**Activity Code:** H84
**Sub-Code:** N/A
**Sub-Code Program Name:** N/A
**Fiscal Year:** 2022
**Funding Opportunity Number:** HRSA-22-069
**Funding Opportunity Name:** Family-to-Family Health Information Centers
**Program Name:** Family Professional Partnership/CSHCN

**Program Specific Forms for the Reporting Year**

###### Within **120 days** of the date of the Notice of Grant Award, grantees/awardees are required to enter their reporting year data in HRSA Electronic Handbooks for the Program-Specific Information forms listed below.

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## **Central Forms**

### **Financial Form**

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| **Financial Form** |
| **Instructions**  |

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| **Line 1** – **MCHB Grant Award Amount:** Enter the amount of the Federal MCHB grant award for this project.**Line 2** – **Required Matching Funds:** If matching funds are required for this grant program list the total amount of matching funds. These can include local, state, program, applicant/grantee, or other funds. Where appropriate, include the dollar value of in-kind contributions.**Line 3** – **Other Project Funds:** Enter the total amount of other funds received for the project. These can include local, state, program, applicant/grantee, or other funds leveraged. Also include the dollar value of in-kind contributions.**Line 4** – **Total Project Funds:** Displays the sum of lines 1 through 3, which is auto-calculated. **Line 5** – **Federal Collaborative Funds:** Enter the total amount of other Federal funds received other than the MCHB grant award for the project. Such funds include those from other Departments, other components of the Department of Health and Human Services, or other MCHB grants or contracts.For all lines:* New Competing Performance Report: enter the budgeted amount for the first budget period
* Non-Competing Continuation Performance Reports: enter the expended amount for the prior budget period and the budgeted amount for the upcoming budget period
* Project Period End Report: enter the expended amount for the last budget period

**Comments:** Enter any comments, if applicable.  |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **Budget Period \_\_\_**  | **Budget Period \_\_\_** |
|  |  | Budgeted | Expended | Budgeted | Expended |
|  |  |  |  |  |  |
| 1. | **MCHB GRANT AWARD AMOUNT** | $ \_\_\_ | $ \_\_\_ | $ \_\_\_ | $ \_\_\_ |
| 2. | **REQUIRED MATCHING FUNDS** (Are matching funds required? Yes ÿ No ÿ If yes, please enter amount) | $ \_\_\_ | $ \_\_\_ | $ \_\_\_ | $ \_\_\_ |
| 3. | **OTHER PROJECT FUNDS** (Not included in Line 1 or Line 2 above) | $ \_\_\_ | $ \_\_\_ | $ \_\_\_ | $ \_\_\_ |
| 4. | **TOTAL PROJECT FUNDS**  (Total of Lines 1 through 3) | $ \_\_\_ | $ \_\_\_ | $ \_\_\_ | $ \_\_\_ |
| 5. | **FEDERAL COLLABORATIVE FUNDS**(Additional federal funds contributing to the project)**Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | $ \_\_\_ | $ \_\_\_ | $ \_\_\_ | $ \_\_\_ |

### **Project Abstract**

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| **Project Abstract** |
| **Instructions** |
| **Section I –** **Project Identifier Information:** These items will be auto-populated. **Section II – Budget:** These figures will be auto-populated from Financial Form, Lines 1 through 4.* New Competing Performance Report: will auto-populate the budgeted amount for the first budget period
* Non-Competing Continuation Performance Reports and Project Period End Report: will auto-populate the budgeted amount from the prior performance report

**Section III – Types of Services**Indicate which type(s) of services your project provides, checking all that apply. For each type of service selected, indicated the percent of the Budget that is dedicated to that type of service (if you do not know the exact percent, provide your best estimate). Percents for all three service types should sum to 100%. **Comments:** Enter any comments, if applicable. **Definitions:****Direct Services** are preventive, primary, or specialty clinical services for which MCHB program funds are used to reimburse or fund providers for these services through a formal process similar to paying a medical billing claim or managed care contracts. Reporting on direct services should not include the costs of clinical services which are delivered with program dollars but reimbursed by Medicaid, CHIP or other public or private payers. Examples include, but are not limited to the following, paid for with program funds: preventive, primary, or specialty care visits, emergency department visits, inpatient services, outpatient and inpatient mental and behavioral health services, prescription drugs, occupational and physical therapy, speech therapy, durable medical equipment and medical supplies, medical foods, dental care, and vision care.**Enabling Services** are non-clinical services (i.e., not included as direct or public health services) that enable individuals to access health care and improve health outcomes where MCHB program funds are used to finance these services. Enabling services include, but are not limited to: case management, care coordination, referrals, translation/interpretation, transportation, eligibility assistance, health education for individuals or families, environmental health risk reduction, health literacy, and beneficiary outreach. Reporting on enabling services should NOT include the costs for enabling services that are reimbursed by Medicaid, CHIP, or other public and private payers. Enabling services may include salary and operational support to a clinic that enable individuals to access health care or improve health outcomes. Examples include the salary of a public health nurse who provides prenatal care in a local clinic or compensation provided to a specialist pediatrician who provides services for children with special health care needs. In both cases the direct services might still be billed to Medicaid or other insurance, but providing for the availability of the provider enables individuals to access the services, and therefore counts as enabling services.**Public Health Services and Systems** are activities and infrastructure to carry out the core public health functions of assessment, assurance, and policy development, and the 10 essential public health services. Examples include the development of standards and guidelines, needs assessment, program planning, implementation, and evaluation, policy development, quality assurance and improvement, workforce development, population-based outreach and education, and research. **Section IV – Grantee Organization Type:** Choose the one that best applies to your organization.**Section V – Special Population(s) Served:** If your program directly targets or serves any of the special populations listed, please select the population(s) that apply.**Section VI – Project Description OR Experience to Date (DO NOT EXCEED THE SPACE PROVIDED)**A. Project description, new projects only: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. Displays up to 5 objectives of the program. The objectives are auto-populated with the objectives from the Notice of Funding Opportunity (NOFO). For each objective, describe the project activities used to reach objectives, and comment on innovation, cost, and other characteristics of the methodology that are proposed or are being implemented. Lists with numbered items can be used in this section.
3. Describe the coordination planned and carried out, if applicable, with appropriate State and/or local health and other agencies in areas(s) served by the project.
4. Briefly describe the evaluation methods that will be used to assess the success of the project in implementing activities and attaining its aims.
	1. Experience to date:
5. For each program objective, select Yes or No to indicate if measurable progress towards the objective was made during the reporting period. Provide data and a brief description that supports the Yes/No selection (not to exceed 200 words).

**Section VII – Key Words** Select the key words to describe the project. Choose key words from the included list. Select all that apply. If a key word is not listed, select Other and specify key word(s). You may select a sub-key word without also selecting the corresponding general key word. For example, you may select “Early Childhood - Newborn Screening” without selecting “Early Childhood - General”. In addition, you may select only the general key word if none of the sub-key words apply.**Comments:** Enter any comments, if applicable.  |

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| **I. PROJECT IDENTIFIER INFORMATION**  1. Project Title: \_\_\_\_\_\_\_\_\_\_\_\_\_ 2. Project Number: \_\_\_\_\_\_\_\_\_\_\_\_\_ 3. Project Director/Principal Investigator as show on NoA: \_\_\_\_\_\_\_\_\_4. E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_**II. BUDGET**  1. MCHB Grant Award $\_\_\_\_\_\_\_\_\_\_\_\_\_ (Line 1, Financial Form) 2. Matching Funds (if applicable) $\_\_\_\_\_\_\_\_\_\_\_\_\_(Line 2, Financial Form) 3. Other Project Funds $\_\_\_\_\_\_\_\_\_\_\_\_\_(Line 3, Financial Form) 4. Total Project Funds $\_\_\_\_\_\_\_\_\_\_\_\_\_(Line 4, Financial Form)**III. TYPE(S) OF SERVICE PROVIDED** *(select all that apply)*ÿ Direct Services  Percent of Budget for Direct Services \_\_\_\_ÿ Enabling Services Percent of Budget for Enabling Services \_\_\_\_ÿ Public Health Services and Systems Percent of Budget for Public Health Services and Systems \_\_\_\_1. **GRANTEE ORGANIZATION TYPE**

ÿ State Agencyÿ Community Government Agencyÿ School Districtÿ University/Institution of Higher Learning (Non-Hospital Based)ÿ Academic Medical Centerÿ Community-Based Non-Governmental Organization (Health Care)ÿ Community-Based Non-Governmental Organization (Non-Health Care)ÿ Professional Membership Organization (Individuals Constitute Its Membership)ÿ National Organization (Other Organizations Constitute Its Membership)ÿ National Organization (Non-Membership Based)ÿ Independent Research/Planning/Policy Organizationÿ Other (specify) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_**1. **SPECIAL POPULATION(S) SERVED** *(select all that apply)*
* Uninsured
* Homeless
* Rural
* Tribal
1. **PROJECT DESCRIPTION OR EXPERIENCE TO DATE**
2. Project description, new projects only:
3. Project Description and Problem *(In 150 words or less, briefly describe the problem that your project addresses)*:
4. Program Objectives and Key Project Activities: *(Objectives auto-populated from the NOFO objectives. For each objective, list project activities used to reach objective, and comment on innovation, cost, and other characteristics of the methodology, proposed or are being implemented)*

 Objective 1: Related Activity 1: Related Activity 2: Objective 2: Related Activity 1: Related Activity 2: Objective 3: Related Activity 1: Related Activity 2: Objective 4: Related Activity 1: Related Activity 2: Objective 5: Related Activity 1: Related Activity 2:1. Coordination (List the state, local, or other organizations involved in the project and briefly describe their roles):
2. Evaluation *(Briefly describe the methods which will be used to determine whether process and outcome objectives are met; be sure to tie to evaluation requirements from NOFO)*:

B. Experience to date: 1. Progress Towards Objectives to Date:
	1. Did you make measurable progress towards Objective 1 in the reporting period?

ÿ Yes ÿ No* + 1. Provide data that support this: \_\_\_\_\_\_
	1. Did you make measurable progress towards Objective 2 in the reporting period?

ÿ Yes ÿ No* + 1. Provide data that support this: \_\_\_\_\_\_
	1. Did you make measurable progress towards Objective 3 in the reporting period?

ÿ Yes ÿ No* + 1. Provide data that support this: \_\_\_\_\_\_
	1. Did you make measurable progress towards Objective 4 in the reporting period?

ÿ Yes ÿ No* + 1. Provide data that support this: \_\_\_\_\_\_
	1. Did you make measurable progress towards Objective 5 in the reporting period?

ÿ Yes ÿ No* + 1. Provide data that support this: \_\_\_\_\_\_
1. **KEY WORDS** *(****s****elect all that apply)*
* Early Childhood – General
	+ Early Childhood – Newborn Screening
	+ Early Childhood – Safe Sleep
	+ Early Childhood – Developmental Health (including developmental screening)
* Adolescent Health
* Maternal Health – General
	+ Maternal Health – Maternal Mortality
	+ Maternal Health – Perinatal/Postpartum Care
	+ Maternal Health – Breastfeeding
	+ Maternal Health – Maternal Depression
* Children, Adolescents, and Young Adults with Special Health Care Needs
* Developmental Disabilities
* Mental/Behavioral Health – General
	+ Mental/Behavioral Health – Autism
	+ Mental/Behavioral Health – Substance Use Disorder(s)
* Clinical Care
	+ Sickle Cell Disease
	+ Heritable Disorders (excluding sickle cell)
	+ Epilepsy
	+ Fetal Alcohol Syndrome
	+ Oral Health
	+ Medical Home
	+ Health Care Transition
	+ Immunizations
* Injury Prevention – General
	+ Injury Prevention – Poison/Toxin Exposure
* Child Maltreatment
* Emergency Services for Children – General
	+ Emergency Services for Children – Emergency Preparedness
* Health Equity
* Social Determinants of Health
* Telehealth
* Preventive Services
* Obesity
* Health Insurance
* Nutrition
* Respiratory Health
* Life Course Approach
* Other (specify): \_\_\_\_\_\_\_\_\_

**Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

### **Health Equity**

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| **Health Equity** |
| **Instructions** |
| Select Yes or No to indicate whether your program advanced health equity during the reporting period. If Yes is selected, continue and complete Part A. If No is selected, the form is complete.**Part** **A. Health Equity**Select the MCHB funded activity/activities that were conducted through your programming during the reporting period to advance health equity. Select all that apply. Select the MCHB funded activity/activities that your program/organization conducted internally during the reporting period to create or maintain an internal culture of equity. Select all that apply. If none of the options are close to the topic of your activity, select “Other” and specify. This question is optional; if internal activities were not conducted, you may skip this question. Select which equity topics your activities (through programming and/or internally) targeted and/or covered. If the specific equity topic of your activity is not listed, select the topic area closest to your topic area. Select all that apply. If none of the equity topics are close to the equity topic of your activity, select “Other” and specify.Select Yes or No to indicate if your program has established stated goals/objectives for health equity. Goals/objectives should have specific health equity components. Goals/objectives may apply to programming and/or internally. If No is selected, the form is complete.If Yes is selected, enter your stated goals/objectives and describe progress made on those goals/objectives during the reporting period. **Comments:** Enter any comments, if applicable. **Definitions:****Health Equity** is the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.  |

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| 1. **During the reporting period, did your program advance health equity?**
 | ÿ Yes *[complete Part A]*ÿ No |
| 1. **Health Equity**
 |  |
| * + 1. How has your program advanced health equity during the reporting period? *(select all that apply)*
 | ÿ **Creating and supporting collaborations and partnerships** with other health and non-health sectors that influence the well-being of individuals in order to advance health equity. ÿ **Engaging persons with lived experience** in active roles that influence program planning and implementation, with a focus on advancing health equity.ÿ Accounting for and addressing **social and structural determinants of health** to drive health equity in our program’s area of focus. ÿ **Creating and supporting the infrastructure and capacity for equity** by improving data collection capacity, promoting cultural responsiveness, and promoting policies and procedures that advance equity. ÿ **Centering equity in data use and performance measurement**, including disaggregating data across various demographic indicators and compiling and integrating diverse forms of quantitative and qualitative data. ÿ **Providing services** to individuals and communities with the greatest need in order to promote equity in a culturally responsive manner, specifically focused on those disproportionately impacted by health outcomes.ÿ Other (specify): \_\_\_\_\_ |
| * + 1. How has your program/organization created or maintained an internal culture of equity? *(select all that apply)* [OPTIONAL]
 | ÿ Hiring policies and practices to advance staff diversityÿ Staff inclusion, belonging, and retention—with a focus on staff from diverse backgrounds ÿ Staff capacity to effectively advance health equity ÿ Organizational policies and practices that intentionally promote equityÿ Other (specify): \_\_\_\_\_ |
| * + 1. Which equity topic(s) did your program’s activities target? *(select all that apply)*
 | * + - Race/ethnicity
		- Sex/gender/sexual orientation/gender identity
		- Income/socioeconomic status
		- Disability
		- Age
		- Language
		- Geography – rural/urban
		- Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * + 1. Has your program established stated goals/objectives for health equity?
 | ÿ Yesÿ No |
| * + - 1. If yes, enter the stated health equity goals/objectives and describe what progress your program made on those goals/objectives in the reporting period.

**Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | \_\_\_\_\_\_\_\_\_\_\_ |

### **Engagement of Persons with Lived Experience**

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| --- |
| **Engagement of Persons with Lived Experience** |
| **Instructions**  |
|

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| Select Yes or No to indicate whether your program supported engagement of family members and/or other persons with lived experience during the reporting period. If your program supported both, select Yes for both, and complete Part A and Part B. If your program only supported engagement of family members, select Yes for family members only and complete Part A. If your program only supported engagement of other persons with lived experience, select Yes for other persons with lived experience and complete Part B. If your program did not support either, select No and the form is complete.**Part A. Family Engagement**1. For each engagement area, indicate whether your program engaged family members during the reporting period and, if yes, enter the number of family members engaged during the reporting period. Multiple individuals from within the same family unit should be counted separately (i.e., if a program engaged two parents, they should each be counted separately). The number engaged may be duplicated across rows (i.e., if a family member is engaged in both Program Development, Planning and Evaluation, as well as Leadership Training, the family member would be counted in each row).
2. If able, complete the table and fill in each of the cells as appropriate. This item is optional. The unduplicated row totals for race and ethnicity will be auto-calculated and may not align with the duplicated numbers presented in Table A.i. When reporting data pertaining to participants’ race, ethnicity, or membership in social or demographic groups—particularly groups those that are underrepresented—awardees should ensure that those data are accurate and collected validly and sensitively. Do not infer or guess individuals’ membership in a particular group.
3. If able, enter the number engaged during the reporting period from other demographic groups that are underrepresented (for example, underrepresented factors include sexual orientation, gender identity, income/socioeconomic status, health status/disability, age, language, geography). This item is optional and should only be completed if data are collected in a valid manner that recognizes the sensitive nature of these topics.
4. Select Yes or No to indicate if family members were compensated for their engagement during the reporting period. Select Yes if at least one family member was compensated. If yes, and if able, enter the number of family members compensated; the item for number of family members compensated is optional.
5. Select Yes or No to indicate whether engaging family members resulted in any changes to your program. If yes, select all the ways engagement resulted in changes to your program. Note that the form does not require you to measure or quantify the degree of change, only that it occurred. Select all that apply.

**Part B.** **Other Persons with Lived Experience Engagement**1. For each engagement area, indicate whether your program engaged other persons with lived experience during the reporting period and, if yes, enter the number of other persons with lived experience engaged during the reporting period. The number engaged may be duplicated across rows (i.e., if a person with lived experience is engaged in both Program Development, Planning and Evaluation, as well as Leadership Training, the person would be counted for each row).
2. Indicate the population categories of persons with lived experience that the program engaged. Select all that apply.
3. If able, complete the table and fill in each of the cells as appropriate. This item is optional. The unduplicated row totals for race and ethnicity will be auto-calculated and may not align with the duplicated numbers presented in Table B.i. When reporting data pertaining to participants’ race, ethnicity, or membership in social or demographic groups—particularly groups those that are underrepresented—awardees should ensure that those data are accurate and collected validly and sensitively. Do not infer or guess individuals’ membership in a particular group.
4. If able, enter the number engaged during the reporting period from other demographic groups that are underrepresented (for example, underrepresented factors include sexual orientation, gender identity, income/socioeconomic status, health status/disability, age, language, geography). This item is optional and should only be completed if data are collected in a valid manner that recognizes the sensitive nature of these topics.
5. Select Yes or No to indicate if persons with lived experience were compensated for their engagement during the reporting period. Select Yes if at least one person with lived experience was compensated. If yes, and if able, enter the number of persons with lived experience compensated; the item for number of persons with lived experience compensated is optional.
6. Select Yes or No to indicate whether engaging other persons with lived experience resulted in any changes to your program. If yes, select all the ways engagement resulted in changes to your program. Note that the form does not require you to measure or quantify the degree of change, only that it occurred. Select all that apply.

**Comments:** Enter any comments, if applicable. **Definitions:****Persons with Lived Experience** refers to individuals with knowledge and experience on health or social issues relevant to a particular program that is gained through direct, first-hand involvement in everyday events rather than through representations constructed by other people.1 Community-based organizations, for example, would not be included under this definition. For the purposes of this form, engagement of persons with lived experience is measured through two categories: “Family Engagement” and “Other Persons with Lived Experience.” Family members often navigate systems and services on behalf of individuals, so their lived experience is collected separately. Therefore, for data collection purposes, the term “Other Persons with Lived Experience” is used to delineate from family engagement and avoid duplicated counts. **Family Engagement:** Family members include individuals in traditional or non-traditional family structures and may include biological, foster, or adoptive parents and/or siblings, spouses or partners, or members of an extended family. These family members have lived experience through their first-hand knowledge of navigating systems and services either on behalf of a family member or for the family as a whole (for example, parents of infants and toddlers, family members of children and youth with special health care needs, etc.). Family engagement refers to family members serving as representatives or leaders who build and strengthen programs and systems rather than being the direct recipient of services. **Other Persons with Lived Experience:** This subcategory excludes family members, as defined above.Engaging other individual persons with lived experience entails actively and intentionally seeking and implementing input from individuals with personal knowledge pertaining to the issue the program is trying to address. For the purpose of this form, individuals with lived experiences represent their own personal history and experience navigating systems and services for themselves, rather than on behalf of a family member. Examples of persons with lived experience include self-advocates or individuals with direct experience on a health issue (for example, youth self-advocates with special health care needs, pregnant or postpartum persons, individual community members affected by a public health emergency, etc.). 1. Chandler, D., & Munday, R. (2016). Oxford: A dictionary of media and communication (2nd ed.). New York, NY: Oxford University Press.  |

|  |  |
| --- | --- |
| 1. **During the reporting period, did your program support engagement of persons with lived experience?** *(select all that apply)*
 | * Yes, engaged with or supported **family members** to expand the capacity and reach of a program in meeting the needs of the program’s MCH population [*complete Part A]*
* Yes, engaged with or supported **other persons with lived experience** to expand the capacity and reach of a program in meeting the needs of the program’s MCH population [*complete Part B]*
* No
 |
| 1. **Family Engagement**
 |  |
| * 1. Number engaged in the reporting period, by engagement area
 |

|  |  |  |
| --- | --- | --- |
| Engagement Area | Has your program engaged family members in this engagement area in the reporting period?  | Number engaged in the reporting period  |
| **Program Development, Planning, and Evaluation**Family members participate in and provide feedback on the planning, implementation, and/or evaluation of the program (for example, strategic planning, program planning, materials development, program activities, teaching, mentoring, measurement, etc.).  | * Yes
* No
 |  |
| **Leadership Training**Within your program, family members are trained or mentored for leadership roles (for example, advisory committees, task forces, teaching, etc.).  | * Yes
* No
 |  |
| **Active Leadership**Within your program, family members have leadership roles on advisory committees or task forces. | * Yes
* No
 |  |

 |
|  |  |
| * 1. Number engaged by race and ethnicity in the reporting period

**(OPTIONAL)** |

|  |  |
| --- | --- |
| **RACE** | **ETHNICITY** |
| American Indian or Alaska Native | Asian | Black or African American | Native Hawaiian or Other Pacific Islander | White | More than One Race | Unknown/Unrecorded | Total | Hispanic or Latino | Not Hispanic or Latino | Unknown/Unrecorded | Total |
|  |  |  |  |  |  |  |  |  |  |  |  |

 |
| * 1. Number engaged from other demographic groups that are underrepresented (for example, underrepresented factors include sexual orientation, gender identity, income/socioeconomic status, health status/disability, age, language, geography), in the reporting period

**(OPTIONAL)** |

|  |
| --- |
| Number engaged from other underrepresented groups  |
|  |

 |
| * 1. In the reporting period, were family members compensated for their engagement (for example, paid faculty or staff, consultants, honoraria, etc.)?
 | * Yes
* No
 |
| 1. If yes, number compensated in the reporting period ?

**(OPTIONAL)** |

|  |
| --- |
| Number compensated in the reporting period  |
|  |

 |
| * 1. In the reporting period, did engagement of family members result in any changes to your program?
		1. If yes, as a result of engaging family members, what did the program achieve in the reporting period? (*select all that apply*)
 | * Yes
* No
* Influenced focus or priorities of programming
* Improved program quality
* Increased reach of the program’s messaging
* Increased enrollment or participation in program activities
* Increased funding or other tangible resources to advance program goals
* Increased community will/“buy-in” for program activities or goals
* Established or implemented shared goals, activities, or measurement
* Other (specify): \_\_\_\_\_\_\_\_\_\_\_
 |
|  |  |
| 1. **Other Persons with Lived Experience Engagement**
 |  |
| * 1. Number engaged in the reporting period, by engagement area
 |

|  |  |  |
| --- | --- | --- |
| Engagement Area | Has your program engaged other persons with lived experience in this engagement area in the reporting period?  | Number engaged in the reporting period  |
| **Program Development, Planning, and Evaluation**Other persons with lived experience participate in and provide feedback on the planning, implementation and/or evaluation of the program (for example, strategic planning, program planning, materials development, program activities, teaching, mentoring, measurement, etc.).  | * Yes
* No
 |  |
| **Leadership Training**Within your program, other persons with lived experience are trained or mentored for leadership roles (for example, advisory committees, task forces, teaching, etc.).  | * Yes
* No
 |  |
| **Active Leadership**Within your program, other persons with lived experience have leadership roles on advisory committees or task forces. | * Yes
* No
 |  |

 |
| * 1. Were the other persons with lived experience from any of the following population categories? (*select all that apply*)
 | * Children, adolescents, young adults (age 1-25)
* Children, adolescents, and young adults (age 1-25) with special health care needs
* Pregnant/postpartum persons
* Non-pregnant women (age 26+)
* Men (age 26+)
* Representatives from community of interest
* Self-advocates
* Other (specify): \_\_\_\_\_\_\_
 |
|  |  |
| * 1. Number engaged by race and ethnicity in the reporting period

**(OPTIONAL)** |

|  |  |
| --- | --- |
| **RACE** | **ETHNICITY** |
| American Indian or Alaska Native | Asian | Black or African American | Native Hawaiian or Other Pacific Islander | White | More than One Race | Unknown/Unrecorded | Total | Hispanic or Latino | Not Hispanic or Latino | Unknown/Unrecorded | Total |
|  |  |  |  |  |  |  |  |  |  |  |  |

 |
| * 1. Number engaged from other demographic groups that are underrepresented (for example, underrepresented factors include sexual orientation, gender identity, income/ socioeconomic status, health status/disability, age, language, geography), in the reporting period

**(OPTIONAL)** |

|  |
| --- |
| Number engaged from other underrepresented groups  |
|  |

 |
| * 1. In the reporting period, were other persons with lived experienced compensated for their engagement (for example, paid faculty or staff, consultants, honoraria, etc.)?
 | * Yes
* No
 |
| 1. If yes, number compensated in the reporting period **(OPTIONAL)**
 |

|  |
| --- |
| Number compensated in the reporting period  |
|  |

 |
| * 1. In the reporting period, did engagement of other persons with lived experience result in any changes to your program?
 | * Yes
* No
 |
| * 1. If yes, as a result of engaging other persons with lived experience, what did the program achieve? (*select all that apply*)
 | * Influenced focus or priorities of programming
* Improved program quality
* Increased reach of the program’s messaging
* Increased enrollment or participation in program activities
* Increased funding or other tangible resources to advance program goals
* Increased community will/“buy-in” for program activities or goals
* Established or implemented shared goals, activities, or measurement
* Other (specify): \_\_\_\_\_\_\_\_\_\_\_
 |
|  **Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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### **Quality Improvement and Evaluation**

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| **Quality Improvement and Evaluation** |
| **Instructions** |
| Select Yes or No to indicate whether your program implemented or participated in quality improvement (QI) initiatives and/or conducted evaluation activities during the reporting period. If your program supported both, select Yes for both, and complete Part A and Part B. If your program only implemented or participated in QI, select Yes only for QI and complete Part A. If your program only conducted evaluation activities, select Yes only for evaluation and complete Part B. If your program did not support either, select No and the form is complete.**Part A. Quality Improvement**1. Select Yes or No to indicate whether your program collected metrics to track QI during the reporting period.
2. Select what action has been taken as a result of the QI process during the reporting period. Select all that apply.

**Part B. Evaluation**1. Select the type of evaluation activity that was conducted during the reporting period. Select all that apply.
2. Select how your program has used evaluation activities in the reporting period. Select all that apply.

 **Comments:** Enter any comments, if applicable. **Definitions:****Quality Improvement** includes activities that use deliberate processes to improve the efficacy and impact of activities, programs, or systems (for example, PDSA cycles, etc.)**Evaluation** includes activities that systematically collect information to assess a project, program, or system’s performance or outcomes. |

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| --- | --- |
| **1. During the reporting period, did your program implement or participate in quality improvement (QI) initiatives, or conduct activities to evaluate a program’s or system’s performance or outcomes?** *(select all that apply)* | ÿ Yes, implemented or participated in QI *[complete Part A]*ÿ Yes, conducted activities to evaluate performance or outcomes *[complete Part B]*ÿ No |
| 1. **Quality Improvement**
 |  |
| * 1. Did you collect metrics to track improvement as part of the QI process in the reporting period?
 | ÿ Yesÿ No |
| * 1. What action have you taken as a result of the QI process in the reporting period?
 | ÿ Used findings to make improvements in your work (for example, improve existing services, ensure reaching the intended groups, review internal processes, etc.)ÿ Used findings in your planning processes (for example, prioritize activities, identify unmet needs, scale-up of intervention, etc.)ÿ Have not taken any action in the reporting period |
| 1. **Evaluation**
 |  |
| * + 1. Type of evaluation activity in the reporting period *(select all that apply)*
 | ÿ Evaluation plan and designÿ Evaluation of program processes and/or implementationÿ Evaluation of program outcomes and/or impactÿ Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * + 1. How have you used the evaluation activities in the reporting period? *(select all that apply)*
 | ÿ Implemented evaluation plan/designÿ Disseminated findings to stakeholdersÿ Used findings to make improvements in your work (for example, improve existing services, ensure reaching the intended groups, review internal processes, etc.)ÿ Used findings in your planning processes (for example, prioritize activities, identify unmet needs, scale-up of intervention, etc.)ÿ Have not used evaluation activities in the reporting period |
|  **Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

## **Program Specific Forms**

### **Family to Family (F2F 1)**

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| --- | --- |
| **F2F 1 Performance Measure** **Goal: Provide National Leadership for families with children with special health needs****Level: Grantee****Category: Family Participation** | The percent of families with Children and Youth with Special Health Care Needs (CYSHCN) that have been provided information, education, and/or training by Family-to-Family Health Information Centers. |
| **GOAL** | To increase the number of families with CYSHCN receiving needed health and related information, training, and/or education opportunities in order to partner in decision making and be satisfied with services that they receive. |
|  |  |
| **MEASURE** | The percent of families with CYSHCN that have been provided information, education and/or training by Family-to-Family Health Information Centers. |
| **­** |  |
| **DEFINITION** | **Numerator:** The total number of families of CYSHCN receiving one-to-one services and training from Family-To-Family Health Information Centers.**Denominator:** The estimated number of families with CYSHCN in the state. ­ **Units:** 100 **Text:** PercentNote: This form utilizes DGIS Form 10.A for annual performance objective and data reporting. |
|  |  |
| **BENCHMARK DATA SOURCES** | Related to Healthy People 2030 Objective MICH-20: Increase the proportion of children and adolescents with special health care needs who have a system of care.  |
|  |  |
| **GRANTEE DATA SOURCES** | Progress reports from Family-To-Family Health Information Centers, National Survey for Children’s Health (NSCH), Title V Information System |
|  |  |
| **SIGNIFICANCE** | The last decade has emphasized the central role of families as informed consumers of services and participants in policy-making activities. Research has indicated that families need information they can understand and information from other parents who have experiences similar to theirs and who have navigated services systems.  |

**DATA COLLECTION FORM FOR DETAIL SHEET #F2F 1**

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| --- |
| **Instructions** |
| Complete the data collection table below. For the purpose of this form:* "Families” includes individuals in traditional or non-traditional family structures and may include biological, foster, or adoptive parents and/or siblings, spouses or partners, or members of an extended family. Families have lived experience through their first-hand knowledge of navigating systems and services either on behalf of a family member or for the family as a whole (for example, parents of infants and toddlers, family members of children and youth with special health care needs, etc.).
* “One-to-one services” include all services that an F2F can collect recipient demographic/identifier information to be able to collect an unduplicated number. Examples include but are not limited to family navigation, consultation, counseling, education, referrals, case management, mentoring and individualized assistance.
* “State agency” is defined as any public agency.

**A**.: The estimate of families with CYSHCN in your state comes from the National Survey of Children’s Health. This number will be provided to and entered by grantees in the New Competing Performance Report (NCPR). The value entered in the NCPR will the stay the same throughout an entire grant cycle and will prepopulate into subsequent DGIS reports. **A.1.b.:** Report ethnicity and race at the level that the F2F collects this information from families (for example, child, caregiver, or at the family level). The “Unknown” option for ethnicity and race is to be used when a family either refuses, is not asked, or their ethnicity or race is not known.**A.2.a.:** This question captures the number of instances families receive services (duplicated count of families) and shows the number of times families are connected with services.**A.2.b:** The numbers reported here do not have to sum to the number in A.2.a.**A.4.a:** Number of service/trainings is the total number of trainings/services provided. |

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| **A. Providing Information, Education, and/or Training** |
| The estimated number of families with CYSHCN in your state: \_\_\_\_\_\_\_\_\_\_\_\_\_(*Denominator: data from the National Survey of Children’s Health*) |
| **1. Families served via “one-to-one” services conducted by the F2F.** a. Total number of families receiving one-to-one services from Family-To-Family Health Information Centers. (*Numerator; unduplicated count*): \_\_\_\_\_\_\_\_\_b. Of the total number of families served/trained, how many families identified themselves as: *Ethnicity* 1. Hispanic \_\_\_\_\_\_
2. Non-Hispanic \_\_\_\_\_\_
3. Unknown \_\_\_\_\_\_

*Race*1. White \_\_\_\_\_\_
2. Black or African American \_\_\_\_\_\_
3. Asian \_\_\_\_\_\_
4. Native Hawaiian or Other Pacific Islander \_\_\_\_\_\_
5. American Indian or Alaska Native \_\_\_\_\_\_
6. Some other Race \_\_\_\_\_\_
7. More than one race \_\_\_\_\_\_
8. Unknown \_\_\_\_\_\_

**2.** **The number and types of services provided to families.** * 1. Total number of service/trainings provided to families ­­­­­­­­\_\_\_\_\_\_\_\_

b. Of the total numbers of service/trainings, how many provided:1. Individualized assistance (Includes one-on-one instruction, consultation, counseling, case management, and mentoring) \_\_\_\_\_
2. Basic contact information and referrals \_\_\_\_\_\_
3. Group training opportunities \_\_\_\_\_\_
4. Meetings/Conferences and Public Events (includes outreach events and presentations) \_\_\_\_\_\_\_
 |
| **3. Our organization provided health** **care information/education to professionals/providers to assist them in better providing services for CYSHCN.**a. Total number of professionals/providers served/trained (unduplicated count): \_\_\_\_\_\_\_\_\_\_\_**4. The total number of services provided to professionals/providers. This includes the duplicated count of one-to-one services and trainings, group trainings, meetings/conferences, and outreach events. This does not include social media impressions or web hits (to be reported in Q5).**1. Total number of services provided to professionals/providers (duplicated count):: ­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **5. Our organization conducted communication and outreach to families and other appropriate entities through a variety of methods.**1. Select the modes of how print/media information and resources are disseminated. (Select all that apply).
	* Electronic newsletters
	* Listservs
	* Hardcopy/print
	* Public television/radio
	* Social media platform description: \_\_\_\_\_\_\_\_\_
	* Text messaging
	* Other (specify): \_\_\_\_\_\_\_\_\_
 |
| **B. MODELS of family engagement Collaboration** |
| **1. Our organization worked with State agencies/programs to assist them with providing services to their populations and/or to obtain their information to better serve our families.**a. Total number of State agencies/programs with which your organization has worked: \_\_\_\_\_\_\_\_\_b. Indicate the types of State agencies/programs with which your organization has worked: \_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
|  | Check the box if you worked with this type of organization |
| Title V MCH/CSYHCN Program |  |
| Newborn Screening Program |  |
| Early Hearing Detection and Intervention/Newborn Hearing Screening |  |
| Emergency Medical Services for Children |  |
| Home Visiting  |  |
| State Medicaid |  |
| State CHIP |  |
| State Mental and/or Behavioral Health |  |
| Government Housing Program  |  |
| Early Intervention/Part C |  |
| Head Start Collaboration Office |  |
| Other (Specify): |  |
| None |  |

**2. Our organization served/worked with community-based organizations to assist them with providing services to their populations and/or to obtain their information to better serve our families.**a. Total number of community-based organizations: \_\_\_\_\_\_\_\_\_b.Indicate the types of community-based organizations with which your organization has worked:

|  |  |
| --- | --- |
|  | Check the box if you worked with this type of organization |
| Medical homes, providers, clinics, hospitals |  |
| Provider organizations (for example, American Academy of Pediatric chapter) |  |
| Provider training programs (for example, residency programs; schools of medicine, nursing, public health, LEND programs, social work, etc.) |  |
| Schools (K-12, pre-school) |  |
| Faith-based organizations, places of worship |  |
| Condition-specific organizations (for example, United Cerebral Palsy, March of Dimes, etc.) |  |
| Child care programs  |  |
| Local Head start  |  |
| Other community organization (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| None |  |

c. Of those community-based organizations, indicate if any were dedicated to specific racial and/or ethnic populations

|  |  |
| --- | --- |
|  | Check the box if you worked with this type of organization |
| American Indian or Alaska Native  |  |
| Black or African-American |  |
| Hispanic or Latino |  |
| Asian-American, Native Hawaiian or Pacific Islander |  |
| Other (please specify) |  |

3. Number of staff who work on Family-to-Family HIC activities\_\_\_\_\_\_\_4. Number of F2F staff who are family/have a disability \_\_\_\_\_**Comments:**  |
|  |