the project, including subcontractors and other significant key stakeholders.

- Form 2, Project Funding Profile
- Form 4, Project Budget and Expenditures by Types of Services –
- Infrastructure Building
- Form 6, Abstract
- Form 7, Discretionary Grant Project Summary Data
- Performance Measures 7, 10, 24, 33, 41, and 71-80
- Products, Publications and Submissions Data Collection Form

xi. Attachments

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

Attachment 1: Staffing Plan and Job Descriptions for Key Personnel

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

Attachment 2: Biographical Sketches of Key Personnel

Include biographical sketches for persons occupying the key positions described in Attachment 1, not to exceed two pages in length for each individual. In the event that a biographical sketch is included for an identified individual who is not yet hired, please include a letter of commitment from that person with the biographical sketch. The Biographical Sketch for Key Personnel form may be found here: Grant Writing Resources at http://www.childrensnational.org/EMSC/ForGrantees/GrantsManagement/Grant-Writing-Resources.aspx.

Attachment 3: Letters of Agreement and/or Description(s) of Proposed/Existing Contracts (*project specific)*

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

Attachment 4: Project Organizational Chart

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

Attachment 5: Summary Progress Report

Provide an Accomplishment Summary (for Category III Applications Only). A well-planned accomplishment summary can be of great value by providing a record of accomplishments. It is an important source of material for HRSA in preparing annual reports, planning programs, and communicating program specific accomplishments. The accomplishments of competing continuation applicants are carefully considered during the review process; therefore, applicants are advised to include previously stated goals and objectives in their application and emphasize the progress made in attaining these goals and objectives. Because the

Accomplishment Summary is considered when applications are reviewed and scored, competing continuation applicants who do not include an Accomplishment Summary may not receive as high a score as applicants who do. The Accomplishment Summary will be evaluated as part of Review Criterion 4: IMPACT. The accomplishment summary should be a brief presentation of the accomplishments, in relation to the objectives of the program during the current project period. The report should include:

(1) The period covered (dates).

(2) Specific Objectives - Briefly summarize the specific objectives of the project as actually funded. Because of peer review recommendations and/or budgetary modifications made by the awarding unit, these objectives may differ in scope from those stated in the competing application.

(3) Results- Describe the program activities conducted for each objective. Include both positive and negative results or technical problems that may be important.

Attachment 6: Letters of Support from Key Stakeholders

Include letters of support from key stakeholders such as Maternal and Child Health, Rural Health, Highway Safety, EMS agencies/regions in the State, the Hospital Association, the FAN representative, key partners in the Department of Public Health, and any other partner mentioned in the project narrative that will be key to the success of the State EMSC Program. Letters of support must be dated. List all other support letters on one page.

Attachment 7: Letter of Endorsement

If the applicant organization is not the State EMS Office, a letter of endorsement designating your agency/organization as the main applicant must accompany the application. The State's endorsement must acknowledge that the applicant has consulted with the State and that the State has been assured that the applicant will work with the State on the proposed project.

Attachment 8: EMSC Performance Report 2011

Required for Category III Applicants. In 2011, the EMSC Program completed a Quality Assurance (QA) review whereby State partnership performance reports and Electronic Handbook data entries were verified. At the conclusion of the QA review, each State Partnership grantee was sent an EMSC Performance Report for 2011. Include this letter as an attachment to help reviewers understand the status of your State.

3. Submission Dates and Times

Application Due Date

The due date for applications under this funding opportunity announcement is *September 26, 2012 at 8:00 P.M. ET.* Applications completed online are considered formally submitted when the application has been successfully transmitted electronically by the

organization's Authorized Organization Representative (AOR) through Grants.gov and validated by Grants.gov on or before the deadline date and time.

Receipt acknowledgement: Upon receipt of an application, Grants.gov will send a series of email messages to document the progress of an application through the system:

1. The first will confirm receipt in the system;
2. The second will indicate whether the application has been successfully validated or has been rejected due to errors;
3. The third will be sent when the application has been successfully downloaded at HRSA; and
4. The fourth will notify the applicant of the Agency Tracking Number assigned to the application.

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

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

4. Intergovernmental Review

The EMSC State Partnership Grant Program is not a program subject to the provisions of Executive Order 12372, as implemented by 45 CFR 100.

5. Funding Restrictions

Applicants responding to this announcement may request funding for project periods of up to four (4) years for Category I at no more than $40,000 per year for the first two years and no more than $130,000 per year for the remaining two years; and up to four (4) years for Categories II and III, at no more than $130,000 per year. Awards to support projects beyond the first budget year will be contingent upon Congressional appropriation, satisfactory progress in meeting the project's objectives, and a determination that continued funding would be in the best interest of the Federal Government.

Salary Limitation: The Consolidated Appropriations Act, 2012 (P.L. 112-74) enacted December 23, 2011, limits the salary amount that may be awarded and charged to HRSA grants and cooperative agreements. Award funds may not be used to pay the salary of an individual at a rate in excess of Executive Level II. The Executive Level II salary of the Federal Executive Pay scale is $179,700. This amount reflects an individual's base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to the applicant organization. This salary limitation also applies to subawards/subcontracts under a HRSA grant or cooperative agreement.

Per Division F, Title V, Section 503 of the Consolidated Appropriations Act, 2012 (P.L. 112-74) enacted December 23, 2011 (a) No part of any appropriation contained in this Act

or transferred pursuant to section 4002 of Public Law 111-148 shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the Congress or any State or local legislature or legislative body, except in presentation to the Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government, except in presentation to the executive branch of any State or local government itself. (b) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111-148 shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government. (c) The prohibitions in subsections (a) and (b) shall include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.

Per Division F, Title V, Section 523 of the Consolidated Appropriations Act, 2012 (P.L. 112-74) enacted December 23, 2011, no funds appropriated in this Act shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug.

6. Other Submission Requirements

As stated in Section IV.1, except in very rare cases HRSA will no longer accept applications in paper form. Applicants submitting for this funding opportunity are ***required*** to submit ***electronically*** through Grants.gov. To submit an application electronically, please use the APPLY FOR GRANTS section at http://www.grants.gov. When using Grants.gov applicants will be able to download a copy of the application package, complete it off-line, and then upload and submit the application via the Grants.gov site.

It is essential that organizations ***immediately register*** in Grants.gov and become familiar with the Grants.gov site application process. Applicants that do not complete the registration process will be unable to submit an application. The registration process can take up to one month.

To be able to successfully register in Grants.gov, it is necessary to complete all of the following required actions:

- Obtain an organizational Data Universal Numbering System (DUNS) number
- Register the organization with Central Contractor Registration (CCR) (or System for

Award Management (SAM) starting late July 2012. See Section IV of this document for more SAM details)
- Identify the organization's E-Business Point of Contact (E-Biz POC)
- Confirm the organization's CCR (or SAM – starting late July 2012) "Marketing Partner ID Number (M-PIN)" password
- Register and approve an Authorized Organization Representative (AOR)
- Obtain a username and password from the Grants.gov Credential Provider

Instructions on how to register, tutorials and FAQs are available on the Grants.gov web site at http://www.grants.gov. Assistance is also available 24 hours a day, 7 days a week (excluding Federal holidays) from the Grants.gov help desk at support@grants.gov or by phone at 1-800-518-4726. Applicants should ensure that all passwords and registration are current well in advance of the deadline.

It is incumbent on applicants to ensure that the AOR is available to submit the application to HRSA by the published due date. HRSA will not accept submission or re-submission of incomplete, rejected, or otherwise delayed applications after the deadline. Therefore, an organization is urged to submit an application in advance of the deadline. If an application is rejected by Grants.gov due to errors, it must be corrected and resubmitted to Grants.gov before the deadline date and time. Deadline extensions will not be provided to applicants who do not correct errors and resubmit before the posted deadline.

If, for any reason, an application is submitted more than once prior to the application due date, HRSA will only accept the applicant's last validated electronic submission prior to the Grants.gov application due date as the final and only acceptable application. Tracking an application: It is incumbent on the applicant to track their application by using the Grants.gov tracking number (GRANTXXXXXXXX) provided in the confirmation email from Grants.gov. More information about tracking an application can be found at https://apply07.grants.gov/apply/checkApplStatus.faces. Be sure the application is validated by Grants.gov prior to the application deadline.

V. Application Review Information

1. Review Criteria

Procedures for assessing the technical merit of applications have been instituted to provide for an objective review of applications and to assist the applicant in understanding the standards against which each application will be judged. Critical indicators have been developed for each review criterion to assist the applicant in presenting pertinent information related to that criterion and to provide the reviewer with a standard for evaluation. Review criteria are outlined below with specific detail and scoring points.

Applications that are significantly deficient in a number of areas of the review criteria may not be awarded funding.

Review Criteria are used to review and rank applications. The *EMSC State Partnership Program* has six (6) review criteria:

No.	Criterion	Narrative Titles/Sections	Points
1	Need	Introduction and Needs Assessment	10
2	Response	Methodology, Work Plan & Resolution of Challenges	30
3	Evaluative Measures	Evaluation & Technical Support Capacity	15
4	Impact	Work Plan	30
5	Resources/Capabilities	Organizational Information	10
6	Support Requested	Budget Narrative	5
		TOTAL POSSIBLE POINTS:	**100**

Criterion 1: NEED *(10 points)*
The extent to which the application demonstrates the problem and associated contributing factors to the problem.

Specific Program Review Sub-Criteria

The extent to which the application:

1) Clearly describes the State's healthcare system.
2) Provides key information to clearly demonstrate the needs of the State.
3) Provides sufficient details related to the EMSC performance measures.
4) Provides the required document (EMSC Program Performance Report for 2011, applicable to Category III Applicants only).

Criterion 2: RESPONSE *(30 points)*
This criterion evaluates the Methodology, Work Plan and Resolution to Challenges project narrative sections.

Specific Program Review Sub-Criteria

The extent to which the application:

1) Responds to the "Purpose" included in the program description.
2) Describes activities in the application that are capable of addressing the problem and attaining the EMSC Performance Measures and any other project objectives.
3) Proposes clear methods to address the EMSC Performance Measures.
4) Clearly describes a plan to include key stakeholders in all phases of project planning, development and implementation.
5) Clearly demonstrates an active engagement of a FAN representative and the EMSC Advisory Committee.

6) Clearly outlines the activities and steps to achieve the EMSC State Partnership Performance Measure Standards.
7) Includes a timeline with each activity and responsible staff.
8) Describes an active collaboration with key partners such as the Office of Rural Health, Office of Highway Safety, Maternal and Child Health, Public Health, EMS, the hospital association and others key to the institutionalization of the EMSC program.
9) Provides a thorough and well-organized data dissemination plan.
10) Describes potential barriers and plans to overcome anticipated barriers.

Criterion 3: EVALUATIVE MEASURES *(15 points)*
The strength and effectiveness of the method proposed to monitor and evaluate the project results.

Specific Program Review Sub-Criteria

The extent to which the application:

1) Demonstrates a process to evaluate and monitor the effectiveness of proposed strategies.
2) Provides an evaluation plan capable of demonstrating and documenting measurable progress toward reaching the stated goals and objectives.
3) Provides background experience and skill of key stakeholders and staff to demonstrate the Applicant organization's ability to achieve the goals and objectives.
4) Clearly describes how data would be collected, analyzed, tracked and disseminated to key target audiences in the State, beyond the Advisory Committee.

Criterion 4: IMPACT *(30 points)*
The extent to which the applicant has discussed how they intend to engage multiple audiences and how project activities will yield materials, resources and other benefits.

Specific Program Review Sub-Criteria

The extent to which the application:

1) Clearly explains the significance of the project.
2) Describes how the proposed project's products and results will have a State- level and national scope and applicability.
3) Describes how the applicant intends to reach multiple audiences.
4) Describes how the applicant intends to mobilize audiences to learn from and actually use the materials, products and resources developed through the project.
5) Provides a plan to achieve the EMSC Performance Measures.
6) Demonstrates sufficient progress toward achievement in previous years (applicable only to Category III Applicants).

Criterion 5: RESOURCES/CAPABILITIES *(10 points) Specific Program Review Sub-Criteria*
The extent to which the application:

1) Demonstrates an assurance of project management oversight through the placement of a full-time program manager and inclusion of a FAN representative.
2) Describes the qualifications and expertise of project personnel by training and/or experience to implement and carry out the project.
3) Demonstrates the organization's capabilities, the quality and availability of facilities and personnel to fulfill the needs and requirements of the project.

Criterion 6: SUPPORT REQUESTED *(5 points)*
This criterion evaluates the reasonableness of the proposed budget for each year of the project period.

Specific Program Review Sub-Criteria

The extent to which the application:

1) Has accounted for costs, as outlined in the budget narrative.
2) Has allocated funds within the budget categories for the required items, as outlined in the funding opportunity announcement.
3) Reasonably allocated costs given the scope of work.
4) Key personnel have adequate time devoted to the project to achieve project objectives.

2. Review and Selection Process

The Division of Independent Review is responsible for managing objective reviews within HRSA. Applications competing for Federal funds receive an objective and independent review performed by a committee of experts qualified by training and experience in particular fields or disciplines related to the program being reviewed. In selecting review committee members, other factors in addition to training and experience may be considered to improve the balance of the committee, e.g., geographic distribution. Each reviewer is screened to avoid conflicts of interest and is responsible for providing an objective, unbiased evaluation based on the review criteria noted above. The committee provides expert advice on the merits of each application to program officials responsible for final selections for award.

Applications that pass the initial HRSA eligibility screening will be reviewed and rated by a panel based on the program elements and review criteria presented in Section V. 1. Review Criteria of this funding opportunity announcement. The review criteria are designed to enable the review panel to assess the quality of a proposed project and determine the likelihood of its success. **Applications that are significantly deficient in a number of areas of the review criteria may not be awarded funding**. The criteria are closely related to each other and are considered as a whole in judging the overall quality of an application.

Funding Priorities
There are no funding priorities for the EMSC State Partnership Program.

Funding Preferences
The authorizing legislation does not provide a funding preference for applicants.

Funding Special Considerations
There no Funding Special Considerations

3. Anticipated Announcement and Award Dates

It is anticipated that awards will be announced prior to the start date of **March 1, 2013**.

VI. Award Administration Information

1. Award Notices

Each applicant will receive written notification of the outcome of the objective review process, including a summary of the expert committee's assessment of the application's strengths and weaknesses, and whether the application was selected for funding. Applicants who are selected for funding may be required to respond in a satisfactory manner to Conditions placed on their application before funding can proceed. Letters of notification do not provide authorization to begin performance.

The Notice of Award (NoA) sets forth the amount of funds granted, the terms and conditions of the award, the effective date of the award, the budget period for which initial support will be given, the non-Federal share to be provided (if applicable), and the total project period for which support is contemplated. Signed by the Grants Management Officer, it is sent to the applicant's Authorized Organization Representative, and reflects the only authorizing document. It will be sent prior to the start date of **March 1, 2013**.

2. Administrative and National Policy Requirements

Successful applicants must comply with the administrative requirements outlined in 45 CFR Part 74 Uniform Administrative Requirements for Awards and Subawards to Institutions of Higher Education, Hospitals, Other Nonprofit Organizations, and Commercial Organizations or 45 CFR Part 92 Uniform Administrative Requirements For Grants And Cooperative Agreements to State, Local, and Tribal Governments, as appropriate.

HRSA grant and cooperative agreement awards are subject to the requirements of the HHS Grants Policy Statement (HHS GPS) that are applicable based on recipient type and purpose of award. This includes any requirements in Parts I and II of the HHS GPS that apply to the award. The HHS GPS is available at http://www.hrsa.gov/grants/hhsgrantspolicy.pdf. The general terms and conditions in

the HHS GPS will apply as indicated unless there are statutory, regulatory, or award-specific requirements to the contrary (as specified in the NoA).

Non-Discrimination Requirements

To serve persons most in need and to comply with Federal law, services must be widely accessible. Services must not discriminate on the basis of age, disability, sex, race, color, national origin or religion. The HHS Office for Civil Rights provides guidance to grant and cooperative agreement recipients on complying with civil rights laws that prohibit discrimination on these bases. Please see http://www.hhs.gov/ocr/civilrights/understanding/index.html. HHS also provides specific guidance for recipients on meeting their legal obligation under Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color or national origin in programs and activities that receive Federal financial assistance (P.L. 88-352, as amended and 45 CFR Part 80). In some instances a recipient's failure to provide language assistance services may have the effect of discriminating against persons on the basis of their national origin. Please see http://www.hhs.gov/ocr/civilrights/resources/laws/revisedlep.html to learn more about the Title VI requirement for grant and cooperative agreement recipients to take reasonable steps to provide meaningful access to their programs and activities by persons with limited English proficiency.

Trafficking in Persons

Awards issued under this funding opportunity announcement are subject to the requirements of Section 106(g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104). For the full text of the award term, go to http://www.hrsa.gov/grants/trafficking.html.

Smoke-Free Workplace

The Public Health Service strongly encourages all award recipients to provide a smoke-free workplace and to promote the non-use of all tobacco products. Further, Public Law 103-227, the Pro-Children Act of 1994, prohibits smoking in certain facilities (or in some cases, any portion of a facility) in which regular or routine education, library, day care, health care or early childhood development services are provided to children.

Cultural and Linguistic Competence

HRSA programs serve culturally and linguistically diverse communities and multiple cultures. Although race and ethnicity are often thought to be dominant elements of culture, HRSA funded programs embrace a broader definition to incorporate diversity within specific cultural groups including but not limited to cultural uniqueness within Native American populations, Native Hawaiian, Pacific Islanders, and other ethnic groups, language, gender, socio-economic status, sexual orientation and gender identity, physical and mental capacity, age, religion, housing status, and regional differences. Organizational behaviors, practices, attitudes, and policies across all HRSA- supported entities respect and respond to the cultural diversity of communities, clients and students served. HRSA is committed to ensuring access to quality health care for all. Quality care means access to services, information, materials delivered by competent providers in a manner that factors in the language needs, cultural richness, and diversity of populations served. Quality also means that, where appropriate, data collection instruments used should adhere to culturally

competent and linguistically appropriate norms. For additional information and guidance, refer to the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) published by HHS and available online at http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15. Additional cultural competency and health literacy tools, resources and definitions are available online at http://www.hrsa.gov/culturalcompetence and http://www.hrsa.gov/healthliteracy.

Healthy People 2020

Healthy People 2020 is a national initiative led by HHS that sets priorities for all HRSA programs. The initiative has four overarching goals: (1) attain high-quality, longer lives free of preventable disease, disability, injury, and premature death; (2) achieve health equity, eliminate disparities, and improve the health of all groups; (3) create social and physical environments that promote good health for all; and (4) promote quality of life, healthy development, and healthy behaviors across all life stages. The program consists of over 40 topic areas, containing measurable objectives. HRSA has actively participated in the work groups of all the topic areas and is committed to the achievement of the Healthy People 2020 goals. More information about Healthy People 2020 may be found online at http://www.healthypeople.gov/.

National HIV/AIDS Strategy (NHAS)

The National HIV/AIDS Strategy (NHAS) has three primary goals: (1) reducing the number of people who become infected with HIV; (2) increasing access to care and optimizing health outcomes for people living with HIV; and (3) reducing HIV-related health disparities. The NHAS states that more must be done to ensure that new prevention methods are identified and that prevention resources are more strategically deployed. Further, the NHAS recognizes the importance of early entrance into care for people living with HIV to protect their health and reduce their potential of transmitting the virus to others. HIV disproportionately affects people who have less access to prevention, care and treatment services and, as a result, often have poorer health outcomes. Therefore, the NHAS advocates adopting community-level approaches to identify people who are HIV-positive but do not know their serostatus and reduce stigma and discrimination against people living with HIV.

To the extent possible, program activities should strive to support the three primary goals of the NHAS. As encouraged by the NHAS, programs should seek opportunities to increase collaboration, efficiency, and innovation in the development of program activities to ensure success of the NHAS. Programs providing direct services should comply with Federally-approved guidelines for HIV Prevention and Treatment (see http://www.aidsinfo.nih.gov/Guidelines/Default.aspx as a reliable source for current guidelines). More information can also be found at http://www.whitehouse.gov/administration/eop/onap/nhas.

Health IT
Health information technology (Health IT) provides the basis for improving the overall quality, safety and efficiency of the health delivery system. HRSA endorses the widespread and consistent use of health IT, which is the most promising tool for making health care services more accessible, efficient and cost effective for all Americans.

Related Health IT Resources:

- ☐ Health Information Technology (HHS)
- ☐ What is Health Care Quality and Who Decides? (AHRQ)

3. Reporting

The successful applicant under this funding opportunity announcement must comply with the following reporting and review activities:

a. **Audit Requirements**
Comply with audit requirements of Office of Management and Budget (OMB) Circular A-133. Information on the scope, frequency, and other aspects of the audits can be found on the Internet at http://www.whitehouse.gov/omb/circulars_default.

b. **Payment Management Requirements**
Submit a quarterly electronic Federal Financial Report (FFR) Cash Transaction Report via the Payment Management System. The report identifies cash expenditures against the authorized funds for the grant or cooperative agreement. The FFR Cash Transaction Reports must be filed within 30 days of the end of each calendar quarter. Failure to submit the report may result in the inability to access award funds. Go to http://www.dpm.psc.gov for additional information.

c. **Status Reports**
1) **Federal Financial Report**. The Federal Financial Report (SF-425) is required according to the following schedule: http://www.hrsa.gov/grants/manage/technicalassistance/federalfinancialreport/ffrschedule.pdf.. The report is an accounting of expenditures under the project that year. Financial reports must be submitted electronically through EHB. More specific information will be included in the NoA.

2) **Progress Report**(s). The awardee must submit a progress report to HRSA on an annual basis. Submission and HRSA approval of grantee Progress Report(s) triggers the budget period renewal and release of subsequent year funds. This report has two parts. The first part demonstrates grantee progress on program-specific goals. The second part collects core performance measurement data including performance measurement data to measure the progress and impact of the project. Further information will be provided in the NoA.

3) **Final Report.** A final report is due within 90 days after the project period ends. The final report collects program-specific goals and progress on strategies;

core performance measurement data; impact of the overall project; the degree to which the grantee achieved the mission, goal and strategies outlined in the program; grantee objectives and accomplishments; barriers encountered; and responses to summary questions regarding the grantee's overall experiences over the entire project period. The final report must be submitted on-line by awardees in the Electronic Handbooks system at https://grants.hrsa.gov/webexternal/home.asp.

4) **Tangible Personal Property Report.** If applicable, the awardee must submit the Tangible Personal Property Report (SF-428) and any related forms. The report must be submitted within 90 days after the project period ends. Awardees are required to report all federally-owned property and acquired equipment with an acquisition cost of $5,000 or more per unit. Tangible personal property means property of any kind, except real property, that has physical existence. It includes equipment and supplies. Property may be provided by HRSA or acquired by the recipient with award funds. Federally-owned property consists of items that were furnished by the Federal Government. Tangible personal property reports must be submitted electronically through EHB. More specific information will be included in the NoA.

5) **Other required reports**

a) Performance Report(s)

The Health Resources and Services Administration (HRSA) has modified its reporting requirements for SPRANS projects, CISS projects, and other grant programs administered by the Maternal and Child Health Bureau (MCHB) to include national performance measures that were developed in accordance with the requirements of the Government Performance and Results Act (GPRA) of 1993 (Public Law 103-62). This Act requires the establishment of measurable goals for Federal programs that can be reported as part of the budgetary process, thus linking funding decisions with performance. Performance measures for States have also been established under the Block Grant provisions of Title V of the Social Security Act, the MCHB's authorizing legislation. Performance measures for other MCHB-funded grant programs have been approved by the Office of Management and Budget and are primarily based on existing or administrative data that projects should easily be able to access or collect.

1. Performance Measures and Program Data

To prepare applicants for these reporting requirements, the designated performance measures for this program and other program data collection are presented in Appendix A of this funding opportunity announcement.

2. Performance Reporting
Successful applicants receiving grant funds will be required, within 120 days of the Notice of Award (NoA), to register in HRSA's Electronic Handbooks (EHBs) and electronically complete the program specific data forms that appear in Appendix A of this funding opportunity announcement. This requirement entails the provision of budget breakdowns in the financial forms based on the grant award amount, the project abstract and other grant summary data as well as providing objectives for the performance measures.

Performance reporting is conducted for each grant year of the project period. Grantees will be required, **within 120 days of the NoA**, to enter HRSA's EHBs and complete the program specific forms. This requirement includes providing expenditure data, finalizing the abstract and grant summary data as well as finalizing indicators/scores for the performance measures.

3. Project Period End Performance Reporting
Successful applicants receiving grant funding will be required, within 90 days from the end of the project period, to electronically complete the program specific data forms that appear in the appendix of this funding opportunity announcement. The requirement includes providing expenditure data for the final year of the project period, the project abstract and grant summary data as well as final indicators/scores for the performance measures.

d. **Transparency Act Reporting Requirements**
New awards ("Type 1") issued under this funding opportunity announcement are subject to the reporting requirements of the Federal Funding Accountability and Transparency Act (FFATA) of 2006 (Pub. L. 109–282), as amended by section 6202 of Public Law 110–252, and implemented by 2 CFR Part 170. Grant and cooperative agreement recipients must report information for each first-tier subaward of $25,000 or more in Federal funds and executive total compensation for the recipient's and subrecipient's five most highly compensated executives as outlined in Appendix A to 2 CFR Part 170 (FFATA details are available online at http://www.hrsa.gov/grants/ffata.html). Competing continuation awardees, etc. may be subject to this requirement and will be so notified in the NoA.

VII. Agency Contacts

Business, Administrative and Fiscal
For information regarding business, administrative, or fiscal issues related to this funding opportunity announcement contact:

Grants Management Specialist
HRSA Division of Grants Management Operations
OFAM, Parklawn Building

5600 Fishers Lane, Rockville, MD 20857

Mickey Reynolds at MReynolds@hrsa.gov
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Tya Renwick at TRenwick@hrsa.gov
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Program and Technical Assistance
For information related to overall program issues and/or technical assistance regarding this funding announcement contact:

State Project Officer
EMSC and Injury Prevention Branch Maternal
and Child Health Bureau, HRSA Parklawn
Building, Room 18A-39
5600 Fishers Lane
Rockville, MD 20857

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

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

Technical Support with Grants.gov (post-award)
Successful applicants/awardees may need assistance when working online to submit information and reports electronically through HRSA's Electronic Handbooks (EHBs). For

assistance with submitting information in HRSA's EHBs, contact the HRSA Call Center, Monday-Friday, 9:00 a.m. to 5:30 p.m. ET:

HRSA Contact Center
Telephone: (877) 464-4772
TTY: (877) 897-9910
E-mail: CallCenter@HRSA.GOV

Additional Resource and Support

The EMSC program funds two national EMSC resource centers; the EMSC National Resource Center - NRC (website: www.childrensnational.org/emsc) and the National EMSC Data Analysis Resource Center – NEDARC (website: www.nedarc.org). Both centers are available to provide technical assistance and support to applicants.

In the areas of offering advice on grant writing, data collection and analysis, and EMSC Performance Measure Needs Assessments and Reassessments, and data dissemination, please send your inquiry to Debbie Norwood at Deborah.Norwood@hsc.utah.edu.

In the areas of understanding EMSC terminology, developing a manageable approach to EMSC implementation, obtaining local support for the grant application process, facilitating development of community linkages for a collaborative effort, and identifying products of previously-funded EMSC projects of interest to potential applicants, contact the NRC by sending an inquiry to Gayathri Jayawardena at GJayawar@childrensnational.org.

VIII. Other Information

Technical Assistance Call

The Program has scheduled a Technical Assistance Conference Call on Monday, July 16, 2012 at 4:00 pm ET to answer questions related to this announcement.
Please dial 866-823-9065 and enter Pass code 1346468.

Resources and detailed information about the EMSC Program may be found on the following websites:

The Health Resources and Services Administration, Maternal and Child Health Bureau
http://www.mchb.hrsa.gov/programs/emergencymedical/index.html

The Children National Medical Center, EMSC National Resource Center
http://www.childrensnational.org/EMSC/

The National EMSC Data Analysis Resource Center
www.nedarc.org

ACRONYMS and DEFINITIONS

ASPR – Assistant Secretary for Preparedness and Response

Collaborative – a group working in partnership to achieve a specific goal or complete a task together.

DCAFH – Division of Child, Adolescent and Family Health

DOT – Department of Transportation

EMS – Emergency Medical Services

FAN – Family Advisory Network. The FAN was created by the EMSC NRC in 1999 to facilitate the inclusion of family representatives in State EMSC programs. Members of the FAN are parents, grandparents, caregivers, and others who may have had first-hand experience with the State's EMS system. The engagement and involvement of FAN representatives in project planning, development and implementation ensures family, youth, and consumer participation in program and policy activities. In the performance measure detail sheets in the Appendix section, FAN representatives are also referred to as family member or family representative.

FAS – Freely Associated States; includes the Republic of Palau, the Republic of the Marshall Islands, and the Federated States of Micronesia.

HHS – Health and Human Services

HRSA – Health Resources and Services Administration

MCHB – Maternal and Child Health Bureau

NRC – EMSC National Resource Center

NEDARC – National EMSC Data Analysis Resource Center

Regionalization – an established network of resources that delivers specific care (e.g., protocols, definitive procedures, higher care levels or care pathways) to a defined population of patients or within a defined geography.

State – the term "State" includes the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Northern Mariana Islands, Guam, American Samoa, the Republic of Palau, the Republic of the Marshall Islands, and the Federated States of Micronesia.

IX. Tips for Writing a Strong Application

HRSA has designed a technical assistance webpage to assist applicants in preparing applications. Resources include help with system registration, finding and applying for funding opportunities, writing strong applications, understanding the review process, and many other topics which applicants will find relevant. The website can be accessed online at: http://www.hrsa.gov/grants/apply/index.html.

In addition, a concise resource offering tips for writing proposals for HHS grants and cooperative agreements can be accessed online at: http://www.hhs.gov/asrt/og/grantinformation/apptips.html.

Appendix A: MCHB Administrative Forms and Performance Measures

To prepare successful applicants for their future performance reporting requirements, the Administrative Forms and Performance Measures assigned to this MCHB program are presented below.

- ☐ Form 1, MCHB Project Budget Details
- ☐ Form 2, Project Funding Profile
- ☐ Form 4, Project Budget and Expenditures by Types of Services, Infrastructure Building
- ☐ Form 6, MCH Abstract
- ☐ Form 7, Discretionary Grant Project Summary Data
- ☐ Performance Measures: PM 7, 10, 24, 33, 41, and 71-80

PM07	The degree to which MCHB-funded programs ensure family, youth, and consumer participation in program and policy activities.
PM10	The degree to which MCHB-funded programs have incorporated cultural and linguistic competence elements into their policies, guidelines, contracts, and training.
PM24	The degree to which MCHB-funded initiatives contribute to infrastructure development through core public health assessment, policy development and assurance functions.
PM33	The degree to which MCHB-funded initiatives work to promote sustainability of their programs or initiatives beyond the life of MCHB funding.
PM41	The degree to which grantees have assisted in developing, supporting, and promoting medical homes for MCH populations.
PM71	The percent of pre-hospital provider agencies in the state/territory that have on-line pediatric medical direction available from dispatch through patient transport to a definitive care facility.
PM72	The percent of pre-hospital provider agencies in the state/territory that have off-line pediatric medical direction available from dispatch through patient transport to a definitive care facility.
PM73	The percent of patient care units in the state/territory that have essential pediatric equipment and supplies as outlined in national guidelines.
PM74	The percent of hospitals recognized through a statewide, territorial, or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies.
PM75	The percent of hospitals recognized through a statewide, territorial, or regional standardized system that are able to stabilize and/or manage pediatric traumatic emergencies.
PM76	The percentage of hospitals in the state/territory that have written interfacility transfer guidelines that cover pediatric patients and that include pre-defined components of transfer.
PM77	The percent of hospitals in the state/territory that have written interfacility transfer agreements that cover pediatric patients.
PM78	The adoption of requirements by the state/territory for pediatric emergency education for license/certification renewal of BLS/ALS providers.
PM79	The degree to which state/territories have established permanence of EMSC in the state/territory EMS system by establishing an EMSC Advisory Committee, incorporating pediatric representation on the EMS Board, and hiring a full-time EMSC manager.
PM80	The degree to which state/territories have established permanence of EMSC in the state/territory EMS system by integrating EMSC priorities into statutes/regulations.

☐ Data Forms: Products, Publications and Submissions Data Collection Form

FORM 1
MCHB PROJECT BUDGET DETAILS FOR FY _____

1.	**MCHB GRANT AWARD AMOUNT**		$
2.	**UNOBLIGATED BALANCE**		$
3.	**MATCHING FUNDS**		$
	(Required: Yes [ ] No [ ] If yes, amount)		
	A. Local funds	$	
	B. State funds	$	
	C. Program Income	$	
	D. Applicant/Grantee Funds	$	
	E. Other funds: _____	$	
4.	**OTHER PROJECT FUNDS** (Not included in 3 above)		$
	A. Local funds	$	
	B. State funds	$	
	C. Program Income (Clinical or Other)	$	
	D. Applicant/Grantee Funds (includes in-kind)	$	
	E. Other funds (including private sector, e.g., Foundations)	$	
5.	**TOTAL PROJECT FUNDS** (Total lines 1 through 4)		$
6.	**FEDERAL COLLABORATIVE FUNDS**		$
	(Source(s) of additional Federal funds contributing to the project)		
	A. Other MCHB Funds (Do not repeat grant funds from Line 1)		
	1) Special Projects of Regional and National Significance (SPRANS)	$	
	2) Community Integrated Service Systems (CISS)	$	
	3) State Systems Development Initiative (SSDI)	$	
	4) Healthy Start	$	
	5) Emergency Medical Services for Children (EMSC)	$	
	6) Traumatic Brain Injury	$	
	7) State Title V Block Grant	$	
	8) Other: _____	$	
	9) Other: _____	$	
	10) Other: _____	$	
	B. Other HRSA Funds		
	1) HIV/AIDS	$	
	2) Primary Care	$	
	3) Health Professions	$	
	4) Other: _____	$	
	5) Other: _____	$	
	6) Other: _____	$	
	C. Other Federal Funds		
	1) Center for Medicare and Medicaid Services (CMS)	$	
	2) Supplemental Security Income (SSI)	$	
	3) Agriculture (WIC/other)	$	
	4) Administration for Children and Families (ACF)	$	
	5) Centers for Disease Control and Prevention (CDC)	$	
	6) Substance Abuse and Mental Health Services Administration (SAMHSA)	$	
	7) National Institutes of Health (NIH)	$	
	8) Education	$	
	9) Bioterrorism		
	10) Other: _____	$	
	11) Other: _____	$	
	12) Other _____	$	
7.	**TOTAL COLLABORATIVE FEDERAL FUNDS**	$	

INSTRUCTIONS FOR COMPLETION OF FORM 1
MCH BUDGET DETAILS FOR FY ____

Line 1. Enter the amount of the Federal MCHB grant award for this project.

Line 2. Enter the amount of carryover (e.g, unobligated balance) from the previous year's award, if any. New awards do not enter data in this field, since new awards will not have a carryover balance.

Line 3. If matching funds are required for this grant program list the amounts by source on lines 3A through 3E as appropriate. Where appropriate, include the dollar value of in-kind contributions.

Line 4. Enter the amount of other funds received for the project, by source on Lines 4A through 4E, specifying amounts from each source. Also include the dollar value of in-kind contributions.

Line 5. Displays the sum of lines 1 through 4.

Line 6. Enter the amount of other Federal funds received on the appropriate lines (A.1 through C.12) **other** than the MCHB grant award for the project. Such funds would include those from other Departments, other components of the Department of Health and Human Services, or other MCHB grants or contracts.

Line 6C.1. Enter only project funds from the Center for Medicare and Medicaid Services. Exclude Medicaid reimbursement, which is considered Program Income and should be included on Line 3C or 4C.

If lines 6A.8-10, 6B .4-6, or 6C.10-12 are utilized, specify the source(s) of the funds in the order of the amount provided, starting with the source of the most funds. .

Line 7. Displays the sum of lines in 6A.1 through 6C.12.

FORM 2
PROJECT FUNDING PROFILE

	FY____		FY____		FY____		FY____		FY____	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1 MCHB Grant Award Amount *Line 1, Form 2*	$	$	$	$	$	$	$	$	$	$
2 Unobligated Balance *Line 2, Form 2*	$	$	$	$	$	$	$	$	$	$
3 Matching Funds (If required) *Line 3, Form 2*	$	$	$	$	$	$	$	$	$	$
4 Other Project Funds *Line 4, Form 2*	$	$	$	$	$	$	$	$	$	$
5 Total Project Funds *Line 5, Form 2*	$	$	$	$	$	$	$	$	$	$
6 Total Federal Collaborative Funds *Line 7, Form 2*	$	$	$	$	$	$	$	$	$	$

INSTRUCTIONS FOR THE COMPLETION OF FORM 2
PROJECT FUNDING PROFILE

Instructions:

Complete all required data cells. If an actual number is not available, use an estimate. Explain all estimates in a note.

The form is intended to provide funding data at a glance on the estimated budgeted amounts and actual expended amounts of an MCH project.

For each fiscal year, the data in the columns labeled Budgeted on this form are to contain the same figures that appear on the Application Face Sheet (for a non-competing continuation) or the Notice of Grant Award (for a performance report). The lines under the columns labeled Expended are to contain the actual amounts expended for each grant year that has been completed.

FORM 4
PROJECT BUDGET AND EXPENDITURES
By Types of Services

	TYPES OF SERVICES	FY _____ Budgeted	FY _____ Expended	FY _____ Budgeted	FY _____ Expended
I.	**Direct Health Care Services** (Basic Health Services and Health Services for CSHCN.)	$	$	$	$
II.	**Enabling Services** (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC and Education.)	$	$	$	$
III.	**Population-Based Services** (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	$	$	$	$
IV.	**Infrastructure Building Services** (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems.)	$	$	$	$
V.	**TOTAL**	$	$	$	$

INSTRUCTIONS FOR THE COMPLETION OF FORM 4
PROJECT BUDGET AND EXPENDITURES BY TYPES OF SERVICES

Complete all required data cells for all years of the g rant. If an actual number is not available, make an estimate. Please explain all estimates in a note. Administrative dollars should be allocated to the appropriate level(s) of the pyramid on lines I, II, II or IV. If an estimate of administrative funds use is necessary, one method would be to allocate those dollars to Lines I, II, III and IV at the same percentage as program dollars are allocated to Lines I through IV.

Note: Lines I, II and II are for projects providing services. If grant funds are used to build the infrastructure for direct care delivery, enabling or population-based services, these amounts should be reported in Line IV (i.e., building data collection capacity for newborn hearing screening).

Line I Direct Health Care Services - enter the budgeted and expended amounts for the appropriate fiscal year completed and budget estimates only for all other years.

Direct Health Care Services are those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and sub-specialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Line II Enabling Services - enter the budgeted and expended amounts for the appropriate fiscal year completed and budget estimates only for all other years.

Enabling Services allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

Line III Population-Based Services - enter the budgeted and expended amounts for the appropriate fiscal year completed and budget estimates only for all other years.

Population Based Services are preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

Line IV Infrastructure Building Services - enter the budgeted and expended amounts for the appropriate fiscal year completed and budget estimates only for all other years.

Infrastructure Building Services are the base of the MCH pyramid of health services and form its foundation. They are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems and resources including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Line V Total – Displays the total amounts for each column, budgeted for each year and expended for each year completed.

FORM 6
MATERNAL & CHILD HEALTH DISCRETIONARY GRANT
PROJECT ABSTRACT
FOR FY____

PROJECT:_____

I. PROJECT IDENTIFIER INFORMATION

1. Project Title:
2. Project Number:
3. E-mail address:

II. BUDGET

1. MCHB Grant Award (Line 1, Form 2) $_____
2. Unobligated Balance (Line 2, Form 2) $_____
3. Matching Funds (if applicable) (Line 3, Form 2) $_____
4. Other Project Funds (Line 4, Form 2) $_____
5. Total Project Funds (Line 5, Form 2) $_____

III. TYPE(S) OF SERVICE PROVIDED (Choose all that apply)

[ ] Direct Health Care Services
[ ] Enabling Services
[ ] Population-Based Services
[ ] Infrastructure Building Services

IV. PROJECT DESCRIPTION OR EXPERIENCE TO DATE

A. Project Description

1. Problem (in 50 words, maximum):

2. Goals and Objectives: (List up to 5 major goals and time-framed objectives per goal for the project)

Goal 1:
Objective 1:
Objective 2:
Goal 2:
Objective 1:
Objective 2:
Goal 3:
Objective 1:
Objective 2:

Goal 4:
Objective 1:
Objective 2:
Goal 5:
Objective 1:
Objective 2:

3. Activities planned to meet project goals

4. Specify the primary *Healthy People 2010* objectives(s) (up to three) which this project addresses:

a.

b.

c.

5. Coordination (List the State, local health agencies or other organizations involved in the project and their roles)

6. Evaluation (briefly describe the methods which will be used to determine whether process and outcome objectives are met)

B. Continuing Grants ONLY

1. Experience to Date (For continuing projects ONLY):

2. Website URL and annual number of hits

V. KEY WORDS

VI. ANNOTATION

INSTRUCTIONS FOR THE COMPLETION OF FORM 6
PROJECT ABSTRACT

NOTE: All information provided should fit into the space provided in the form. The completed form should be no more than 3 pages in length. Where information has previously been entered in forms 1 through 5, the information will automatically be transferred electronically to the appropriate place on this form.

Section I – Project Identifier Information

Project Title: Displays the title for the project.
Project Number: Displays the number assigned to the project (e.g., the grant number)
E-mail address: Displays the electronic mail address of the project director

Section II – Budget - These figures will be transferred from Form 1, Lines 1 through 5.

Section III - Types of Services

Indicate which type(s) of services your project provides, checking all that apply.

Section IV – Program Description OR Current Status (DO NOT EXCEED THE SPACE PROVIDED)

A. New Projects only are to complete the following items:
   1. A brief description of the project and the problem it addresses, such as preventive and primary care services for pregnant women, mothers, and infants; preventive and primary care services for children; and services for Children with Special Health Care Needs.
   2. Provide up to 5 goals of the project, in priority order. Examples are: To reduce the barriers to the delivery of care for pregnant women, to reduce the infant mortality rate for minorities and "services or system development for children with special healthcare needs." MCHB will capture annually every project's top goals in an information system for comparison, tracking, and reporting purposes; you must list at least 1 and no more than 5 goals. For each goal, list the two most important objectives. The objective must be specific (i.e., decrease incidence by 10%) and time limited (by 2005).
   3. Displays the primary Healthy people 2010 goal(s) that the project addresses.
   4. Describe the programs and activities used to attain the goals and objectives, and comment on innovation, cost, and other characteristics of the methodology, proposed or are being implemented. Lists with numbered items can be used in this section.
   5. Describe the coordination planned and carried out, in the space provided, if applicable, with appropriate State and/or local health and other agencies in areas(s) served by the project.
   6. Briefly describe the evaluation methods that will be used to assess the success of the project in attaining its goals and objectives.

B. For continuing projects ONLY:
   1. Provide a brief description of the major activities and accomplishments over the past year (not to exceed 200 words).
   2. Provide website and number of hits annually, if applicable.

Section V – Key Words

Provide up to 10 key words to describe the project, including populations served. Choose key words from the included list.

Section VI – Annotation

Provide a three- to five-sentence description of your project that identifies the project's purpose, the needs and problems, which are addressed, the goals and objectives of the project, the activities, which will be used to attain the goals, and the materials, which will be developed.

FORM 7
DISCRETIONARY GRANT PROJECT
SUMMARY DATA

1. Project Service Focus

[ ] Urban/Central City [ ] Suburban [ ] Metropolitan Area (city & suburbs)
[ ] Rural [ ] Frontier [ ] Border (US-Mexico)

2. Project Scope

[ ] Local [ ] Multi-county [ ] State-wide
[ ] Regional [ ] National

3. Grantee Organization Type

[ ] State Agency
[ ] Community Government Agency
[ ] School District
[ ] University/Institution Of Higher Learning (Non-Hospital Based)
[ ] Academic Medical Center
[ ] Community-Based Non-Governmental Organization (Health Care)
[ ] Community-Based Non-Governmental Organization (Non-Health Care)
[ ] Professional Membership Organization (Individuals Constitute Its Membership)
[ ] National Organization (Other Organizations Constitute Its Membership)
[ ] National Organization (Non-Membership Based)
[ ] Independent Research/Planning/Policy Organization
[ ] Other _____ _____

4. **Project Infrastructure Focus** (from MCH Pyramid) if applicable

[ ] Guidelines/Standards Development And Maintenance
[ ] Policies And Programs Study And Analysis
[ ] Synthesis Of Data And Information
[ ] Translation Of Data And Information For Different Audiences
[ ] Dissemination Of Information And Resources
[ ] Quality Assurance
[ ] Technical Assistance
[ ] Training
[ ] Systems Development
[ ] Other ____

5. Demographic Characteristics of Project Participants

Indicate the service level:

☐ **Direct Health Care Services**	☐ **Population-Based Services**
☐ **Enabling Services**	☐ **Infrastructure Building Services**

	RACE (Indicate all that apply)								**ETHNICITY**			
	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	White	More than One Race	Unrecorded	Total	Hispanic or Latino	Not Hispanic or Latino	Unrecorded	Total
Pregnant Women (All Ages)												
Infants <1 year												
Children and Youth 1 to 25 years												
CSHCN Infants <1 year												
CSHCN Children and Youth 1 to 25 years												
Women 25+ years												
Men 25+												
TOTALS												

6. Clients' Primary Language(s)

_____
_____
_____

7. Resource/TA and Training Centers ONLY

Answer all that apply.

a. Characteristics of Primary Intended Audience(s)
   - [ ] Policy Makers/Public Servants
   - [ ] Consumers
   - [ ] Providers/Professionals

b. Number of Requests Received/Answered: ___/____
c. Number of Continuing Education credits provided: _____
d. Number of Individuals/Participants Reached: _____
e. Number of Organizations Assisted: _____
f. Major Type of TA or Training Provided:
   - [ ] continuing education courses,
   - [ ] workshops,
   - [ ] on-site assistance,
   - [ ] distance learning classes
   - [ ] other

INSTRUCTIONS FOR THE COMPLETION OF FORM 7

PROJECT SUMMARY

Section 1 – Project Service Focus
Select all that apply

Section 2 – Project Scope
Choose the one that best applies to your project.

Section 3 – Grantee Organization Type
Choose the one that best applies to your organization.

Section 4 – Project Infrastructure Focus
If applicable, choose all that apply.

Section 5 – Demographic Characteristics of Project Participants
Indicate the service level for the grant program. Multiple selections may be made. Infrastructure cannot be selected by itself; it must be selected with another service level. Please fill in each of the cells as appropriate.

Direct Health Care Services are those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and sub-specialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

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Section 6 – Clients Primary Language(s)
Indicate which languages your clients speak as their primary language, other than English, for the data provided in Section 6. List up to three languages.

Section 7 – Resource/TA and Training Centers (Only)
Answer all that apply.

Health Resources and Services Administration

Maternal and Child Health Bureau

Discretionary Grant Performance Measures

Specific to the
Emergency Medical Services for Children Program

OMB No. 0915-0298

Number	Performance Measures Title
PM07	The degree to which MCHB-funded programs ensure family, youth, and consumer participation in program and policy activities.
PM10	The degree to which MCHB-funded programs have incorporated cultural and linguistic competence elements into their policies, guidelines, contracts, and training.
PM24	The degree to which MCHB-funded initiatives contribute to infrastructure development through core public health assessment, policy development and assurance functions.
PM33	The degree to which MCHB-funded initiatives work to promote sustainability of their programs or initiatives beyond the life of MCHB funding.
PM41	The degree to which grantees have assisted in developing, supporting, and promoting medical homes for MCH populations.

07 PERFORMANCE MEASURE

Goal 1: Provide National Leadership for MCHB (Promote family participation in care)
Level: Grantee
Category: Family/Youth/Consumer Participation

	The degree to which MCHB-funded programs ensure family, youth, and consumer participation in program and policy activities.
GOAL	To increase family/youth/consumer participation in MCHB programs.
MEASURE	The degree to which MCHB-funded programs ensure family/youth/consumer participation in program and policy activities.
DEFINITION	Attached is a checklist of eight elements that demonstrate family participation, including an emphasis on family-professional partnerships and building leadership opportunities for families and consumers in MCHB programs. Please check the degree to which the elements have been implemented.
HEALTHY PEOPLE 2010 OBJECTIVE	Related to Objective 16.23. Increase the proportion of Territories and States that have service systems for Children with Special Health Care Needs to 100 percent.
DATA SOURCE(S) AND ISSUES	Attached data collection form is to be completed by grantees.
SIGNIFICANCE	Over the last decade, policy makers and program administrators have emphasized the central role of families and other consumers as advisors and participants in policy-making activities. In accordance with this philosophy, MCHB is facilitating such partnerships at the local, State and national levels. Family/professional partnerships have been: incorporated into the MCHB Block Grant Application, the MCHB strategic plan. Family/professional partnerships are a requirement in the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) and part of the legislative mandate that health programs supported by Maternal and Child Health Bureau (MCHB) Children with Special Health Care Needs (CSHCN) provide and promote family centered, community-based, coordinated care.

DATA COLLECTION FORM FOR DETAIL SHEET #07

Using a scale of 0-3, please rate the degree to which the grant program has included families, youth, and consumers into their program and planning activities. Please use the space provided for notes to describe activities related to each element and clarify reasons for score.

0	1	2	3	Element
				1. Family members/youth/consumers participate in the planning, implementation and evaluation of the program's activities at all levels, including strategic planning, program planning, materials development, program activities, and performance measure reporting.
				2. Culturally diverse family members/youth/consumers facilitate the program's ability to meet the needs of the populations served.
				3. Family members/youth/consumers are offered training, mentoring, and opportunities to lead advisory committees or task forces.
				4. Family members/youth/consumers who participate in the program are compensated for their time and expenses.
				5. Family members/youth/consumers participate on advisory committees or task forces to guide program activities.
				6. Feedback on policies and programs is obtained from families/youth/consumers through focus groups, feedback surveys, and other mechanisms as part of the project's continuous quality improvement efforts.
				7. Family members/youth/consumers work with their professional partners to provide training (pre-service, in-service and professional development) to MCH/CSHCN staff and providers.
				8. Family /youth/consumers provide their perspective to the program as paid staff or consultants.

0=Not Met
1=Partially Met
2=Mostly Met
3=Completely Met

Total the numbers in the boxes (possible 0-24 score) _____

NOTES/COMMENTS:

10 PERFORMANCE MEASURE **Goal 2: Eliminate Health Barriers & Disparities (Develop and promote health services and systems of care designed to eliminate disparities and barriers across MCH populations)** **Level: Grantee** **Category: Cultural Competence**	The degree to which MCHB-funded programs have incorporated cultural and linguistic competence elements into their policies, guidelines, contracts and training.
GOAL	To increase the number of MCHB-funded programs that have integrated cultural and linguistic competence into their policies, guidelines, contracts and training.
MEASURE	The degree to which MCHB-funded programs have incorporated cultural and linguistic competence elements into their policies, guidelines, contracts and training.
DEFINITION	Attached is a checklist of 10 elements that demonstrate cultural and linguistic competency. Please check the degree to which the elements have been implemented. The answer scale for the entire measure is 0-30. Please keep the completed checklist attached. Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (Adapted from Cross, 1989; sited from DHHS Office of Minority Health--http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlid=11) Linguistic competence is the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic competency requires organizational and provider capacity to respond effectively to the health literacy needs of populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity. (Goode, T. and W. Jones, 2004. National Center for Cultural Competence;

http://www.nccccurricula.info/linguisticcompetence.html)

Cultural and linguistic competency is a process that occurs along a developmental continuum. A culturally and linguistically competent program is characterized by elements including the following: written strategies for advancing cultural competence; cultural and linguistic competency policies and practices; cultural and linguistic competence knowledge and skills building efforts; research data on populations served according to racial, ethnic, and linguistic groupings; participation of community and family members of diverse cultures in all aspects of the program; faculty and other instructors are racially and ethnically diverse; faculty and staff participate in professional development activities related to cultural and linguistic competence; and periodic assessment of trainees' progress in developing cultural and linguistic competence.

HEALTHY PEOPLE 2010 OBJECTIVE

Related to the following HP2010 Objectives:

16.23: Increase the proportion of States and jurisdictions that have service systems for children with or at risk for chronic and disabling conditions as required by Public Law 101-239.

23.9: (Developmental) Increase the proportion of schools for public health workers that integrate into their curricula specific content to develop competency in the essential public health services.

23.11:(Developmental) Increase the proportion of State and local public health agencies that meet national performance standards for essential public health services.

23.15: (Developmental) Increase the proportion of Federal, Tribal, State, and local jurisdictions that review and evaluate the extent to which their statutes, ordinances, and bylaws assure the delivery of essential public health services.

DATA SOURCE(S) AND ISSUES

Attached data collection form is to be completed by grantees.
There is no existing national data source to measure the extent to which MCHB supported programs have incorporated cultural competence elements into their policies, guidelines, contracts and training.

SIGNIFICANCE

Over the last decade, researchers and policymakers have emphasized the central influence of cultural values and cultural/linguistic barriers: health seeking behavior, access to care, and racial and ethnic disparities. In accordance with these concerns, cultural competence objectives have

been: (1) incorporated into the MCHB strategic plan; and (2) in guidance materials related to the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), which is the legislative mandate that health programs supported by MCHB Children with Special Health Care Needs (CSHCN) provide and promote family centered, community-based, coordinated care.

DATA COLLECTION FORM FOR DETAIL SHEET #10

Using a scale of 0-3, please rate the degree to which your grant program has incorporated the following cultural/linguistic competence elements into your policies, guidelines, contracts and training.

Please use the space provided for notes to describe activities related to each element, detail data sources and year of data used to develop score, clarify any reasons for score, and or explain the applicability of elements to program.

0	1	2	3	Element
				1. Strategies for advancing cultural and linguistic competency are integrated into your program's written plan(s) (e.g., grant application, recruiting plan, placement procedures, monitoring and evaluation plan, human resources, formal agreements, etc.).
				2. There are structures, resources, and practices within your program to advance and sustain cultural and linguistic competency.
				3. Cultural and linguistic competence knowledge and skills building are included in training aspects of your program.
				4. Research or program information gathering includes the collection and analysis of data on populations served according to racial, ethnic, and linguistic groupings, where appropriate.
				5. Community and family members from diverse cultural groups are partners in planning your program.
				6. Community and family members from diverse cultural groups are partners in the delivery of your program.
				7. Community and family members from diverse cultural groups are partners in evaluation of your program.
				8. Staff and faculty reflect cultural and linguistic diversity of the significant populations served.
				9. Staff and faculty participate in professional development activities to promote their cultural and linguistic competence.
				10. A process is in place to assess the progress of your program participants in developing cultural and linguistic competence.

0 = Not Met
1 = Partially Met
2 = Mostly Met
3 = Completely Met

Total the numbers in the boxes (possible 0-30 score) _____

NOTES/COMMENTS*:*

24 PERFORMANCE MEASURE **Goal 4: Improve the Health Infrastructure and Systems of Care** **(Assist States and communities to plan and develop comprehensive, integrated health service systems)** **Level: State, Community, or Grantee** **Category: Infrastructure**	The degree to which MCHB-funded initiatives contribute to infrastructure development through core public health assessment, policy development and assurance functions**.**
GOAL	To develop infrastructure that supports comprehensive and integrated services.
MEASURE	The degree to which MCHB-supported initiatives contribute to the implementation of the 10 MCH Essential Services and Core Public Health Program Functions of assessment, policy development and assurance.
DEFINITION	Attached is a checklist of 10 elements that comprise infrastructure development services for maternal and child health populations. Please score the degree to which each your program contributes to the implementation of each of these elements Each element should be scored 0-2, with a maximum total score of 20 across all elements.
HEALTHY PEOPLE 2010 OBJECTIVE	Related to Healthy People Goal 23, Objective 12 (23.12): Increase the proportion of tribes, States, and local health agencies that have implemented a health improvement plan and increase the proportion of local health jurisdictions that have a health improvement plan linked with their State plan.
DATA SOURCE(S) AND ISSUES	Attached data collection form to be completed by grantees based on activities they are directly engaged in or that they contribute to the implementation of by other MCH grantees or programs.
SIGNIFICANCE	Improving the health infrastructure and systems of care is one of the five goals of MCHB. There are five strategies under this goal, all of which are addressed in a number of MCHB initiatives which focus on system-building and infrastructure development. These five strategies follow: Build analytic capacity for assessment, planning, and evaluation. Using the best available evidence, develop and

promote guidelines and practices that improve services and systems of care.
Assist States and communities to plan and develop comprehensive, integrated health service systems.
Work with States and communities to assure that services and systems of care reach targeted populations.
Work with States and communities to address selected issues within targeted populations.

The ten elements in this measure are comparable to the 10 Essential Public Health Services outlined in Grason H, Guyer B, 1995. *Public MCH Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America*. Baltimore, MD: The Women's and Children's Health Policy Center, The Johns Hopkins University.

DATA COLLECTION FORM FOR DETAIL SHEET #24

Use the scale below to describe the extent to which your program or initiative has contributed to the implementation of each of the following Public MCH Program core function activities at the local, State, or national level. Please use the space provided for notes to clarify reasons for score

.

0	1	2	Element
Assessment Function Activities			
			1. Assessment and monitoring of maternal and child health status to indentify and address problems, including a focus on addressing health disparities [Examples of activities include: developing frameworks, methodologies, and tools for standardized MCH data in public and private sectors; implementing population-specific accountability for MCH components of data systems, and analysis, preparation and reporting on trends of MCH data and health disparities among subgroups.]
			2. Diagnosis and investigation health problems and health hazards affecting maternal and child health populations [Examples of activities include conduct of population surveys and reports on risk conditions and behaviors, identification of environmental hazards and preparation of reports on risk conditions and behaviors.]
			3. Informing and educating the public and families about MCH issues.
Policy Development Function Activities			
			4. Mobilization of community collaborations and partnerships to identify and solve MCH problems. [Examples of stakeholders to be involved in these partnerships include: policymakers, health care providers, health care insurers and purchasers, families, and other MCH care consumers.]
			5. Provision of leadership for priority setting, planning and policy development to support community efforts to assure the health of maternal and child health populations.
			6. Promotion and enforcement of legal requirements that protect the health and safety of maternal and child health populations.
Assurance Function Activities			
			7. Linkage of maternal and child health populations to health and other community and family services, and assuring access to comprehensive quality systems of care
			8. Assuring the capacity and competency of the public health and personal health workforce to effectively and efficiently address MCH needs.
			9. Evaluate the effectiveness, accessibility and quality of direct, enabling and population-based preventive MCH services
		\	10. Research and demonstrations to gain new insights and innovative solutions to MCH-related issues and problems

0 = Grantee does not provide or contribute to the provision of this activity.
1 = Grantee sometimes provides or contributes to the provision of this activity.
2 = Grantee regularly provides or contributes to the provision of this activity
Total the numbers in the boxes (possible 0–20 score): _____

NOTES/COMMENTS*:*

33 PERFORMANCE MEASURE **Goal 4: Improve the Health Infrastructure and Systems of Care (Assist States and communities to plan and develop comprehensive, integrated health service systems)** **Level: Grantee** **Category: Infrastructure**	The degree to which MCHB-funded initiatives work to promote sustainability of their programs or initiatives beyond the life of MCHB funding.
GOAL	To develop infrastructure that supports comprehensive and integrated systems of care for maternal and child health at the local and/or state level.
MEASURE	The degree to which MCHB grantees are planning and implementing strategies to sustain their programs once initial MCHB funding ends.
DEFINITION	Attached is a checklist of nine actions or strategies that build toward program sustainability. Please check the degree to which each of the elements is being planned or carried out by your program, using the three-point scale. The maximum total score for this measure would be 27 across all elements.
HEALTHY PEOPLE 2010 OBJECTIVE	Related to Healthy People Goal 23, Objective 12 (23.12): Increase the proportion of Tribes, States, and local health agencies that have implemented a health improvement plan and increase the proportion of local health jurisdictions that have a health improvement plan linked with their State plan.
DATA SOURCE(S) AND ISSUES	Attached is a data collection form to be completed by grantees. Since these actions and their outcomes are necessarily progressive over time from the beginning to the end of a program funding period, grantees' ratings on each element are expected to begin lower in the first year of grant award and increase over time.
SIGNIFICANCE	In recognition of the increasing call for recipients of public funds to sustain their programs after initial funding ends, MCHB encourages grantees to work toward sustainability throughout their grant periods. A number of different terms and explanations have been used as operational components of sustainability. These components fall into four major categories, each emphasizing a distinct focal point as being at the heart of the sustainability process: (1) adherence to program

principles and objectives, (2) organizational integration, (3) maintenance of health benefits, and (4) State or community capacity building. Specific recommended actions that can help grantees build toward each of these four sustainability components are included as the data elements for this PM.

DATA COLLECTION FORM FOR DETAIL SHEET #33

Use the scale below to rate the degree to which your program has taken the following actions to promote sustainability of your program or initiative. Since these actions and their outcomes are necessarily progressive over the funding period, the ratings are expected to begin lower and progress over the grant period.

Please use the space provided for notes to clarify reasons for score.

0	1	2	3	Element
				1. A written sustainability plan is in place within two years of the MCHB grant award, with goals, objectives, action steps, and timelines to monitor plan progress.
				2. Staff and leaders in the organization engage and build partnerships with consumers, and other key stakeholders in the community, in the early project planning, and in sustainability planning and implementation processes.
				3. There is support for the MCHB-funded program or initiative within the parent agency or organization, including from individuals with planning and decision making authority.
				4. There is an advisory group or a formal board that includes family, community and state partners, and other stakeholders who can leverage resources or otherwise help to sustain the successful aspects of the program or initiative.
				5. The program's successes and identification of needs are communicated within and outside the organization among partners and the public, using various internal communication, outreach and marketing strategies.
				6. The grantee identified, actively sought, and obtained other funding sources and in-kind resources to sustain the program or initiative.
				7. Policies and procedures developed for the successful aspects of the program or initiative are incorporated into the parent or another organization's system of programs and services.
				8. The responsibilities for carrying out key successful aspects of the program or initiative have begun to be transferred to permanent staff positions in other ongoing programs or organizations.
				9. The grantee has secured financial or in-kind support from within the parent organization or external organizations to sustain the successful aspects of the MCHB-funded program or initiative.

0 = Not Met
1 = Partially Met
2 = Mostly Met
3 = Completely Met

Total the numbers in the boxes (possible 0–27 score): _____

NOTES/COMMENTS*:*

41 PERFORMANCE MEASURE **Goal 3: Ensure Quality of Care (Develop and promote health services and systems designed to improve quality of care)** **Level: National** **Category: Medical Home**	The degree to which grantees have assisted in developing, supporting, and promoting medical homes for MCH populations.
GOAL	To increase the prevalence of medical homes within the systems that serve MCH populations.
MEASURE	The degree to which grantees have assisted in developing and supporting systems of care for MCH populations that promote the medical home.
DEFINITION	Attached is a set of five categories with a total of 24 elements that contribute to a family/patient-centered, accessible, comprehensive, continuous, and compassionate system of care for MCH populations. Please use the space provided for notes to describe activities related to each element and clarify reasons for score.
HEALTHY PEOPLE 2010 OBJECTIVE	Related to Objective 16.22 (Developmental): Increase the proportion of CSCHN who have access to a medical home.
DATA SOURCE(S) AND ISSUES	Attached is a data collection form to be completed by grantees. The data collection form presents a range of activities that contribute to the development of medical homes for MCH populations.
SIGNIFICANCE	Providing primary care to children in a "medical home" is the standard of practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, less likely to be hospitalized for preventable conditions, and more likely to be diagnosed early for chronic or disabling conditions. Data collected for this measure would help to ensure that children have access to a medical home and help to document the performance of several programs, including EPSDT, immunization, and IDEA in reaching that goal.

DATA COLLECTION FORM FOR DETAIL SHEET #41

Using the scale below, indicate the degree to which your grant has assisted in the development and implementation of medical homes for MCH populations. Please use the space below to indicate the year the score is reported for and clarify reasons for the score.

Indicate population: pregnant and postpartum women, infants, children, children with special health care needs, adolescents

(While this is a single performance measure, for analytic purposes each of the categories will be scored as an independent measure. Grantees may identify specific categories as not applicable to their grant program by selecting a score of 0 for every item within the category.)

0	1	2	3	Element
Category A: Establishing and Supporting Medical Home Practice Sites				
				1. The grantee has conducted needs and capacity assessments to assess the adequacy of the supply of medical homes in their community, state, or region.
				2. The grantee has recruited health care providers to become the medical homes.
				3. The grantee has developed or adapted training curricula for primary care providers in the medical home concept.
				4. The grantee has provided training to health care providers in the definition and implementation of the medical home and evaluated its effectiveness.
				5. The grantee has assisted practice sites in implementing health information technologies in support of the medical home.
				6. The grantee has developed/implemented tools for the monitoring and improvement of quality within medical homes.
				7. The grantee has disseminated validated tools such as the Medical Home Index to practice sites and trained providers in their use.
				8. The grantee has developed/implemented quality improvement activities to support medical home implementation.
Category A Subtotal (possible 0-24):				
Category B: Developing and Disseminating Information and Policy Development Tools: The grantee has developed tools for the implementation of the medical home and promoted the medical home through policy development				
				9. Referral resource guides
				10. Coordination protocols
				11. Screening tools
				12. Web sites
				13. The grantee has developed and promoted policies,

0	1	2	3	Element
				including those concerning data-sharing, on the State or local level to support the medical home
				14. The grantee has provided information to policymakers in issues related to the medical home
Category B Subtotal (possible 0-18):				
Category C: Public Education and Information Sharing: The grantee has implemented activities to inform the public about the medical home and its features and benefits				
				15. The grantee has developed Web sites and/or other mechanisms to disseminate medical home information to the public.
				16. The grantee has provided social service agencies, families and other appropriate community-based organizations with lists of medical home sites.
				17. The grantee has engaged in public education campaigns about the medical home.
Category C Subtotal (possible 0-9):				
Category D: Partnership-Building Activities				
				18. The grantee has established a multidisciplinary advisory group, including families and consumers representative of the populations served, to oversee medical home activities
				19. The grantee has coordinated and/or facilitated communication among stakeholders serving MCH populations (e.g., WIC, domestic violence shelters, local public health departments, rape crisis centers, and ethnic/culturally-based community health organizations)
				20. The grantee has worked with the State Medicaid agency and other public and private sector purchasers on financing of the medical home.
				21. The grantee has worked with health care providers and social service agencies to implement integrated data systems.
Category D Subtotal (possible 0-12):				
Category E: Mentoring Other States and Communities				
				22. The degree to which the grantee has shared medical home tools with other communities and States.
				23. The degree to which the grantee has presented its experience establishing and supporting medical homes to officials of other communities, family champions, and/or States at national meetings
				24. The degree to which the grantee has provided direct consultation to other States on policy or program development for medical home initiatives

0	1	2	3	Element
Category E Subtotal (possible 0-9):				

0 = Not Met
1 = Partially Met
2 = Mostly Met
3 = Completely Met

Total the numbers in the boxes (possible 0-72 score)_____

NOTES/COMMENTS:

71 PERFORMANCE MEASURE	The percent of pre-hospital provider agencies in the State/Territory that have on-line pediatric medical direction.
GOAL	By 2011: • 90% of basic life support (BLS) pre-hospital provider agencies in the State/Territory have on-line pediatric medical direction available from dispatch through patient transport to a definitive care facility. • 90% of advanced life support (ALS) pre-hospital provider agencies in the State/Territory have on-line pediatric medical direction available from dispatch through patient transport to a definitive care facility.
MEASURE	The percent of pre-hospital provider agencies in the State/Territory that have on-line pediatric medical direction available from dispatch through patient transport to a definitive care facility.
DEFINITION	**Numerator (BLS provider agencies):** Number of BLS pre-hospital provider agencies that have on-line pediatric medical direction according to the data collected. **Denominator (BLS provider agencies):** Total number of BLS pre-hospital provider agencies that provided data. **Units:** 100 **Text:** Percent **Numerator (ALS provider agencies):** Number of ALS pre-hospital provider agencies that have on-line pediatric medical direction according to the data collected. **Denominator (ALS provider agencies):** Total number of ALS pre-hospital provider agencies

that provided data.

Units: 100 **Text:** Percent

On-line pediatric medical direction: An individual is available 24/7 to EMS providers who need medical advice when providing care to a pediatric patient. This person must be a medical professional (e.g., nurse, physician, physician assistant [PA], nurse practitioner or EMT-P) and must have a higher level of pediatric training/expertise than the EMS provider to whom he/she is providing medical advice.

Pre-hospital provider agency: A provider of emergency medical services staffed with BLS and/or ALS personnel who render medical care in response to a 911 or similar emergency call. For purposes of this measure, agencies will be classified as either BLS or ALS according to their highest level of licensure (BLS or ALS) from the state or local licensing/recognizing authority. Data will need to be gathered from both transporting and non-transporting agencies.

Pediatric: Any person 0 to 18 years of age.

EMSC STRATEGIC OBJECTIVE

Related to EMSC Strategic Plan Objective 2: Ensure the operational capacity and infrastructure to provide pediatric emergency care.

Objective 2.1: Develop evidence or consensus based on-line and off-line pediatric medical direction for basic and advanced life support providers

DATA SOURCE(S) AND ISSUES

- Surveys of pre-hospital provider agencies
- Other approved data source

SIGNIFICANCE

At the scene of an emergency, EMS providers that

may not have the expertise to deal with pediatric patients need 24/7 access to a higher level medical provider who can provide real time patient care advice.

72 PERFORMANCE MEASURE	The percent of pre-hospital provider agencies in the State/Territory that have off-line pediatric medical direction.
GOAL	By 2011: • 90% of basic life support (BLS) pre-hospital provider agencies in the State/Territory have off-line pediatric medical direction available from dispatch through patient transport to a definitive care facility. • 90% of advanced life support (ALS) pre-hospital provider agencies in the State/Territory have off-line pediatric medical direction available from dispatch through patient transport to a definitive care facility.
MEASURE	The percent of pre-hospital provider agencies in the State/Territory that have pediatric off-line medical direction available from dispatch through patient transport to a definitive care facility.
DEFINITION	**Numerator (BLS provider agencies):** Number of BLS pre-hospital provider agencies that have off-line pediatric medical direction according to the data collected. **Denominator (BLS provider agencies):** Total number of BLS pre-hospital provider agencies that provided data. **Units:** 100 **Text:** Percent **Numerator (ALS provider agencies):** Number of ALS pre-hospital provider agencies that have off-line pediatric medical direction according to the data collected.

Denominator (ALS provider agencies):

Total number of ALS pre-hospital provider agencies that provided data.

Units: 100 **Text:** Percent

Off-line pediatric medical direction: Treatment guidelines and protocols used by EMS providers to ensure the provision of appropriate pediatric patient care, available in written or electronic (e.g., laptop/tablet computer) form in the unit or with a provider. **Protocols must be available from the time of dispatch through patient transport to a definitive care facility.**

Pre-hospital provider agency: A provider of emergency medical services staffed with BLS and/or ALS personnel who render medical care in response to a 911 or similar emergency call. For purposes of this measure, agencies will be classified as either BLS or ALS according to their highest level of licensure (BLS or ALS) from the state or local licensing/recognizing authority. Data will need to be gathered from both transporting and non-transporting agencies.

Pediatric: Any person 0 to 18 years of age.

EMSC STRATEGIC OBJECTIVE

Related to EMSC Strategic Plan Objective 2: Ensure the operational capacity and infrastructure to provide pediatric emergency care.

Objective 2.1: Develop evidence or consensus based on-line and off-line pediatric medical direction for basic and advanced life support providers.

DATA SOURCE(S) AND ISSUES

- Surveys of pre-hospital provider agencies.
- Review of state inspection reports

SIGNIFICANCE

There are gaps that currently exist in the pediatric emergency care system. For example, while pediatric patient care protocols are available, standardized adoption and use of the guidelines among providers is problematic. These gaps can result in poor pediatric outcomes (e.g., increased morbidity and mortality). This measure will ensure that providers across the pre-hospital and hospital settings are delivering optimal pediatric emergency care based on a standardized set of guidelines, which will ultimately improve the quality and adequacy of pediatric emergency care.

73 PERFORMANCE MEASURE	The percent of patient care units in the State/Territory that have essential pediatric equipment and supplies.
GOAL	By 2011: • 90% of basic life support (BLS) patient care units in the State/Territory have the essential pediatric equipment and supplies, as outlined in national guidelines for pediatric equipment and supplies for basic life support ambulances. • 90% of advanced life support (ALS) patient care units in the State/Territory have the essential pediatric equipment and supplies, as outlined in national guidelines for pediatric equipment and supplies for advanced life support ambulances.
MEASURE	The percent of patient care units in the State/Territory that have the essential pediatric equipment and supplies as outlined in national guidelines.
DEFINITION	**Numerator (BLS patient care units):** Number of BLS patient care units that have the essential pediatric equipment and supplies according to the data collected. **Denominator (BLS patient care units):** Total number of BLS patient care units for which data was provided. **Units:** 100 **Text:** Percent **Numerator (ALS patient care units):** Number of ALS patient care units that have the essential pediatric equipment and supplies according to the data collected. **Denominator (ALS patient care units):** Total number of ALS patient care units for which

data was collected.

Units: 100 **Text:** Percent

Patient Care Unit: A patient care unit is defined as a vehicle staffed with EMS providers (BLS and/or ALS) dispatched in response to a 911 or similar emergency call AND responsible for transporting a patient to the hospital. Examples include an ambulance, or other type of transporting unit. This definition excludes non-transport vehicles (such as chase cars) to provide additional personnel resources, air ambulances, exclusively defined specialty care units, and water ambulances/units.

Pediatric: Any person 0 to 18 years of age.

National guidelines: Equipment list recognized by the EMSC Program.

Essential: The item is deemed necessary for the care of pediatric patients and should be carried by a patient care unit.

EMSC STRATEGIC OBJECTIVE

Related to EMSC Strategic Plan Objective 2: Ensure the operational capacity and infrastructure to provide pediatric emergency care

Objective 2.2: Assess the availability of essential pediatric equipment and supplies for basic and advanced life support ambulances.

DATA SOURCE(S) AND ISSUES

- Surveys of pre-hospital provider agencies that transport patients.
- Review of state inspection reports.

SIGNIFICANCE

There are gaps that currently exist in the pediatric emergency care system. For example, while equipment guidelines are available, standardized adoption and use of the guidelines among providers is problematic. These gaps can result in poor

pediatric outcomes (e.g., increased morbidity and mortality). This measure will ensure that providers across the pre-hospital and hospital settings are delivering optimal pediatric emergency care based on a standardized set of equipment guidelines, which will ultimately improve the quality and adequacy of pediatric emergency care.

74 PERFORMANCE MEASURE	The percent of hospitals with an Emergency Department (ED) recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies.
GOAL	By 2017: • 25% of hospitals are recognized as part of a statewide, territorial, or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies.
MEASURE	The percent of hospitals recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies.
DEFINITION	**Numerator:** Number of hospitals with an ED that are recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies. **Denominator:** Total number of hospitals with an ED in the State/Territory. **Units:** 100 **Text:** Percent **Standardized system:** A system that recognizes the readiness and capability of a hospital and its staff to triage and provide care appropriately, based upon the severity of illness/injury of the child. The system designates/verifies hospitals as providers of a certain level of emergency care within a specified geographic area (e.g., region). A facility recognition process usually involves a formal assessment of a hospital's capacity to provide pediatric emergency care via site visits and/or a formal application process implemented by a State/Territory or local government body, such as

	the State EMSC Program, State EMS Office, and/or local hospital/health care provider association.
	Hospital: Facilities that provide definitive medical and/or surgical assessment, diagnoses, and life and/or limb saving interventions for the ill and injured AND have an Emergency Department. Excludes Military and Indian Health Service hospitals.
EMSC STRATEGIC OBJECTIVE	Related to EMSC Strategic Plan Objective 2: Ensure the operational capacity and infrastructure to provide pediatric emergency care. Objective 2.3: Develop a statewide, territorial, or regional standardized system that recognizes hospitals that are able to stabilize and/or manage pediatric medical emergencies and trauma.
DATA SOURCE(S) AND ISSUES	• This performance measure will require grantees to determine how many hospitals participate in their facility recognition program (if the state has a facility recognition program) for trauma and for medical.
SIGNIFICANCE	The performance measure emphasizes the importance of the existence of a standardized statewide, territorial, or regional system that recognizes hospitals capable of stabilizing and/or managing pediatric medical emergencies and trauma. A standardized categorization and/or designation process assists hospitals in determining their capacity and readiness to effectively deliver pediatric emergency and specialty care.

DATA COLLECTION FORM FOR DETAIL SHEET # 74

The percent of hospitals with an Emergency Department (ED) that are recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies.

Numerator:	
Denominator:	
Percent	

Numerator: Number of hospitals with an ED that are recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies.

Denominator: Total number of hospitals with an ED in the State/Territory.

Using a scale of 0-5, please rate the degree to which your State/Territory has made towards establishing a recognition system for pediatric medical emergencies.

Element	0	1	2	3	4	5
1. Indicate the degree to which a standardized system for pediatric medical emergencies exists.						

0= No progress has been made towards developing a statewide, territorial, or regional system that recognizes hospitals that are able to stabilize and/or manage pediatric medical emergencies

1= Research has been conducted on the effectiveness of a pediatric medical facility recognition program (i.e., improved pediatric outcomes)

And/or

Developing a pediatric medical facility recognition program has been discussed by the EMSC Advisory Committee and members are working on the issue.

2= Criteria that facilities must meet in order to receive recognition as a pediatric medical facility have been developed.

3= An implementation process/plan for the pediatric medical facility recognition program has been developed.

4= The implementation process/plan for the pediatric medical facility recognition program has been piloted.

5= At least one facility has been formally recognized through the pediatric medical facility recognition program

75 PERFORMANCE MEASURE	The percent of hospitals with an Emergency Department (ED) recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric traumatic emergencies.
GOAL	By 2017: • 50% of hospitals are recognized as part of a statewide, territorial, or regional standardized system that recognizes hospitals that are able to stabilize and/or manage pediatric trauma.
MEASURE	The percent of hospitals recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric traumatic emergencies.
DEFINITION	**Numerator:** Number of hospitals with an ED that are recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric traumatic emergencies. **Denominator:** Total number of hospitals with an ED in the State/Territory. **Units:** 100 **Text:** Percent **Standardized system:** A system that recognizes the readiness and capability of a hospital and its staff to triage and provide care appropriately, based upon the severity of illness/injury of the child. The system designates/verifies hospitals as providers of a certain level of emergency care within a specified geographic area (e.g., region). A facility recognition process usually involves a formal assessment of a hospital's capacity to provide pediatric emergency care via site visits and/or a formal application process implemented by a State/Territory or local government body, such as

	the State EMSC Program, State EMS Office, and/or local hospital/health care provider association.
	Hospital: Facilities that provide definitive medical and/or surgical assessment, diagnoses, and life and/or limb saving interventions for the ill and injured AND have an Emergency Department. Excludes Military and Indian Health Service hospitals.
EMSC STRATEGIC OBJECTIVE	Related to EMSC Strategic Plan Objective 2: Ensure the operational capacity and infrastructure to provide pediatric emergency care. Objective 2.3: Develop a statewide, territorial, or regional standardized system that recognizes hospitals that are able to stabilize and/or manage pediatric medical emergencies and trauma.
DATA SOURCE(S) AND ISSUES	• This performance measure will require grantees to determine how many hospitals participate in their facility recognition program (if the state has a facility recognition program) for trauma and for medical.
SIGNIFICANCE	The performance measure emphasizes the importance of the existence of a standardized statewide, territorial, or regional system that recognizes hospitals capable of stabilizing and/or managing pediatric medical emergencies and trauma. A standardized categorization and/or designation process assists hospitals in determining their capacity and readiness to effectively deliver pediatric emergency and specialty care.

DATA COLLECTION FORM FOR DETAIL SHEET # 75

The percent of hospitals with an Emergency Department (ED) that are recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric traumatic emergencies.

Numerator:	
Denominator:	
Percent	

Numerator: Number of hospitals with an ED that are recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric traumatic emergencies.

Denominator: Total number of hospitals with an ED in the State/Territory.

Using a scale of 0-5, please rate the degree to which your State/Territory has made towards establishing a recognition system for pediatric traumatic emergencies.

Element	0	1	2	3	4	5
1. Indicate the degree to which a standardized system for pediatric traumatic emergencies exists.						

0= No progress has been made towards developing a statewide, territorial, or regional system that recognizes hospitals that are able to stabilize and/or manage pediatric trauma emergencies

1= Research has been conducted on the effectiveness of a pediatric trauma facility recognition program (i.e., improved pediatric outcomes)

And/or

Developing a pediatric trauma facility recognition program has been discussed by the EMSC Advisory Committee and members are working on the issue.

2= Criteria that facilities must meet in order to receive recognition as a pediatric trauma facility have been developed.

3= An implementation process/plan for the pediatric trauma facility recognition program has been developed.

4= The implementation process/plan for the pediatric trauma facility recognition program has been piloted.

5= At least one facility has been formally recognized through the pediatric trauma facility recognition program

76 PERFORMANCE MEASURE	The percent of hospitals with an Emergency Department (ED) in the State/Territory that have written inter-facility transfer guidelines that cover pediatric patients and that contain all the components as per the implementation manual.
GOAL	By 2011: • 90% of hospitals in the State/Territory have written inter-facility transfer guidelines that cover pediatric patients and that include specific components of transfer.
MEASURE	The percentage of hospitals in the State/Territory that have written inter-facility transfer guidelines that cover pediatric patients and that include the following components of transfer: • Defined process for initiation of transfer, including the roles and responsibilities of the referring facility and referral center (including responsibilities for requesting transfer and communication). • Process for selecting the appropriate care facility. • Process for selecting the appropriately staffed transport service to match the patient's acuity level (level of care required by patient, equipment needed in transport, etc.). • Process for patient transfer (including obtaining informed consent). • Plan for transfer of patient medical record • Plan for transfer of copy of signed transport consent • Plan for transfer of personal belongings of the patient • Plan for provision of directions and referral institution information to family
DEFINITION	**Numerator:**

Number of hospitals with an ED that have written inter-facility transfer guidelines that cover pediatric patients and that include specific components of transfer according to the data collected.

Denominator:

Total number of hospitals with an ED that provided data.

Units: 100 **Text:** Percent

Pediatric: Any person 0 to 18 years of age.

Inter-facility transfer guidelines: Hospital-to-hospital, including out of State/Territory, guidelines that outline procedural and administrative policies for transferring critically ill patients to facilities that provide specialized pediatric care, or pediatric services not available at the referring facility. Inter-facility guidelines do not have to specify transfers of pediatric patients only. A guideline that applies to **all patients or patients of all ages** would suffice, as long as it is not written only for adults. Grantees should consult the EMSC Program representative if they have questions regarding guideline inclusion of pediatric patients. In addition, hospitals may have one document that comprises both the inter-facility transfer guideline and agreement. This is acceptable as long as the document meets the definitions for pediatric inter-facility transfer guidelines and agreements (i.e., the document contains all components of transfer).

All hospitals in the State/Territory should have guidelines to transfer to a facility capable of providing pediatric services not available at the referring facility. If a facility cannot provide a particular type of care (e.g., burn care), then it also should have transfer guidelines in place. Consult the NRC to ensure that the facility (facilities) providing the highest level of care in the state/territory is capable of definitive care for all pediatric needs. Also, note that being in compliance with EMTALA does not constitute having inter-facility transfer guidelines.

Hospital: Facilities that provide definitive medical and/or surgical assessment, diagnoses, and life and/or limb saving interventions for the ill and injured AND have an Emergency Department (ED). Excludes Military and Indian Health Service hospitals.

EMSC STRATEGIC OBJECTIVE

Related to EMSC Strategic Plan Objective 2: Ensure the operational capacity and infrastructure to provide pediatric emergency care

Objective 2.4: Develop written pediatric inter-facility transfer guidelines for hospitals.

DATA SOURCE(S) AND ISSUES

- Surveys of hospitals with an emergency department.
- Hospital licensure rules and regulations

SIGNIFICANCE

In order to assure that children receive optimal care, timely transfer to a specialty care center is essential. Such transfers are better coordinated through the presence of inter-facility transfer agreements and guidelines.

77 PERFORMANCE MEASURE	The percent of hospitals with an Emergency Department (ED) in the State/Territory that have written inter-facility transfer agreements that cover pediatric patients.
GOAL	By 2011: • 90% of hospitals in the State/Territory have written inter-facility transfer agreements that cover pediatric patients.
MEASURE	The percentage of hospitals in the State/Territory that have written inter-facility transfer agreements that cover pediatric patients.
DEFINITION	**Numerator:** Number of hospitals with an ED that have written inter-facility transfer agreements that cover pediatric patients according to the data collected. **Denominator:** Total number of hospitals with an ED that provided data. **Units:** 100 **Text:** Percent **Pediatric:** Any person 0 to 18 years of age. **Inter-facility transfer agreements:** Written contracts between a referring facility (e.g., community hospital) and a specialized pediatric center or facility with a **higher level of care** and the appropriate resources to provide needed care required by the child. The agreements must formalize arrangements for consultation and transport of a pediatric patient to the higher-level care facility. Inter-facility agreements do not have to specify transfers of pediatric patients only. An agreement that applies to **all** patients or patients of **all** ages would suffice, as long as it is not written ONLY for adults. Grantees should consult the NRC if they have questions regarding inclusion of

	pediatric patients in established agreements.
EMSC STRATEGIC OBJECTIVE	Related to EMSC Strategic Plan Objective 2: Ensure the operational capacity and infrastructure to provide pediatric emergency care. Objective 2.5: Develop written pediatric inter-facility transfer agreements to facilitate timely movement of children to appropriate facilities.
DATA SOURCE(S) AND ISSUES	• Surveys of hospitals with an emergency department. • Hospital licensure rules and regulations
SIGNIFICANCE	In order to assure that children receive optimal care, timely transfer to a specialty care center is essential. Such transfers are better coordinated through the presence of inter-facility transfer agreements and guidelines.

78 PERFORMANCE MEASURE	The adoption of requirements by the State/Territory for pediatric emergency education for the license/certification renewal of basic life support (BLS) and advanced life support (ALS) providers.
GOAL	By 2011, the State/Territory will have adopted requirements for pediatric emergency education for the recertification of BLS and ALS providers.
MEASURE	The adoption of requirements by the State/Territory for pediatric emergency education for the license/certification renewal of basic life support (BLS) and advanced life support (ALS) providers.
DEFINITION	**Calculation:** Calculation of this measure involves completing the attached Data Collection Form. Indicate whether your State/Territory has adopted requirements for pediatric emergency education for the recertification of BLS and ALS providers. If yes, provide information on the number of hours and courses required for BLS and ALS providers. If your State/Territory has not adopted requirements, please indicate on the form reasons why, and the steps you have taken towards adopting requirements. You may need to collaborate with the State/Territory EMS Office to complete the form.

Definition of Terms:

Adoption

The requirements have been formally put into place in a mandate at either the State/Territory or County/Regional level (i.e., at every county/region in the State/Territory) and apply to BLS and ALS providers in the State/Territory.

Requirements

Formal written recommendations and guidelines exist for pediatric emergency care education as part of the recertification of BLS and ALS providers. Recommended training curricula and/or courses for BLS and ALS providers may include, but are not limited to,

Pediatric Education for Pre-hospital Professionals (PEPP), Advanced Pediatric Life Support (APLS), and Pediatric Advanced Life Support (PALS) courses. Recommended training courses exclude cardiopulmonary resuscitation (CPR) courses. Requirements that offer a choice of

topics, including pediatrics, do not meet the measure. The requirements must be specific to pediatric education.

Pediatric

Any person 0 to 18 years of age.

Recertification

Refers to the process of re-registering and fulfilling requirements for certification or licensure to continue practicing as a BLS or ALS provider.

Paramedic

Among other procedures, Advanced Life Support (ALS) providers administer higher life and limb saving assessment and interventions including the administration of medications, advanced airway procedures, and cardiac rhythm analysis as well as interpretation and electrical interventions. ALS personnel will include the EMT-Paramedic (EMT-P).and Advanced Cardiac

Rescue certifications/ratings.

EMSC STRATEGIC OBJECTIVE

Related to EMSC Strategic Plan Objective 2: Ensure the operational capacity and infrastructure to provide pediatric emergency care

- Objective 2.6: Develop and adopt minimum requirements for pediatric emergency education as part of the recertification requirements of BLS and ALS emergency medical service providers

DATA SOURCE(S)

Data Sources:

- *State/Territory* EMS rules, regulations, codes or policies
- *County/regional* EMS rules, regulations, codes or policies

IMPLEMENTATION PROCESS

Process to Collect Data For This Measure:

A process for data collection and analysis, as well as an example of supporting documentation are provided below under each data source.

1. ***State/Territory*** **EMS Rules, Regulations, Codes, or Policies**: Your State/Territory EMS Rules, Regulations, Codes, or Policies may include requirements for pediatric emergency education for the re-certification of BLS and ALS providers. These requirements may include those developed by the National Registry of Emergency Medical Technicians (NREMT) or any other recertification requirements adopted by your State/Territory.
   - Review State/Territory EMS Rules, Regulations, Codes, or Policies on an annual basis for pediatric emergency education requirements for the re-certification of BLS and ALS providers.
   - *Supporting documentation* for the measure may include a copy of the State/Territory EMS Rules, Regulations, Codes, or Policies stating the requirements for pediatric emergency education for the re-certification of BLS and ALS providers. Supporting documentation will only need to be submitted if requested by HRSA.
2. ***County/Regional*** **EMS Rules, Regulations, Codes, Policies, or Requirements:** If requirements for pediatric emergency education for the re-certification of BLS and ALS providers have *not* been adopted at the State/Territory level, requirements may have been adopted at the county/regional level in the State/Territory.

- Review County/Regional EMS Rules, Regulations, Codes, Policies, or Requirements on an annual basis for pediatric emergency education requirements for the re-certification of BLS and ALS providers.
- Supporting documentation for the measure may include a copy of the County/Regional EMS Rules, Regulations, Codes, Policies, or Requirements stating the requirements for pediatric emergency education for the re-certification of BLS and ALS providers. Supporting documentation will only need to be submitted if requested by HRSA.

SIGNIFICANCE

Adopting requirements for pediatric emergency care education as part of the recertification of BLS and ALS providers helps to ensure the provision of appropriate pediatric emergency care. This, as a result, helps to improve the quality and adequacy of pediatric emergency care, and thereby, improve pediatric outcomes (e.g., reduced morbidity and mortality).

Data Collection Form for Performance Measure #78

The adoption of requirements by the State/Territory for pediatric emergency education for the recertification of basic life support (BLS) and advanced life support (ALS) providers:

1. Has your State/Territory adopted requirements for pediatric education for the license/certification renewal of BLS providers?

☐**YES** ☐**NO** ☐**NOT APPLICABLE**

1.a If "**Yes,"** please provide the following information.

- Total number of hours required for BLS license/certification renewal: _____
- Of the total number of hours required for BLS license/certification renewal, indicate the number of hours that need to be dedicated to pediatrics: _____

Note: Supporting documentation for the measure will only need to be submitted if requested by HRSA.

Comments:

_____
_____
_____
_____
_____

1.b. If "**No**," please indicate the reasons why your State/Territory has not adopted requirements for pediatric education for the license/certification of BLS providers. Please also indicate what steps you have taken towards adopting requirements, highlighting any major barriers towards adoption.

_____
_____
_____
_____
_____

1.c. If "**Not Applicable**," please provide reasons why the measure is not applicable to your State/Territory (e.g., State/Territory does not have BLS providers).

_____
_____
_____
_____

2. Has your State/Territory adopted requirements for pediatric education for the license/certification renewal of ALS providers?

☐**YES** ☐**NO** ☐**NOT APPLICABLE**

2.a. If "**Yes,"** please provide the following information.

- Total number of hours required for ALS license/certification renewal: _____
- Of the total number of hours required for ALS license/certification renewal, indicate the number of hours that need to be dedicated to pediatrics: _____

Note: Supporting documentation for the measure will only need to be submitted if requested by HRSA.

Comments:

_____
_____
_____
_____
_____

2.b. If "**No**," please indicate the reasons why your State/Territory has not adopted requirements for pediatric education for the license/certification of ALS providers. Please also indicate what steps you have taken towards adopting requirements, highlighting any major barriers towards adoption.

_____
_____
_____
_____
_____

2.c. If "**Not Applicable**," please provide reasons why the measure is not applicable to your State/Territory (e.g., State/Territory does not have ALS providers).

_____
_____
_____
_____
_____

79 PERFORMANCE MEASURE	The degree to which the State/Territory has established permanence of EMSC in the State/Territory EMS system.
GOAL	To increase the number of States/Territories that have established permanence of EMSC in the State/Territory EMS system.
MEASURE	The degree to which States/Territories have established permanence of EMSC in the State/Territory EMS system.
DEFINITION	**Permanence of EMSC in a State/Territory EMS system** is defined as: • The EMSC Advisory Committee has the required members as per the implementation manual. • The EMSC Advisory Committee meets at least four times a year. • By 2011, pediatric representation will have been incorporated on the State/Territory EMS Board. • By 2011, the State/Territory will mandate requiring pediatric representation on the EMS Board. • By 2011, one full time EMSC Manager that is dedicated solely to the EMSC Program will have been established. **EMSC** The component of emergency medical care that addresses the infant, child, and adolescent needs, and the Program that strives to ensure the establishment and permanence of that component. EMSC includes emergent at the scene care as well as care received in the emergency department, surgical care, intensive care, long-term care, and rehabilitative care. EMSC extends far beyond these areas yet for the purposes of this manual this will be the extent currently being sought and reviewed.

EMS system

The continuum of patient care from prevention to rehabilitation, including pre-hospital, dispatch communications, out-of-hospital, hospital, primary care, emergency care, inpatient, and medical home. It encompasses every injury and illness

EMSC STRATEGIC OBJECTIVE

Related to EMSC Strategic Plan Objective 4: Establish permanence of EMSC in each State/Territory EMS system.

Objective 4.1: Establish an EMSC Advisory Committee within each State/Territory

Objective 4.2: Incorporate pediatric representation on the State/Territory EMS Board

Objective 4.3: Establish one full-time equivalent EMSC manager that is dedicated solely to the EMSC Program.

DATA SOURCE(S) AND ISSUES

- Attached data collection form to be completed by grantee.

SIGNIFICANCE

Establishing permanence of EMSC in the State/Territory EMS system is important for building the infrastructure of the EMSC Program and is fundamental to its success. For the EMSC Program to be sustained in the long-term and reach permanence, it is important to establish an EMSC Advisory Committee to ensure that the priorities of the EMSC Program are addressed. It is also important to establish one full time equivalent EMSC Manager whose time is devoted solely (i.e., 100%) to the EMSC Program. Moreover, by ensuring pediatric representation on the State/Territory EMS Board, pediatric issues will more likely be addressed.

DATA COLLECTION FORM FOR DETAIL SHEET # 79

Please indicate the elements that your grant program has established to promote permanence of EMSC in the State/Territory EMS system.

Element	Yes	No
1. The EMSC Advisory Committee has the required members as per the implementation manual.		
2. The EMSC Advisory Committee has met four or more times during the grant year.		
3. There is pediatric representation on the EMS Board.		
4. There is a State/Territory mandate requiring pediatric representation on the EMS Board.		
5. There is one full-time EMSC Manager that is dedicated solely to the EMSC Program.		

Yes = 1

No = 0

Total number of elements your grant program has established (possible 0-5 score) _____

Detail Sheet for Performance Measure #80

80 PERFORMANCE MEASURE	The degree to which the State/Territory has established permanence of EMSC in the State/Territory EMS system by integrating EMSC priorities into statutes/regulations.
GOAL	By 2011, the six EMSC priorities will have been integrated into existing EMS or hospital/healthcare facility statutes/regulations.
MEASURE	The degree to which the State/Territory has established permanence of EMSC in the State/Territory EMS system by integrating EMSC priorities into statutes/regulations.
DEFINITION	**Priorities**: The priorities of the EMSC Program include the following six areas: 1. BLS and ALS pre-hospital provider agencies in the State/Territory have on-line and off-line pediatric medical direction available from dispatch through patient transport to a definitive care facility. 2. BLS and ALS patient care units in the State/Territory have the essential pediatric equipment and supplies, as outlined in the nationally recognized and endorsed guidelines. 3. The existence of a statewide, territorial, or regional standardized system that recognizes hospitals that are able to stabilize and/or manage • pediatric medical emergencies • trauma 4. Hospitals in the State/Territory have written inter-facility transfer guidelines that cover pediatric patients and that include the following components of transfer:

- Defined process for initiation of transfer, including the roles and responsibilities of the referring facility and referral center (including responsibilities for requesting transfer and communication).
- Process for selecting the appropriate care facility.
- Process for selecting the appropriately staffed transport service to match the patient's acuity level (level of care required by patient, equipment needed in transport, etc.).
- Process for patient transfer (including obtaining informed consent).
- Plan for transfer of patient medical record
- Plan for transfer of copy of signed transport consent
- Plan for transfer of personal belongings of the patient
- Plan for provision of directions and referral institution information to family

5. Hospitals in the State/Territory have written inter-facility transfer agreements that cover pediatric patients.

6. The adoption of requirements by the State/Territory for pediatric emergency education for the license/certification renewal of BLS and ALS providers.

EMSC STRATEGIC OBJECTIVE

Related to EMSC Strategic Plan Objective 4: Establish permanence of EMSC in each State/Territory EMS system.

DATA SOURCE(S) AND ISSUES

- Attached data collection form to be completed by grantee.

SIGNIFICANCE

For the EMSC Program to be sustained in the long-term and reach permanence, it is important for the Program's priorities to be integrated into existing State/Territory mandates. Integration of the EMSC priorities into mandates will help ensure pediatric emergency care issues and/or deficiencies are being addressed State/Territory-wide for the long-term.

DATA COLLECTION FORM FOR DETAIL SHEET # 80

Please indicate the elements that your grant program has established to promote the permanence of EMSC in the State/Territory EMS system by integrating EMSC priorities into statutes/regulations.

Element	Yes	No
1. There is a statute/regulation for pediatric on-line medical direction for ALS and BLS pre-hospital provider agencies.		
2. There is a statute/regulation for pediatric off-line medical direction for ALS and BLS pre-hospital provider agencies.		
3. There is a statute/regulation for pediatric equipment for BLS and ALS patient care units.		
4. There is a statute/regulation for a hospital recognition system for identifying hospitals capable of dealing with pediatric medical emergencies.		
5. There is a statute/regulation for a hospital recognition system for identifying hospitals capable of dealing with pediatric traumatic emergencies.		
6. There is a statute/regulation for written inter-facility transfer guidelines that cover pediatric patients and include specific components of transfer.		
7. There is a statute/regulation for written inter-facility transfer agreements that cover pediatric patients.		
8. There is a statute/regulation for the adoption of requirements for continuing pediatric education during recertification of BLS and ALS providers.		

Yes = 1
No = 0

Total number of elements your grant program has established (possible 0-8 score) _____

Products, Publications and Submissions Data Collection Form

Part 1

Instructions: Please list the number of products, publications and submissions addressing maternal and child health that have been published or produced by your staff during the reporting period (counting the original completed product or publication developed, not each time it is disseminated or presented). Products and Publications include the following types:

Type	Number
Peer-reviewed publications in scholarly journals – published (including peer-reviewed journal commentaries or supplements)	
Peer-reviewed publications in scholarly journals – submitted	
Books	
Book chapters	
Reports and monographs (including policy briefs and best practices reports)	
Conference presentations and posters presented	
Web-based products (Blogs, podcasts, Web-based video clips, wikis, RSS feeds, news aggregators, social networking sites)	
Electronic products (CD-ROMs, DVDs, audio or videotapes)	
Press communications (TV/Radio interviews, newspaper interviews, public service announcements, and editorial articles)	
Newsletters (electronic or print)	

Pamphlets, brochures, or fact sheets	
Academic course development	
Distance learning modules	
Doctoral dissertations/Master's theses	
Other	

Part 2

Instructions: For each product, publication and submission listed in Part 1, complete all elements marked with an "*."

Data collection form: Peer-reviewed publications in scholarly journals – published

*Title: _____

*Author(s): _____

*Publication: _____

*Volume: _____ *Number: _____ Supplement: _____ *Year: _____ *Page(s):_____

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL): _____

Key Words (No more than 5): _____

Notes: _____

Data collection form: Peer-reviewed publications in scholarly journals – submitted

*Title: _____

*Author(s): _____

*Publication: _____

*Year Submitted: _____

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

Key Words (No more than 5): _____

Notes: _____

Data collection form: Books

*Title: _____

*Author(s): _____

*Publisher: _____

*Year Published: _____

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

Key Words (No more than 5): _____

Notes: _____

Data collection form for: Book chapters

Note: If multiple chapters are developed for the same book, list them separately.

*Chapter Title: _____

*Chapter Author(s): _____

*Book Title: _____

*Book Author(s): _____

*Publisher: _____

*Year Published: _____

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Reports and monographs

*Title: _____

*Author(s)/Organization(s): _____

*Year Published: _____

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Conference presentations and posters presented

(This section is not required for MCHB Training grantees.)

*Title: _____

*Author(s)/Organization(s): _____

*Meeting/Conference Name: _____

*Year Presented: _____

*Type: ☐ Presentation ☐ Poster

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Web-based products

*Product: _____

*Year: _____

*Type: ☐ blogs ☐ podcasts ☐ Web-based video clips

☐ wikis ☐ RSS feeds news aggregators

☐ social networking sites ☐ Other (Specify)

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL): _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Electronic Products

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Type: ☐ CD-ROMs ☐ DVDs ☐ audio tapes ☐ videotapes ☐ Other (Specify)

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Press Communications

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Type: ☐ TV interview ☐ Radio interview ☐ Newspaper interview ☐ Public service announcement ☐ Editorial article ☐ Other (Specify)

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Newsletters

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Type: ☐ Electronic ☐ Print ☐ Both

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

*Frequency of distribution: ☐ weekly ☐ monthly ☐ quarterly ☐ annually ☐ Other (Specify)

Number of subscribers: _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Pamphlets, brochures or fact sheets

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Type: ☐ Pamphlet ☐ Brochure ☐ Fact Sheet

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Academic course development

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Distance learning modules

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Media Type:

- ☐ blogs
- ☐ podcasts
- ☐ Web-based video clips
- ☐ wikis
- ☐ RSS feeds
- ☐ news aggregators
- ☐ social networking sites
- ☐ CD-ROMs
- ☐ DVDs
- ☐ audio tapes
- ☐ videotapes
- ☐ Other (Specify)

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

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