

# COB - BOSAIR FORM

11/05/2025 4:56 PM (MST)

Submitted by Angelica.Aros@pima.gov



## BOARD OF SUPERVISORS AGENDA ITEM REPORT (BOSAIR)

**\*All fields are required. Enter N/A if not applicable. For number fields, enter 0 if not applicable.\***

Record Number:

Amplifund Grant Record Number: 93893

Award Type: Grant

Is a Board Meeting Date Requested? Yes

Requested Board Meeting Date: 12/02/2025

Signature Only:

NO

Procurement Director Award / Delegated Award: • N/A

Supplier / Customer / Grantor / Subrecipient: The Arizona Department of Health Services

Project Title / Description: Health Start Home Visiting Program

### Purpose:

The Health Start program is a home visiting program for high-risk pregnant women and families with children under the age of two. Under the supervision of a Public Health Nurse, the Community Health Workers (CHWs) provide basic prenatal, postpartum and parenting information and screen for alcohol, tobacco and other substance use, perinatal depression, relationship issues, child growth and development and home/environment safety hazards. The CHWs refer families to other community resources as appropriate.

PCHD does not anticipate issuance of an Intergovernmental Agreement (IGA) as ADHS has implemented a new process in which the grant offer and acceptance of the award is completed during the submission of the grant application. Therefore, approval is requested to accept year one funding in the amount of \$292,510 in accordance with the scope of services and pricing sheet provided. If an IGA or subsequent agreement is later issued reflecting this new award, PCHD requests authorization for the Chair to sign such IGA or agreement.

**Procurement Method:** Grant: Not applicable

**Procurement Method Additional Info:** N/A

**Program Goals/Predicted Outcomes:**

- 1) Increase prenatal care services to pregnant women;
- 2) Reduce the incidence of infants who at birth weigh less than 1,500 grams (3 lbs. 4 oz.) and who require more than seventy-two hours of neonatal intensive care;
- 3) Reduce the incidence of diseases among children;
- 4) Increase the number of children receiving age appropriate immunizations by two years of age; and
- 5) Educate families on the importance of good nutritional habits to improve the overall health of their children; the need for developmental assessments to promote the early identification of learning disabilities, physical handicaps or behavioral health needs; the benefits of preventative health care; and the need for screening examinations such as hearing and vision.

**Public Benefit and Impact:** This program increases the number of high-risk pregnant women who have healthy pregnancies and babies. Low birth weight babies are 40 times more likely to die in the first month of life, and are at greater risk for long-term health and developmental problems. Babies born to women with no prenatal care are 16 times more likely to die in the first month of life than babies of women who had more than five prenatal visits.

**Budget Pillar**

- Improve the quality of life

**Support of Prosperity Initiative:**

- 2. Improve Quality of Life and Opportunity in High Poverty Areas

**Provide information that explains how this activity supports the selected Prosperity Initiatives**

This program increases the number of high-risk pregnant women who have healthy pregnancies and babies. Low birth weight babies are 40 times more likely to die in the first month of life, and are at greater risk for long-term health and developmental problems. Babies born to women with no prenatal care are 16 times more likely to die in the first month of life than babies of women who had more than five prenatal visits.

**Metrics Available to Measure Performance:**

- 1) Number of enrolled women that receive early and regular prenatal care;
- 2) Number of low birth weight and very low birth weight infants born to enrolled clients;
- 3) Gestational age of infants born to enrolled women; and
- 4) Immunization status of enrolled children.

**Retroactive:**

YES

**Retroactive Description:** Yes. This grant year begins October 1, 2025, but Pima County did not receive the award letter until October 30, 2025. Grantor (ADHS) required a portal acceptance of the award in advance of the Board's action. If not approved, Pima County will not



have access to funds needed to provide prenatal care services, education, and resources to families.

## Grant / Amendment Information (for grants acceptance and awards)

Record Number:

Amplifund Grant Record Number: 93893

Type: Award

Department Code: HD

AmpliFund Grant Record Number: 93893

Amendment Number: 00

Commencement Date: 10/01/2025

Termination Date: 09/30/2030

Advantage Initial GTAW# (If Applicable): NA

Total Revenue Amount:

\$292,510.00

Total Match Amount

\$0.00

Advantage Grant ID # (If Applicable): NA

All Funding Source(s) required: Proposition 203, Arizona State Lottery Funds

Does PCAO need to review the grant award (or grant amendment)?

NO

Does PCAO need to sign the grant award (or grant amendment)?

NO

Match funding from General Fund?

NO

Match funding from other sources?

NO

Are Federal Funds Involved?

NO

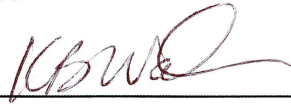
Department: Health

Name: Angelica Aros

Telephone:

(520) 724-7495

GMI Director: \_\_\_\_\_



Date: \_\_\_\_\_

11/10/2025

Department Director Signature: \_\_\_\_\_



Date: \_\_\_\_\_

11/10/20

Deputy County Administrator Signature: \_\_\_\_\_



Date: \_\_\_\_\_

11-10-2018

County Administrator Signature: \_\_\_\_\_

Date: \_\_\_\_\_

11/12/2025



## Award Notification Letter

**Dear Josh Cohn,**

Congratulations! An award package has been created for the following program:

**Project:** Pima County Health Start

**Program:** RFGA2025-013 Health Start Home Visiting Program

**Award Amount:** \$292,510.00

**Federal Awards:**

- ORG3616 BWCH-MIECHFOR-Maternal, Infant and Early Childhood Homevisiting Grant Program ENDS:2609: \$146,255.00
  - Agency: U.S. Department of Health and Human Services
  - Fiscal Year: 2024
  - CFDA/ALN: 93.870

**Total Federal:** \$146,255.00

**Other Awards:**

- ORG2871 BWCH-State Lottery Funds: \$146,255.00
  - Agency: HSA
  - Fiscal Year: 2022

**Total Other:** \$146,255.00

**Total Match:** \$0.00

**Period of Performance:** 10/01/2025 - 09/30/2030

**Award/Contract  
Number:** RFGA2025-013-009

**Ein:** 86-6000543



**ATTACHMENT A  
OFFER & ACCEPTANCE  
RFGA NO. 2025-013  
HEALTH START HOME VISITING PROGRAM**

**ARIZONA DEPARTMENT OF  
HEALTH SERVICES**  
150 N. 18<sup>th</sup> Avenue, Suite 530  
Phoenix, Arizona 85007

**GRANT OFFER AND ACCEPTANCE**

The Undersigned hereby applies and agrees to furnish the materials, service(s) or construction in compliance with all the terms, conditions, specifications, any amendments in the Request and any written exceptions in the Application.

Applicant's Arizona Transaction (Sales) Privilege Tax License Number:

Applicant's Federal Employer Identification Number:

Applicant's UEI Number:

Pima County Health Department  
Applicant's Name

Dorothee Harmon  
Name of Person Authorized to Sign Application

3950 South Country Club Rd, Ste 100  
Street Address

Division Manager, Grants Management and Innovation  
Title of Authorized Person

Tucson, Arizona, 85714  
City State Zip Code

- g.d., I - 6/24/2025  
Signature of Authorized Person Date

Telephone Number: 520-724-6760  
E-Mail Address: Dorothee.Harmon@pima.gov

Facsimile Number:

**ACCEPTANCE OF APPLICATION AND GRANT AWARD**  
(For State of Arizona Use Only)

Your Application is hereby accepted as described in the Notice of Award. Awardee is now bound to perform, based upon the RFGA and Awardee's Application, as accepted by the State.

This Grant shall henceforth be referred to as Grant No. RFGA2025-013-009

The effective date of the Grant is October 1, 2025

Awardee is hereby cautioned not to commence any billable work or provide any material or service under this Grant until Awardee receives an executed Purchase Order, Grant release document, or written notice to proceed, if applicable.

State of Arizona, Arizona Department of Health Services

Awarded this \_\_\_\_\_ day of \_\_\_\_\_ 2025

**Gina Corwin**  
Digitally signed by Gina Corwin  
Date: 2025.09.26 16:53:00 -07'00'  
ADHS Chief Procurement Officer

	<p style="text-align: center;"><b>SCOPE OF SERVICES</b></p> <p style="text-align: center;"><b>REQUEST FOR GRANT APPLICATION</b>  <b>RFGA NO. 2025-013</b>  <b>HEALTH START HOME VISITING PROGRAM</b></p>	<p><b>ARIZONA DEPARTMENT OF HEALTH SERVICES</b>  150 N. 18<sup>th</sup> Avenue, Suite 530  Phoenix, Arizona 85007</p>
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## SCOPE OF SERVICES

### 1. Background

- 1.1. The Arizona Department of Health Services (ADHS) Bureau of Women and Children's Health (BWCH) supports efforts to improve the health of Arizona's women and children. Within BWCH, the Office of Children's Health supports the increased focus within the state and nation on the importance of early childhood programs. It also supports enhanced integration of existing children's programs both within the ADHS and among other state and federal agencies and our outside partners. The Office of Children's Health administers the Health Start program as a promising approach model under the Maternal, Infant and Early Childhood Home Visiting (MIECHV) (<https://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting-overview>) federal grant funded by Health Resources and Service Administration (HRSA). The MIECHV program is funded entirely through federal funds. The Health Start Program is funded partially through MIECHV funds.
- 1.2. The goal of the MIECHV Program is to deliver evidence-based, or evidence informed, home visiting models to communities identified in the Needs Assessment developed as a requirement for the grant and based on increasing positive health outcomes to identified priority populations including households that have: a family member in the military; a mother under the age of twenty-one (21); a family member with a developmental disability; a family member with low student achievement; a tobacco user in the home; a history of substance use; a history of child abuse; or are low income. HRSA commissioned a study by Mathematica to determine which models of home visiting were considered evidence-based. Based on these findings, HRSA determined which models would be eligible for funding. States are able to determine which models they will implement.
- 1.3. The Inter-Agency Leadership Team (IALT) was organized and convened to plan and implement the first MIECHV grant application in 2009, awarded to the ADHS. The IALT committed to work together on the process of developing a statewide system of evidence-based and evidence-informed home visiting programs. This collaborative decision making guided the initial implementation process to ensure that services were not supplanted, duplicated or saturated in a community. The IALT continues to meet regularly to identify statewide home visiting system priorities; develop goals and objectives aligned with the identified priorities; execute the action plan created to improve on the identified priorities; and collaborate and coordinate all efforts pertaining to the Arizona Home Visiting System.
- 1.4. HRSA allows for up to twenty-five percent (25%) of the grant award to support a Promising Approach; a home visiting program that is being evaluated to become evidence-based but has not yet received evidence-based status from Mathematica. MIECHV provides funding for the Health Start program, a home visiting program in Arizona that provides home visits to pregnant women and families with young children beginning in 2019.
- 1.5. Data collection across programs is a critical component of the MIECHV grant. Data collection is also critical to the success of the Arizona Home Visiting System. Through the partnerships of IALT, Arizona procures a contract to establish the Arizona Efforts to Outcomes (ETO) Home Visiting Data Management System. As a result, there are five (5) evidence-based and evidence-informed modes across three (3) state agencies and five (5) funders entering home visiting data into the same system. This collaborative effort and continued coordination allow for home visiting to be implemented throughout the state to ensure that programs are effective, non-duplicative, and reaches the highest need and most underserved communities.
- 1.6. The Arizona Health Start Program was developed over thirty (30) years ago to address the steady increases in the rate of women receiving inadequate or no prenatal care during the 1980s. Late or no prenatal care is associated with preterm and low birth weight births, which increases the risk of infant mortality. The trend continued through 1990, when Arizona was ranked forty-fifth (45<sup>th</sup>) lowest in the nation for the number of women receiving adequate prenatal care. In 2021, Arizona ranked forty-third (43<sup>rd</sup>) lowest in the nation, indicating that entry into early, consistent prenatal care is still a challenge. Many Arizona women experienced barriers that kept them from seeking prenatal care especially during the first (1<sup>st</sup>) trimester. These barriers encompassed a number of social and cultural factors, as well as geographical accessibility. Early prenatal care is very important in identifying potential risks early in the pregnancy and initiating treatment.



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- 1.7. More recent research indicates that the health of a woman prior to pregnancy and throughout her life course might have a greater influence on improving birth outcomes. The life course perspective provides a newer way of viewing health as an integrated continuum and not as unrelated stages. According to the U.S. Department of Health and Human Services (DHHS) Maternal and Child Health Bureau (MCHB), the Life Course Theory (LCT) is a conceptual framework that helps explain health and disease patterns across populations and over time. LCT points to broad social, economic and environmental factors as underlying causes of persistent inequalities in health for a wide range of diseases and conditions across population groups. Preconception health is a woman's health before she becomes pregnant. Preconception care aims to promote the health of women of reproductive age before conception and thereby improve pregnancy related outcomes. Interconception health is a woman's health between pregnancies. Preconception care includes assessing health risk factors and implementing intervention strategies to support women and families as they strive to adopt healthier behaviors. The Health Start Program will have a strong focus on the integration of the LCT in the provision of preconception and interconception care through home visits, educational services, screenings and assessments to women and families. Efforts to prevent the cycle of repeat teen births will be addressed through family planning and birth spacing education. The Health Start Program will promote father and family involvement in home visiting services and classes when appropriate. Babies who get lots of warm and positive attention from their dads feel more secure. Father involvement is linked to positive cognitive outcomes for a child, and father involvement in pregnancy is linked to a reduction in infant mortality. Health Start is a community based, evidence informed home visiting program that identifies, screens and enrolls pregnant and postpartum women and families at any time during their pregnancies and assists them with obtaining early and consistent prenatal care, provides prenatal and postpartum education, information and referral services, advocacy and emphasizes timely immunizations and developmental assessments for their children up to age two (2).
- 1.8. In addition to MIECHV funding, the Health Start Program administration is subject to the appropriation of lottery fund monies as provided through the 1996 [Proposition 203, the Healthy Arizona Initiative](#). The program shall be statewide, based in identified communities and neighborhoods.
- 1.9. Health Start is based on an earlier program titled "Un Comienzo Sano/A Healthy Beginning" that was created in 1984 through the Rural Health Office of the University of Arizona College of Medicine, Department of Family and Community Medicine, utilizing community health workers or "Promotoras" to address the needs of rural, minority pregnant women in Arizona. In 1992, the Arizona Health Start Program was administered by the ADHS, BWCH based on the earlier model. In 1994, the Arizona State Legislature passed the Arizona Children and Families Stability Act, [A.R.S. § 36-697](#), which formalized and expanded Health Start. The legislation describes the purpose, requirements and administration of the program at the ADHS.
- 1.10. The Health Start Program is an evidence informed program that allows for flexibility in enrollment of clients and families and in the structure of home visits based on the needs of the woman and her family and the established goals of the program. The Health Start Program supports and requires the acquisition of, training, and use of one (1) of the following evidence-based or research-based curricula to guide the content of home visits with pregnant and parenting women and their families:
  - 1.10.1. Partners for a Healthy Baby: Home Visiting Curriculum for Families, Florida State University (FSU) Center for Prevention & Early Intervention Policy; [www.cpeip.fsu.edu](http://www.cpeip.fsu.edu).
  - 1.10.2. Family Spirit; [www.familyspirit@jhu.edu](mailto:www.familyspirit@jhu.edu)
- 1.11. The Health Start Program has integrated optional birth doula support services to provide short term support for enrolled Health Start clients and families in labor and during birth, who are in need of emotional and physical comfort measures. Community Health Workers (CHWs) that have obtained birth doula certification may offer birth support services to clients. Many women and families without local community connections or family members desire the support of a birth doula.
- 1.12. In State Fiscal Year 2023 (July 1, 2022 – June 30, 2023), the Health Start Program provided 2886 prenatal visits and 7684 family follow-up visits to clients and their families. The research published in the Health Start



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Impact Report in 2021 found that Health Start participants had higher birth weight babies (above 2,500 grams), improved prenatal care attendance and improvement in on-time child immunizations.

- 1.13. The Mission of the Health Start Program is to educate, support and advocate for families by promoting optimal use of community-based family health care services and education services through the use of CHWs who live in the community they serve.

## **2. AWARD INFORMATION**

- 2.1. Funding for this award is granted through a combination of Arizona State Lottery monies and the Federal MIECHE Program, administered by HRSA, Maternal, Infant and Early Childhood Home visiting Grant Program ENDS:2609.
- 2.2. The MIECHV funds are awarded to ADHS and awarded to sub-grantees through the RFGA process.
- 2.3. The Grantee has the discretion to develop and determine the annual budget needed to fulfill the requirements of the grant and the activities that are proposed to accomplish that. The Grantee should provide a detailed outline of costs using Attachment G – Budget Workbook. The Grantee shall adhere to the funding restrictions as outlined in this RFGA.
- 2.4. Approximately \$3,312,000.00 shall be available to approximately fourteen (14) awardees each Grant year for a five (5) year grant period (Upon award through June 2030). Budgets and workplans shall be reviewed annually and may be decreased based on:
  - 2.4.1. Changes to Arizona Lottery funding allocation, including changes to available funding amount or changes to allocated activities.
  - 2.4.2. Changes to MIECHV funding allocation, including changes to available funding amount or changes to allocated activities.
  - 2.4.3. Failure to meet the goals and activities outlined in this RFGA.
- 2.5. ADHS has the right to partially award based on the needs and areas being services.

## **3. FUNDING OPPORTUNITY ELIGIBILITY**

- 3.1. To be eligible for funding the following shall be met:
  - 3.1.1. Ability to implement the Health Start home visiting program and serve eligible caregivers in one (1) or more approved service areas outlined in Exhibit Seven (7).
  - 3.1.2. Eligible entities include:
    - 3.1.2.1. State or local governments.
    - 3.1.2.2. Tribal entities.
    - 3.1.2.3. Not-for-profit 501(c)3 organizations.
    - 3.1.2.4. Federally Qualified Health Centers.

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3.1.3. Eligible entities may apply in partnership with other eligible entities in which the direct awardee subcontracts to another eligible entity for program implementation.

3.1.3.1. Applicant shall demonstrate that the proposed Subrecipient has agreed to the partnership by providing a letter of support.

3.1.3.2. Sub-contract shall demonstrate the scope of work aligns with the requirements of this award.

3.1.3.3. Applicants awarded with a Subrecipient shall provide a copy of the proposed contract for prior approval for assurances that MIECHV requirements are met.

3.1.3.4. Applicants awarded with a Subrecipient shall provide a copy of the contract between the awardee and the sub-Subrecipient within fourteen (14) days of sub-contract execution.

3.1.3.5. Additional requirements indicated with “Subrecipient” are applicable.

#### **4. FUNDING RESTRICTIONS**

4.1. Funds shall not be expended to support inherently religious activities including, but not limited to, religious instruction, worship, prayer, lobbying, or proselytizing.

4.2. Funds shall not be used to supplant or replace current public or private funding, supplant ongoing or usual activities of any organization involved in the project.

4.3. Funds shall not be used to purchase or improve land, or to purchase, construct, or make permanent improvements to any building.

4.4. Funds shall not be used for the delivery or costs of direct medical, dental, mental health or legal services; however, some limited direct services may be provided by the home visitor to the extent required to maintain fidelity to an evidence-based model approved for use under this award.

4.5. Funds shall not be used to purchase food or drink items without prior authorization and the request shall meet the state and federal guidelines for approval to purchase.

4.6. The Health Start program will not reimburse sites for the establishment of birth doula certification for CHW's.

4.7. Reimbursement of continuing education training in support of currently held certifications will be at the discretion of the ADHS Health Start team, and must be approved prior to enrollment.

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## 5. AREAS OF SERVICE

State of Arizona

- 5.1. Subrecipients shall provide Health Start Home Visiting services to awarded service areas, as outlined in the awarded methodology.
  - 5.1.1. A list of eligible service area PCAs and corresponding zip codes can be found in Exhibit Seven (7).
  - 5.1.2. Zip Codes within a PCA may be updated to include changes, additions, or deletions to align with changes initiated by the United States Postal Service and/or adjusted based on annual population data. Participants enrolled at the time of updates will not be impacted.

## 6. TARGET POPULATION

- 6.1. Pregnant or postpartum women and families
  - 6.1.1. With children under the age of two (2).
  - 6.1.2. Living in an identified Area of Service as outlined in Exhibit Seven (7).
  - 6.1.3. Who meet the medical and social risk eligibility criteria as described in the HSPPM.
  - 6.1.4. Voluntary participates in the Health Start program.
  - 6.1.5. Is not enrolled in another evidence-based or evidence-informed home visiting program.
    - 6.1.5.1. Enrolled participants may be eligible to receive the Health Start Home Visiting Program and some services provided by the HRPP concurrently. Eligibility is determined by the programs.
  - 6.1.6. Enrolled caseload should align with the community data as indicated in Exhibit Six (6), MIECHV Service Utilization by PCA or the latest MIECHV Service Utilization by Geographic Boundary. Updated MIECHV Service maps will be provided when applicable.
    - 6.1.6.1. If caseload does not align with the community data as indicated in Exhibit Six (6), MIECHV Service Utilization by PCA the Subrecipient shall provide a quarterly narrative outlining barriers and efforts to increase caseload in accordance with community needs.

## 7. SCOPE OF SERVICES

Subrecipient shall:

- 7.1. Provide Health Start Home Visiting Services to eligible participants in identified communities from the latest needs assessment completed, including the Primary Care Areas (PCA) or latest geographic boundary determination utilized by the ADHS, and corresponding Zip Codes found in Exhibit Seven (7). Updated Needs Assessments and Geographic Boundary maps when applicable. Zip Codes within a PCA or geographic



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boundary were determined based on percent of population in the zip code residing in the PCA. This information can also be reviewed in Exhibit Six (6) – MIECHV Service Utilization by Primary Care Area.

7.1.1. The intent of this RFGA is to provide services to priority populations within a contracted service area. Priority Populations are defined and determined by Health Resources and Services Administration (HRSA) as eligible participants that are:

7.1.1.1. Residing in an identified high-risk community.

7.1.1.2. Low income as outlined by the US Department of Health and Human Services Poverty Guidelines.

7.1.1.2.1. The HSS Poverty Guidelines are updated annually in February and published to the Federal Register. See <https://aspe.hhs.gov/poverty-guidelines>. Low Income guidelines must be followed based on the annual updated information.

7.1.1.3. Pregnant women who have not attained the age of twenty-one (21) during the reporting period.

7.1.1.4. Have self-reported a history of child abuse, neglect or have had interactions with child welfare services.

7.1.1.5. Have self-reported a history of substance use or need substance abuse treatment.

7.1.1.6. Have self-reported at least one (1) household member who uses tobacco products in the home or who have been identified as using tobacco through a substance abuse screening administered during intake.

7.1.1.6.1. Substance abuse screening administered during intake can only be done within the fidelity of the evidence-informed home visiting model as outlined in the Health Start Policy and Procedures and can only be administered utilizing the approved screening tool provided by the model developer of the implemented model.

7.1.1.6.2. Tobacco is defined as combustibles (cigarettes, cigars, pipes, hookahs, bidis), non-combustibles (chew, dip, snuff, snus, and dissolvable), and electronic nicotine delivery systems (ENDS).

7.1.1.7. Have, or have children with, low student achievement based on self-reporting.

7.1.1.8. Have children with developmental delays or disabilities based on self-reporting or home visitor/staff observation.

7.1.1.9. Families that self-report themselves or other members of the household who are

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serving or have formally served in the armed forces; including families that have members of the armed forces who have multiple deployments outside of the United States.

- 7.1.1.9.1. Household members include a military member's dependents acquired through marriage, adoption or other action during the course of a member's current tour of assigned duty.

- 7.2. Gaps in available resources, services and support does not disqualify a community from receiving MIECHV funded Home Visiting Services.
- 7.3. Subrecipient may already be embedded within the communities they are proposing to serve in which community information is readily available known to the Subrecipient may be proposing to serve an underserved community in which there is not an established home visiting infrastructure. See the Arizona State University Interactive Map for Child Abuse and Neglect Prevention Resources in Arizona (Interactive Maps: Child Abuse and Neglect Prevention Resources in Arizona | Morrison Institute for Public Policy (asu.edu)) for information pertaining to community resources. Note that these are not comprehensive lists and should only be used as resources.

## 8. Deliverables

The Subrecipient shall:

- 8.1. Submit all required data pertaining to the benchmark constructs and participant demographics within fourteen (14) days of data collection and within fourteen (14) days of funding period end.
- 8.2. Submit monthly CER Exhibit One (1), and all required supporting documentation by the twenty-first (21<sup>st</sup>) of the month following the previous month's expenses.
- 8.3. Complete monthly LIA Report review, data entry, and feedback entry by the twenty-first (21<sup>st</sup>) of the month following the data collection.
- 8.4. Provide monthly program documentation and quarterly reports with results of efforts related to achieving quality improvement indicators developed as described in the HSPPM.
- 8.5. Additional updates shall be completed as required to ensure alignment with federal and state policy and procedures impacting the MIECHV grant and ADHS protocols for administering the grant.
- 8.6. Submit the Health Start Quarterly Report within thirty (30) days of the end of September, December, March and June of each year. Report shall follow the most current version as provided by the ADHS Health Start Manager.

## 9. Approvals

ADHS will require prior approval of:

- 9.1. Monthly CER shall be approved by the ADHS prior to payment.

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- 9.2. Written approvals shall be received prior to utilizing funds for travel; training; equipment; marketing or education materials; food, program incentives and other items determined by the ADHS in accordance with the fiscal policy manuals.
- 9.3. All marketing or educational materials, promotional items, media or forms, including but not limited to brochures, posters, publications or journal articles developed using funds awarded under this contract OR are used for the purpose of informing, recruiting or referring eligible participants to services funded under this contract shall be approved by the ADHS Program Manager prior to printing, production and distribution by submitting:
  - 9.3.1. A draft of the materials including how the final product is anticipated to appear.
  - 9.3.2. Justification for item.
  - 9.3.3. Details about how the item will be distributed.
- 9.4. Any changes to the awarded budget line items shall receive prior approval and include justification for the requested adjustment.
- 9.5. Use of any other curriculum for CHW training or for visit topic content that is not referred to in this RFGA.
- 9.6. Subrecipient visits to clients, their families or caregivers temporarily residing in alternative living situations including, but not limited to, rehabilitation centers, jails, inpatient treatment centers or homeless shelters, and when primary caregiver is out of the home for extended periods of time, shall require approval in advance by the ADHS.
- 9.7. Subrecipient extended use of virtual visits with clients, exceeding guidelines in the HSPPM.

## **10. Requirements**

- 10.1. The Subrecipient shall:
  - 10.1.1. Comply with the State of [Arizona Accounting Manual \(SAAM\)](#).
  - 10.1.2. Comply with all state and federal reporting requirements which can be found in Exhibit Eight (8) The ADHS Guidance for Federal Award.
  - 10.1.3. Comply with all [HIPAA Privacy Rules](#).
  - 10.1.4. Comply with all [Health Start Program Policies and Procedures](#).
  - 10.1.5. Comply with all MIECHV Program Policies and Procedures per Exhibit Ten (10): MIECHV Program Policy Manual.
  - 10.1.6. Procure and maintain access to at least one (1) of the following Health Start approved curriculum:
    - 10.1.6.1. Partners of a Health Baby
      - 10.1.6.1.1. Cost associated with curriculum training and access, initially and



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upon renewal, is the responsibility of the Subrecipient, and is eligible for reimbursement to the site, if budgeted and approved.

10.1.6.2. Family Spirit

10.1.6.2.1. Family Spirit Curriculum is intended to be utilized by Subrecipients providing services to Native American communities.

10.1.6.2.2. Family Spirit is considered an evidence-based curriculum and sites shall meet all requirements of the curriculum to maintain model fidelity.

10.1.6.2.3. Cost associated with curriculum training and access, initially and upon renewal, is the responsibility of the Subrecipient, and is eligible for reimbursement to the site, if budgeted and approved.

10.1.6.2.3.1. Cost associated with the Family Spirit curriculum training and access, initially and upon renewal, may be waived and paid for by ADHS, depending on available funding.

10.1.7. Perform background checks on all Community Health Workers and program staff who will have interaction with Health Start enrolled clients and their families;

10.1.8. Provide all required documentation requested by the ADHS, for monthly invoices, including but not limited to items found in section 8 of this document.

10.1.9. Provide a valid Certificate of Insurance (COI) that meets the written specifications in the Special Terms and Conditions within five (5) days of Contract Award, and maintained throughout the life of the Contract. The ADHS will not be able to issue a Purchase Order for the commencement of services without a current and valid COI in the Contract file.

## 11. Tasks

The Subrecipient shall:

11.1. Provide a home visitation program through the development of administrative, management, organizational systems and information, and referral networks to implement and manage a Health Start Program at the contracted site in targeted communities/service areas at risk for preterm and low birth weight births and high rates of infant mortality per the [Health Start Policy and Procedure Manual](#) (HSPPM):

11.1.1. The HSPPM shall be reviewed and updated at least once per year and made available to Subrecipients electronically.

11.1.2. Additional updates shall be completed as required to ensure alignment with federal and state policy and procedures impacting the MIECHV grant and ADHS protocols for administering the grant.

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- 11.2. Provide monthly program documentation and quarterly reports with results of efforts related to achieving quality improvement indicators developed as described in the HSPPM.
- 11.3. Submit the Health Start Quarterly Report within thirty (30) days of the end of September, December, March and June of each year. Report shall follow the most current version as provided by the ADHS Health Start Manager.
- 11.4. Annually provide a recruitment and referral strategy plan for evidence-based home visiting programs demonstrating how the Subrecipient proposes to recruit eligible participants.
- 11.5. Annually submit all file quality assurance documentation for completed data and file.12 checks.
- 11.6. Annually submit documentation of one (1) observed home visitor per CHW employed during the year.
- 11.7. Submit Health Start Form for Assessment Results (FAR) Core Training Scoring Sheets for all newly hired CHW staff within ninety (90) days after employment as described in the HSPPM.
- 11.8. Submit Certifications for training in approved curriculum issued to CHW following successful completion of training within ninety (90) days after employment as described in the HSPPM.
- 11.9. Annually provide a copy of their sites Policy and Procedures for Health Start, which includes:
  - 11.9.1. Process for participant enrollment.
  - 11.9.2. Enrollment of priority populations.
  - 11.9.3. Fiscal Management.
  - 11.9.4. Training schedule for home visitors demonstrating required agency, model and MIECH specific training.
- 11.10. Annually provide an updated Organizational Chart.
- 11.11. Within thirty (30) days of a newly hired supervisor, the site shall submit the resume of the individual to ADHS Health Start Manager.
- 11.12. Within thirty (30) days of a vacancy in the program site shall provide plans of staff recruiting sources including a statement of assurance that proposed positions can be filled with qualified candidates.
- 11.13. Prior to posting, provide positions that are not being proposed to be funded with MIECHV or Health Start Lottery funding but will support staff and/or tasks associated with this contract.
  - 11.13.1. Description of Duties
  - 11.13.2. How the position and/or tasks are funded.
  - 11.13.3. Assurance that if the position and/or tasks are no longer supported by other funds, that the tasks that support activities under this contract will continue without interruption.

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- 11.14. Monthly submission of PDSA cycles to ADHS MIECHV team, and attending monthly Continuous Quality Improvement (CQI) Meetings.
- 11.15. Annual submission of completed CQI project.
- 11.16. Community Readiness Assessment.
- 11.16.1. MIECHV Funded Local Implementing Agencies are responsible for establishing appropriate linkages and referral networks to other community resources, services and supports.
- 11.16.2. The purpose of the assessment is to identify community strengths and gaps in providing appropriate linkages and referral networks to other community resources, services and supports. The assessment will help awardees determine the extent to which their community is ready to address service gaps and unmet needs among MIECHV-eligible families.
- 11.17. Provide indication of community readiness annually by:
- 11.17.1. Completing Attachment I: Community Assessment for each PCA proposed to be served. Attachment I includes directions for completing each section and includes:
- 11.17.1.1. Identifying the community to be served.
- 11.17.1.2. Summary of community strengths and challenges to fulfill the gaps of unmet needs among MIECHV-Eligible families.
- 11.17.1.3. Summary on known specific views, beliefs or perceptions of home visiting in the proposed community that need to be addressed for successful program implementation.
- 11.17.1.4. Compiling information for existing community organizations and agencies in the proposed community that provide resources, support and services to pregnant women and families with children birth to age five (5) in the areas of maternal and child health; school readiness and achievement; domestic violence prevention; child abuse, neglect and maltreatment prevention; reducing emergency department visits; family economic self-sufficiency including the:
- 11.17.1.4.1. Service type.
- 11.17.1.4.2. Organization/Agency providing the listed resource, support or service.
- 11.17.1.4.3. Description for the listed resource, support or service.
- 11.17.1.4.4. Description for how referrals are received and provided to and from the home visiting program and the listed resource, support or service.





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11.17.1.4.5. Indication if the referral process is formal, informal or not yet established.

11.17.1.4.6. Selection of priority populations targeted by the resource, support or service.

11.17.1.5. Provide annually an up-to-date list of non-MIECHV funded evidence-based home visiting programs currently being implemented in the community proposed to be served including the:

11.17.1.5.1. Evidence-based home visiting model.

11.17.1.5.2. Implementing Organization.

11.17.1.5.3. Caseload Capacity.

11.17.1.5.4. Case Capacity Source.

11.17.1.5.5. Description of how referrals are received and provided to and from this provider.

11.17.1.5.6. Indication if the referral process is formal, information or not yet established.

11.17.1.5.7. Selection of priority populations to be served by the non-MIECHV funded evidence-based home visiting program.

11.17.1.6. Provide annually an up-to-date list of individuals and/or organizations that are viewed as community advocates, including parents, caregivers and other stakeholders that support access to resources, supports and services for pregnant women and families with children birth-age five in the community proposed to be served.

#### 11.18. Home Visiting Recruitment and Retention

11.18.1. The intent of the MIECHV funds is to provide quality, voluntary evidence-based home visiting services to pregnant women and families with young children residing in communities outlined in the MIECHV Needs Assessment; report grant required demographic and benchmark measure data; participate in evaluation, monitoring and Continuous Quality Improvement. Subrecipient shall provide the Health Start home visiting program to voluntary participants in the service area:

11.18.1.1. Caseload capacity must be at or exceed eighty-five percent (85%).

11.18.1.2. Ensure participants remain engaged in the program with no more than thirty-five percent (35%) attrition.

11.18.1.2.1. Participants who graduate or complete the program are not calculated in the attrition percentage.

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11.19. Additional Services and Supports Available

- 11.19.1. Health Start Subrecipients shall demonstrate partnership with community entities that support home visitors by providing resources to enrolled participants that will impact the MIECHV program goals.
- 11.19.2. Some of these may include but are not limited to:
  - 11.19.2.1. Pregnancy Testing.
  - 11.19.2.2. Prenatal and Postnatal Doula to reduce maternal and infant mortality and decrease postpartum mood disorders.
  - 11.19.2.3. Community classes for clients.
  - 11.19.2.4. Car Passenger Safety Technician to decrease child injury.
  - 11.19.2.5. Certified Trainers in Ages to Stages Questionnaire to assist in early detection of developmental delays.
  - 11.19.2.6. Other experts that support pregnant women and families with children birth to age five (5) enrolled in evidence-based home visiting programs.

11.20. Recruitment and Referral Strategic Plan

- 11.20.1. The intent of developing and providing an outreach and referral plan is to assist in ensuring that the Subrecipient is able to recruit eligible participants and have partnerships in the community that support home visiting messaging and referrals to the local implementing agency. Strategies shall demonstrate:
  - 11.20.1.1. Coordinated effort with evidence-based and evidence informed home visiting programs within the same community to:
    - 11.20.1.1.1. Prevent dual enrollment.
    - 11.20.1.1.2. Ensure referrals are enrolled in the program that best fit their needs, which may or may not be the evidence-based program proposed by the applicant.
    - 11.20.1.1.3. Awareness of known barriers and strategies to overcome the barriers to increase recruitment and enrollment of eligible participants.
  - 11.20.1.2. Community involvement through convening of and/or participation in community advisory boards, advisory networks, local coalitions, etc to:
    - 11.20.1.2.1. Build relationships with partners.
    - 11.20.1.2.2. Maximize resources in a community.
    - 11.20.1.2.3. Identify and address gaps of services in a community.



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11.20.1.2.4. Develop processes to better serve pregnant women, children and families with children birth to age five (5).

11.20.1.2.5. Other activities to improve services for pregnant women, children and families with children birth to age five (5).

11.20.1.3. The subrecipient shall ensure services are accessible and effectively provided to the community it proposes to serve.

#### 11.21. Program Staff Planning

Programs shall meet minimum program requirements outlined by the ADHS Health Start requirements; local implementing agency requirements; and requirements to work within the United States. Subrecipient shall:

11.21.1. Recruit, hire, train and retain staff for all proposed funded and supported positions and ensure all hired staff meet the requirements for employment:

11.21.1.1. Identify a Health Start Supervisor, at a minimum of 0.25 Full Time Equivalent (FTE) (one (1) position).

11.21.1.1.1. The Health Start Supervisor may oversee ten (10) CHW's per one (1) FTE.

11.21.1.1.2. The Health Start Supervisor shall, at a minimum:

11.21.1.1.2.1. Serve as a primary day-to-day contact with the ADHS Program Manager.

11.21.1.1.2.2. Attend, lead, and prepare materials for meetings as requested.

11.21.1.1.2.3. Troubleshoot and correct problems after implementation.

11.21.1.1.2.4. Provide administrative oversight of all contracted activities.

11.21.1.1.3. Attend all required site visits, virtually and in person, as scheduled with the ADHS Health Start Manager.

11.21.1.1.4. Recruit, hire, train and supervise at a minimum one (1) individual .50 FTE CHW from the communities to be served and who shall identify, screen, enroll pregnant and postpartum women.

11.21.1.1.5. Complete a background check for all staff working under this Contract and follow agency guidelines for maintenance of documents. Background checks for employees shall confirm the following:



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11.21.1.1.5.1. Identity.

11.21.1.1.5.2. Criminal history.

11.21.1.1.5.3. Employment history.

11.21.1.1.5.4. Education.

11.21.1.1.5.5. Driving records.

11.21.1.1.6. Ensure that each .50 FTE CHW maintains a minimum caseload of thirteen (13) clients and families and that each 1.0 FTE CHW maintains a minimum caseload of twenty-five (25) clients and families with a majority being prenatal clients; develop a plan for outreach to recruit and maintain the minimum number of clients.

11.21.1.1.7. Attend all Health Start sponsored annual meetings and trainings.

11.21.1.1.8. Ensure that CHW's attend all Health Start sponsored annual meetings and trainings.

11.21.1.1.9. Ensure that CHWs or other appropriate health care workers provide education including information on enrollment in Health Start, prenatal care and the importance of taking multivitamins with folic acid education to women that have positive pregnancy tests.

11.21.1.1.10. Ensure education is provided to women that have negative pregnancy tests.

11.21.1.1.11. Provide access to at least sixteen (16) hours of training to CHWs to ensure adequate knowledge of pregnancy, prenatal care, maternal nutrition, women's health, child health, infant massage, immunization requirements, preconception and inter-conception health, reproductive health, birth spacing, multivitamins, father involvement and life plans, screenings regarding alcohol, tobacco and other substance use, partner abuse, child abuse, perinatal depression, home assessments, child safety, injury prevention, safe sleep and car seat safety, and how to facilitate referrals as described in the HSPPM.

11.21.1.1.12. Provide or arrange for a minimum sixteen (16) hours of approved continuing education and training on an annual basis to CHWs.

11.21.1.1.13. Instruct CHWs on how to screen and enroll clients utilizing enrollment form with a health risk assessment, provide home/office visits of a minimum of sixty (60) minutes duration, conduct developmental assessments, screenings, and referrals, and optional educational classes of at least one (1) hour duration.



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- 11.21.1.1.14. Provide at least eight (8) hours of supervised home visits with CHWs within ninety (90) days after employment.
- 11.21.1.1.15. Provide one (1) supervised home visit per year thereafter of each CHW, complete Health Start Home Visiting Checklist and save the checklist in the personnel file as described in HSPPM.
- 11.21.1.1.16. Train CHWs on accurate completion of forms, the identification and utilization of information, and referral resources that are available within the Subrecipient's service area.
- 11.21.1.1.17. Identify and annually update a network of available health care, behavioral health and social service providers and resources to which participants could be actively referred for services as they may need.
- 11.21.1.1.18. Ensure that CHWs verify that participants received, declined or were denied services, through documentation on the visit forms and on a Subrecipient Referral form.
- 11.21.1.1.19. Assist CHWs with referrals and all encounter form documentation.
- 11.21.1.1.20. Maintains the following professional support roles:
  - 11.21.1.1.20.1. A Registered Professional Nurse (R.N.) for a minimum of one (1) hour of consultation per month to assist with training of CHWs, attend monthly case management conferencing and to provide reflective supervision and/or guidance regarding difficult issues.
  - 11.21.1.1.20.2. A Certified Independent, Licensed Certified, Licensed Masters Social Worker and/or Licensed Professional Counselor (CISW, LCSW, LMSW, LPC) for a minimum of one (1) hour of consultation per month to assist with training of CHWs, attend monthly case management conferencing and to provide reflective supervision and/or guidance regarding difficult issues.
- 11.21.1.1.21. Ensure that any Subrecipients or consultants fulfill required duties and responsibilities as described in the HSPPM and the Contract.
- 11.21.1.1.22. Maintain client records that are complete, organized and kept in a secure electronic format and/or locked location at the Subrecipient's site as described in the HSPPM.
- 11.21.1.1.23. Ensure that all Health Start Program forms and visit notes are accurate and complete every month and filed in client charts and/or in a client electronic file.





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11.21.1.1.24. Conduct monthly data preparation to:

11.21.1.1.24.1. Ensure all forms are accurate.

11.21.1.1.24.2. Ensure timely response to the ADHS Health Start Data Quality Specialist and/or Health Start Manager if there are any questions.

11.21.1.1.24.3. Ensure accurate reflection of all entered data on the Exhibit 12 MIECHV LIA Report.

11.21.1.1.25. Submit quarterly progress reports to ADHS Health Start Manager utilizing template provided to programs.

11.21.1.1.26. Ensure that CHWs maintain a daily/monthly online calendar of scheduled home visits, classes and any other activities related to Health Start. Copies of all monthly staff calendars for each month shall be available for review at Subrecipient site visits.

11.21.1.1.27. Maintain regular communication and work closely with the ADHS on the subjects of:

11.21.1.1.27.1. Program Development.

11.21.1.1.27.2. Implementation.

11.21.1.1.27.3. Notification regarding any changes to personnel and daily operations as issues arise.

11.21.1.1.27.4. Share information with the ADHS and other Health Start Subrecipients through conference calls, webinars and other sources regarding resources, forms, reports, challenges and barriers.

11.21.1.1.27.5. Be responsive to the ADHS requests for clarification, missing data or other requested information.

11.21.1.1.27.6. Collaborate with other community-based agencies, health departments or other providers that may be providing similar home visiting programs in the targeted service area.

11.21.1.1.28. Identify and implement community-based outreach strategies to:

11.21.1.1.28.1. Identify.

11.21.1.1.28.2. Screen.

11.21.1.1.28.3. Enroll pregnant or postpartum women and families:

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- 11.21.1.1.28.3.1. With children under age two (2).
- 11.21.1.1.28.3.2. Who reside in the Subrecipient's targeted service area.
- 11.21.1.1.28.3.3. Who meet the medical and social risk eligibility criteria as described in the HSPPM.
- 11.21.1.1.28.3.4. Conduct pregnancy testing (CHW or other designated health care worker) of potential clients as necessary and as an option:
  - 11.21.1.1.28.3.4.1. If pregnancy tests result is positive, provide education and offer enrollment into the Health Start Program for a minimum of thirty (30) minutes and referrals, as needed, per HSPPM.
  - 11.21.1.1.28.3.4.2. If pregnancy test result is negative, conduct screening using a health risk assessment tool and/or provide appropriate preconception/and interconception education for a minimum of thirty (30) minutes and referrals, as needed, per HSPPM.
- 11.21.1.1.28.3.5. Complete Intent to Participate and Client Enrollment forms per HSPPM if a pregnant or postpartum woman agrees to participate in the Health Start Program.
- 11.21.1.1.28.3.6. Schedule and conduct prenatal visits

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for a minimum of sixty (60) minutes per visit per client and as described in the HSPPM.

11.21.1.1.28.3.7. Schedule and conduct a birth doula support prenatal visit as a visit option, for a minimum of four (4) hours, not exceeding twenty-four (24) hours per birth per client per Contract year per HSPPM.

11.21.1.1.28.3.8. Schedule and conduct family follow-up visits for a minimum of sixty (60) minutes per visit per client as described in the HSPPM.

11.21.1.1.28.3.9. Conduct alcohol, tobacco and other drug use screening, and brief intervention education if necessary, of all enrolled prenatal clients at enrollment or next visit per HSPPM.

11.21.1.1.28.3.10. Conduct depression screening for all clients, at the required timepoints provided in the HSPPM.

11.21.1.1.28.3.11. Conduct relationship assessment tool/partner abuse screening or all clients, at the required timepoints provided in the HSPPM; and other health/behavioral health screenings as necessary of all enrolled prenatal and postpartum clients per HSPPM.

11.21.1.1.28.3.12. Administer the Ages and Stages Developmental Assessment Screening, Third (3<sup>rd</sup>) Edition, at the four (4), eight (8), twelve (12), eighteen (18) and twenty-four (24) month intervals and Social Emotional (SE) Assessment at twelve (12) and twenty-four (24) months for all children per HSPPM.

11.21.1.1.28.3.13. Provide health education services, support, advocacy and referrals to enrolled clients and their families during each visit as described in the HSPPM.

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- 11.21.1.1.28.3.14. Assist enrolled clients in securing an established source of prenatal care and/or primary care and assist the family with establishing a medical home for all family members in the service area or nearest location.
- 11.21.1.1.28.3.15. Provide referrals using Subrecipient's referral form as necessary, verify and document outcome of the referrals on visit forms and on referral forms as described in the HSPPM.
- 11.21.1.1.28.3.16. Provide and administer the Healthy @ Home Assessment in the enrolled client's place of residence for all clients, at the required timepoints provided in the HSPPM.
- 11.21.1.1.28.3.17. Provide *Never Shake a Baby* education and commitment forms to all prenatal clients within one (1) month of delivery, or postpartum clients within two (2) months after child is born as described in the HSPPM; collect completed forms and keep on file for site review.
- 11.21.1.1.28.3.18. Provide child safety education including injury prevention, safe sleep, car seat safety and car seat forms to enrolled women and their families; collect completed forms and keep on file for site review.
- 11.21.1.1.28.3.19. Ensure that the social determinants of health are addressed per the HSPPM and that preconception and interconception screening, education, referrals and support are provided.
- 11.21.1.1.28.3.20. Provide a client satisfaction survey to clients at a minimum of four (4) weeks after the prenatal period, and after two (2) years of family follow-up services, or at disenrollment from the program; collect completed surveys and keep on file for site review.



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- 11.21.2. Ensure reflective supervision and reflective practice is provided to all home visitors and supervisor monthly.
- 11.21.3. Ensure home visitors, supervisors and other staff funded with MIECHV funds are representative of the communities they serve and are culturally competent to serve within the proposed community.
- 11.21.4. Ensure that there are adequate recruiting sources and qualified candidates to fill requested positions.
- 11.21.5. Provide CHW's access to Health Start Core Competency Training prior to providing home visiting services.
- 11.21.6. Ensure that newly hired CHW's are provided training in the approved site curriculum within ninety (90) days of hire.
- 11.21.7. Provide all training required to ensure that home visitors are able, competent and qualified to complete required assessments and screenings for required HRSA data collection and reporting.
- 11.21.8. Ensure that all newly hired CHW's register for and access the Strong Families Home Visitor Learning portal located at:  
["https://portal.strongfamiliesaz.com/login/?redirect\\_to=https%3A%2F%2Fportal.strongfamiliesaz.com%2Fwp-admin%2F&reauth=1"](https://portal.strongfamiliesaz.com/login/?redirect_to=https%3A%2F%2Fportal.strongfamiliesaz.com%2Fwp-admin%2F&reauth=1)
- 11.21.9. Ensure that all required staff attend the ADHS sponsored meetings, trainings, conference calls and webinars as directed including but not limited to:
  - 11.21.9.1. CQI via webcam through identified web access service.
  - 11.21.9.2. Quarterly MIECHV Funded Agency Meetings, in person unless otherwise specified.
  - 11.21.9.3. Site visits ADHS Health Start Manager; either virtually or in person.
  - 11.21.9.4. Annual data collection and reporting training related to Arizona Efforts to Outcomes (AZ ETO), in person unless otherwise specified.
- 11.21.10. Notify the ADHS Health Start Manager within fifteen (15) days of a new hire, including training/onboarding scheduled for hired staff that includes Health Start specific training.
  - 11.21.10.1. Maintain and updated Organizational Chart.
- 11.21.11. Ensure that newly hired Community Health Workers are trained in Ages and Stages Assessment Questionnaires Third (3<sup>rd</sup>) Edition, (ASQ-3) and Social Emotional (English and Spanish versions) within ninety (90) days of hire.
- 11.21.12. Required Policy and Procedures.





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Subrecipients are required to have written and up to date policies and procedures to ensure thorough administrative, programmatic and fiscal oversight of the grant. Copies of policy and procedures impacting the implementation of this contract can be requested from the ADHS at any time throughout the contract period. Policy and Procedures that require annual review include but are not limited to:

#### 11.21.13. Participant enrollment including.

11.21.13.1. How participants are identified, screened and recruited.

11.21.13.2. Participants are informed and enrolled on a voluntary basis.

11.21.13.3. How the funded site ensures participants are not dually enrolled in home visiting programs.

#### 11.21.14. Enrollment of priority populations

11.21.14.1. Low income as outlined by the US Department of Health and Human Services Poverty Guidelines.

11.21.14.1.1. The HSS Poverty Guidelines are updated annually in February and published to the Federal Register. See <https://aspe.hhs.gov/poverty-guidelines>. Low Income guidelines must be followed based on the annual updated information.

11.21.14.2. Pregnant women who have not attained the age of twenty-one (21) during the reporting period.

11.21.14.3. Have self-reported a history of child abuse, neglect or have had interactions with child welfare services.

11.21.14.4. Have self-reported a history of substance use or need substance abuse treatment.

11.21.14.5. Have self-reported at least one household member who uses tobacco products in the home or who have been identified as using tobacco through a substance abuse screening administered during intake.

11.21.14.5.1. Substance abuse screening administered during intake can only be done within the fidelity of the evidence-based home visiting model as outlined in the specific national model developer guidelines and can only be administered utilizing the approved screening tool provided by the national model developer.

11.21.14.5.2. Tobacco is defined as combustibles (cigarettes, cigars, pipes, hookahs, bidis), non-combustibles (chew, dip, snuff, snus, and dissolvable), and electronic nicotine delivery systems (ENDS).

11.21.14.6. Have, or have children with, low student achievement based on self-reporting.

11.21.14.7. Have children with developmental delays or disabilities based on self-reporting or



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home visitor/staff observation.

- 11.21.14.8. Families that self-report themselves or other members of the household who are serving or have formally served in the armed forces; including families that have members of the armed forces who have multiple deployments outside of the United States.

11.21.14.8.1. Household members include a military member's dependents acquired through marriage, adoption or other action during the course of a member's current tour of assigned duty.

- 11.21.15. If policies and procedures are not currently developed and/or do not contain the necessary components, the Subrecipient shall develop and implement required policy and procedures.

- 11.21.16. The Subrecipient shall, as outlined in the MIECHV Policy and Procedure Manual:

- 11.21.16.1. Provide the promising approach home visiting Health Start model to the assigned service area.
- 11.21.16.2. Enroll pregnant women and families with children birth to age two (2) identified as a Target Population.
- 11.21.16.3. Maintain the contracted caseload capacity at or above eighty-five percent (85%).
- 11.21.16.4. Maintain participant retention at or above sixty-five percent (65%).
- 11.21.16.5. Coordinate effort with evidence based-based and evidence-informed home visiting programs within the same community to prevent dual enrollment and ensure referrals are enrolled in the program that best fit their needs.
- 11.21.16.6. Develop and maintain strong partnerships in the community with existing programs and resources that make referrals to evidence-based home visiting programs and the evidence-based home visiting program can refer families to needed resources.
- 11.21.16.7. Convene and/or participate in community advisor boards, advisory networks, local coalitions, or similar.
- 11.21.16.8. Recruit, hire, train and retain staff for all proposed funded and supported positions and ensure all hired staff meet the requirements for employment.
- 11.21.16.9. Ensure all staffing requirements and responsibilities are met.
- 11.21.16.10. Develop and/or update and implement required and supplemental policy and procedures to ensure thorough administrative, programmatic and fiscal oversight of the grant.
- 11.21.16.11. Ensure fiscal oversight of the award including but not limited to implementation of the Arizona MIECHV Program Fiscal Policy Management; providing and maintaining adequate documentation to support expenditures; ensure



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expenditures are allocable and allowable costs; maintain budget tracking; participate in all required state and federal audits; complete forms required to meet the Federal Funding Accountability and Transparency Act.

- 11.21.16.12. Participate in the Home Visiting Budget Assessment Tool as requested.
- 11.21.16.13. Collect, enter and report all required programmatic data in the specified data management system.
- 11.21.16.14. Participate in all required Continuous Quality Improvement activities.
- 11.21.16.15. Demonstrate improvement in the required benchmarks for each reporting period.

#### 11.22. Fiscal Management

##### 11.22.1. Ensure fiscal oversight of the award including:

- 11.22.1.1. Following policy and procedures as outlined in the Exhibit Eight (8) ADHS Guidance for Federal Award Management and the Exhibit Eleven (11) Arizona MIECHV Program Fiscal Policy Management resources.
- 11.22.1.2. Provide monthly completed Subrecipient Expenditure Reports (CER), utilizing the most recent CER provided by the ADHS and provide all required documentation to support the expenses including but not limited to:
  - 11.22.1.2.1. Time sheets, labor distribution reports, percentage of time, pay stubs for funded staff.
  - 11.22.1.2.2. Proof of enrollment and payment of employee fringe benefits.
  - 11.22.1.2.3. Approvals, quotes, purchase orders, invoices, copies of checks/deposits for professional and outside services.
  - 11.22.1.2.4. Approvals, justifications, receipts, documentation of conference/training attendance, proof of payment for all in state and out of state travel expenses.
  - 11.22.1.2.5. Calculation of occupancy rent/lease amount and/or an agreement of lease terms including expenses from MIECHV funds, proof of payment for rent/lease based on rent/lease terms.
  - 11.22.1.2.6. Approvals, quotes, purchase orders, receipts and proof of payment for supplies and operating expenses.
  - 11.22.1.2.7. Any expenses in which there is a shared cost with another program should outline how the amount as calculated for the MIECHV funded program.
  - 11.22.1.2.8. Calculation and description of uses for indirect costs.



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- 11.22.1.2.9. Any additional information as requested by ADHS and/or HRSA to determine expenses were allowable and allocable.
- 11.22.1.3. Maintain monthly budget tracking for anticipated and actual expenses to ensure awarded funds are expended as budgeted.
- 11.22.1.3.1. Any changes to the awarded budget line items must receive prior approval and include justification for the requested adjustment.
- 11.22.1.3.2. Up to ten percent (10%) of the total budget amount between line items can be requested to be changed during an annual budget period.
- 11.22.1.3.3. Requests exceeding ten percent (10%) of the total budget or requests to move funds to a non-funded line item is not permitted without a contract amendment and may require additional approvals.
- 11.22.1.4. Program participant incentives, as outlined in the MIECHV Program Fiscal Management Policy cannot exceed two percent (2%) of the total award amount.
- 11.22.1.4.1. All program participant incentives must receive approval prior to purchasing and/or production of a product. An approved budget with incentives indicated is not considered approval.
- 11.22.2. Subrecipients shall display the following funding language on materials when issuing statements, press releases, requests for proposals, bid solicitations, publications and forums describing projects or programs funded in whole or in part with the HRSA funding. Examples of publications may include but are not limited to manuals, toolkits, resource guides, case studies, visual presentations, issues briefs and program flyers/brochures/rack cards/etc. that are describing services funded with these dollars.
- 11.22.2.1. This [ENTER PROJECT/ PUBLICATION/WEBSITE/ PRODUCT/ PROGRAM/ ETC NAME] [IS/WAS] supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling [FEDERAL AWARD AMOUNT] with [ENTER PERCENTAGE OF NON-GOVERNMENTAL CONTRIBUTIONS] percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.
- 11.22.3. Participation in Federal Financial Audits is required.
- 11.22.3.1. HRSA and the Federal Division of Financial Integrity complete a site visit and fiscal audit at a minimum of once every three years and may review up to five (5) years of expenditures.
- 11.22.3.2. A selection of expenditures for any active or closed grants may be selected for auditing purposes.

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11.22.3.3. The ADHS MIECHV Program will provide all documentation that is on file that was submitted with your CER at the time of reimbursement. If that documentation is not adequate to meet the requirements of the audit, additional documentation may be required.

11.22.3.4. Failure to provide adequate documentation for the determination of an expense being supported and/or allowable will result in the LIA repayment of funds. HRSA will provide the necessary information pertaining to this process at the time of the findings.

11.22.4. Complete the required information pertaining to the Federal Funding Accountability and Transparency Act (FFATA).

11.22.4.1. Submission is required for each encumbrance of federal funds.

11.22.4.2. The ADHS Health Start Program will provide the form within thirty (30) days of a purchase order issuance.

#### 11.23.Data Management System

AZ ETO Data Management System is the statewide home visiting data management system used for program level, state and federal reporting.

11.23.1. Data shall be collected and reported to the ADHS through the AZ ETO data management system.

#### 11.24.Data Collection, Reporting, and Evaluation

Required data is based on the HRSA reporting requirements and is subject to change throughout the contract period. This includes all individual-level benchmarks, demographics and service utilization data on participants in the implemented evidence-based program which at least meet the following federal requirements for individual-level data.

11.24.1. MIECHV Benchmark Areas are:

11.24.1.1. Improved maternal and newborn health.

11.24.1.2. Decrease child injuries, maltreatment, and reduction of emergency department visits for accidental injuries.

11.24.1.3. Improve school readiness and achievement.

11.24.1.4. Decrease crime and domestic violence.

11.24.1.5. Improve family economic self-sufficiency.

11.24.1.6. Increase coordination and referrals to community resources.

11.24.2. There shall be demonstration of improvement in at least four (4) of the six (6) benchmarks, each annual reporting period.





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11.24.2.1. HRSA sets the parameters for determining improvement.

11.24.3. At the time of this notice, required data includes but is not limited to:

11.24.3.1. Demographic and Characteristic data:

11.24.3.1.1. Race of children and caregivers served.

11.24.3.1.2. Ethnicity of children and caregivers served.

11.24.3.1.3. Language Spoken by children served.

11.24.3.1.4. Age of children and caregivers served.

11.24.3.1.5. Education level of caregivers served.

11.24.3.1.6. Student status of caregivers served.

11.24.3.1.7. Employee status of caregivers served.

11.24.3.1.8. Marital status of caregivers served.

11.24.3.1.9. Housing status of caregivers served.

11.24.3.1.10. Household income.

11.24.3.1.11. Health Insurance source for children and caregivers served.

11.24.3.1.12. Zip code.

11.24.3.2. Priority Population data:

11.24.3.2.1. Number of households served identified as:

11.24.3.2.1.1. Low income.

11.24.3.2.1.2. Teen parent.

11.24.3.2.1.3. History of child abuse.

11.24.3.2.1.4. History of substance abuse.

11.24.3.2.1.5. Current tobacco use.

11.24.3.2.1.6. Low student achievement.

11.24.3.2.1.7. Family member with developmental delay.

11.24.3.2.1.8. Military family member.

11.24.3.3. Benchmark measure data as outlined in the Performance Measure, Data



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Collection and Data Analysis Plan for MIECHV Measures which includes but is not limited to:

- 11.24.3.3.1. Infants enrolled prenatally born preterm.
- 11.24.3.3.2. Infants enrolled prenatally breastfed at 6 months of age.
- 11.24.3.3.3. Enrolled caregivers screened for depression.
- 11.24.3.3.4. Enrolled children received the last recommended well child visit.
- 11.24.3.3.5. Mothers enrolled prenatally had timely postpartum health care visit.
- 11.24.3.3.6. Enrolled caregivers who reported smoking received a cessation referral.
- 11.24.3.3.7. Enrolled infants always safe sleeping.
- 11.24.3.3.8. Enrolled children emergency department visits.
- 11.24.3.3.9. Enrolled children with investigated case of maltreatment.
- 11.24.3.3.10. Enrolled caregivers received a parent-child interaction assessment.
- 11.24.3.3.11. Enrolled children who had a family member who read, sang or told stories to them daily.
- 11.24.3.3.12. Enrolled children who had a timely developmental delay screenings.
- 11.24.3.3.13. Home visits included a discussion of parent concerns related to child development.
- 11.24.3.3.14. Enrolled caregivers screened for intimate partner violence.
- 11.24.3.3.15. Enrolled caregivers without a high school degree completed or maintained enrollment in high school.
- 11.24.3.3.16. Enrolled caregivers who had six (6) months of continuous health insurance.
- 11.24.3.3.17. Enrolled caregivers with a positive depression screening received services.
- 11.24.3.3.18. Enrolled children with a positive developmental delay screen received services in a timely manner.
- 11.24.3.3.19. Enrolled caregivers with a positive intimate partner violence screen who received a referral.



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#### 11.24.3.4. Service Utilization data:

11.24.3.4.1. Number of newly enrolled participants.

11.24.3.4.2. Number of participants to disengage in the program.

11.24.3.4.3. Number of participants to graduate or complete the program.

11.24.3.4.4. Number of participants to transfer in or out of the program from another funded site.

11.24.3.4.5. Number of participants enrolled but not currently engaging in services.

11.24.3.4.6. Number of home visits completed.

11.24.3.4.7. Number of referrals to identified community services which includes but is not limited to:

11.24.3.4.7.1. Food support and services.

11.24.3.4.7.2. Domestic Violence Shelters, services and hotline.

11.24.3.4.7.3. Education services for the caregiver.

11.24.3.4.7.4. Shelter and housing services.

11.24.3.4.7.5. Transportation services.

11.24.3.4.7.6. Developmental or disability services.

11.24.3.4.7.7. Childcare services.

11.24.3.4.7.8. Mental health services.

11.24.3.4.7.9. Medical or dental services.

11.24.3.4.7.10. Legal services.

11.24.3.4.7.11. Socialization or recreational services for the caregiver or child.

11.24.3.4.7.12. Legal services.

11.24.3.4.7.13. Job development or placement services.

11.24.3.4.7.14. Other community support services.

11.24.3.4.8. Reason for disengagement from the program that include but is not



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limited to:

- 11.24.3.4.8.1. Moved out of service area.
- 11.24.3.4.8.2. Unable to locate.
- 11.24.3.4.8.3. Declines services.
- 11.24.3.4.8.4. Declined a home visitor change.
- 11.24.3.4.8.5. Caregiver no longer has parental custody of the enrolled child(ren).
- 11.24.3.4.8.6. Pregnant woman experienced miscarriage or fetal death.
- 11.24.3.4.8.7. Caregiver experienced death of the enrolled infant or child(ren).
- 11.24.3.4.8.8. Graduated or completed the program.
- 11.24.3.4.8.9. Caregiver met self-sufficiency goals.
- 11.24.3.4.8.10. Did not respond to outreach efforts.
- 11.24.3.4.8.11. Program Supervisor Discretion.
- 11.24.3.4.8.12. Duplication of Services.

#### 11.24.3.5. Funded Staff Data:

- 11.24.3.5.1. Number of home visitors continuing employment between reporting periods.
- 11.24.3.5.2. Number of home visitors hired.
- 11.24.3.5.3. Number of home visitor vacancies.
- 11.24.3.5.4. Number of MIECHV funded supervisors continuing employment between reporting periods.
- 11.24.3.5.5. Number of MIECHV funded supervisors hired.
- 11.24.3.5.6. Number of MIECHV funded supervisor vacancies.
- 11.24.3.5.7. Number of other MIECHV funded staff positions continuing employment between reporting periods.
- 11.24.3.5.8. Number of other MIECHV funded staff positions hired.



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11.24.3.5.9. Number of other MIECHV funded staff position vacancies.

- 11.24.4. Provide narrative updates, utilizing the Local Implementing Agency Report (access provided upon award) on programmatic concerns impacting the quality of the program and/or maintaining fidelity to the model; impacting the ability to reach and maintain capacity and retention; and staffing concerns.
- 11.24.5. All required data shall be entered into the AZ ETO data management system within two (2) weeks of data collection.
- 11.24.5.1. All data for annual reporting must be entered within seven (7) days of year end.
- 11.24.6. The Subrecipient shall conduct, at minimum, quarterly quality assurance checks to ensure that data entered is complete and accurate.
- 11.24.6.1. Programs utilizing the AZ ETO data management system have access to reports to assist in quality assurance checks and data clean up including but not limited to and subject to change:
- 11.24.6.1.1. Report providing number of days since last home visit for enrolled participant.
- 11.24.6.1.2. Report providing information on missing data from enrolled participants.
- 11.24.6.1.3. Local Implementing Agency Report for service utilization.
- 11.24.6.1.4. Home Visitor funding report.
- 11.24.6.1.5. Benchmark reports.
- 11.24.7. Data collection changes required by HRSA will be updated in the AZ ETO data management system by the ADHS Health Start Program.
- 11.24.8. Data collection that is not HRSA required but is requested through the Home Visiting State System Inter-Agency Leadership Team may be collected and shared at the discretion of the Subrecipient.
- 11.24.9. Ensure that terminated employees and employees who are no longer needing access to data in the data management system have their account deactivated within twenty-four (24) hours;
- 11.24.10. Ensure that paper forms and visit notes are kept in a secure electronic location or physically locked location and are transported in a locked file.
- 11.24.11. Be responsive and ensure timely response to the ADHS Program Managers and the ADHS Evaluators to any request for clarification, documentation, reports and/or any questions regarding program implementation and evaluation and provide all requested information in the





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format and medium requested.

- 11.24.12. Participate in any HRSA required evaluation which may include additional data collection, reporting, meeting attendance, presentations and other tasks associated with an evaluation. Required evaluations will not exceed a reasonable burden of hours. Reasonable burden of hours is determined by HRSA
- 11.24.13. Subrecipients are encouraged to participate in additional HRSA evaluations that are voluntary and may include but are not limited to a range of opportunities such as rigorous evaluations, surveys, focus groups, and other opportunities for participation.
- 11.24.14. Annual reports and site visit documents from a central administration and/or national model developer must be provided to the ADHS Health Start program that demonstrate that the funded site has met requirements for program fidelity.
- 11.24.15. In the event that the ADHS is unable to access the data in the identified data management and reporting system, the site will provide the required data through manual reporting in a format identified by the ADHS.

#### 11.25. Continuous Quality Improvement (CQI)

Sites receiving MIECHV funds are required to participate in the statewide CQI team.

- 11.25.1. CQI topics are determined by the ADHS Health Start Program based on HRSA required benchmark data and are selected annually.
- 11.25.2. At least one (1) supervisor and a direct contract representative from MIECHV funded sites shall participate in CQI. This includes but is not limited to:
  - 11.25.2.1. Participating in monthly meetings remotely via webcam and provided web access service.
  - 11.25.2.2. Complete CQI PDSA cycles and projects at the site level.
  - 11.25.2.3. Report on project progress monthly including the submission of a brief monthly presentation.
  - 11.25.2.4. Participate in the annual CQI Final Project presented during the annual Strong Families AZ Home Visiting Conference. This includes the completion of a storyboard and one of the following:
    - 11.25.2.4.1. Poster Presentation.
    - 11.25.2.4.2. Workshop or keynote speaker session.
    - 11.25.2.4.3. CQI Booklet Development.
    - 11.25.2.4.4. Other identified strategies.

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11.25.2.5. Request technical assistance from the ADHS to ensure CQI participate and project process as needed.

11.25.2.6. Have at least one (1) parent representative on the local site CQI team.

11.26. Subrecipient is required to ensure that appropriate linkages and referral networks are established, and families are referred to appropriate community resources, services and supports.

11.27. Subrecipient is required to conduct outreach and/or partner with other local agencies/organizations within their designated service area, to ensure caseload capacity is met, and referrals for program are gathered

11.28. Subrecipient is required to Adhere to Arizona Revised Statute [A.R.S.§36-697](#)

11.28.1. (<http://www.azleg.gov/ArizonaRevisedStatutes.asp>) and perform all services in accordance with the HSPPM.

11.29. Subrecipient is required to hire, train and utilize Community Health Workers to deliver Health Start Home Visiting Services.

11.30. Subrecipient is required to hire, train and utilize qualified supervisors to oversee the work of the Community Health Workers.

11.30.1. Supervisors are required to attend all virtual and in-person required meetings at a minimum of 1 (one) time per month.

11.31. Subrecipient is required to create and maintain required policy and procedure documents.

11.32. Subrecipient is required to Comply with the State of Arizona Accounting Manual (SAAM).

11.33. Subrecipient is required to utilize Arizona Efforts to Outcomes (ETO) for all data collection and reporting.

11.34. Subrecipient is required to collect all data pertaining to MIECHV established benchmarks and efforts. Subrecipient is required to participate in annual Continuous Quality Improvement (CQI) projects, as determined by MIECHV.

## 12. State-Provided Items

The ADHS will provide upon award:

- 12.1. Technical assistance and guidance to the Subrecipient's staff that are implementing the Health Start Program.
- 12.2. Monitoring of the operation of the program, and ongoing compliance with Contract provisions and the HSPPM, through site visits, review of submitted forms and other mechanisms.
- 12.3. Forms, guides, screening forms, and any other forms that may be necessary to implement the program.
- 12.4. Summary information from the Health Start forms and other information if available.
- 12.5. Healthy @ Home Assessment forms and kit (English and Spanish versions).

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- 12.6. Ages and Stages Assessment Questionnaires Third (3<sup>rd</sup>) Edition, (ASQ-3) and Social Emotional (English and Spanish versions).
- 12.7. Arizona Family Resource Guide (English and Spanish digital versions).
- 12.8. Quarterly Report Templates.
- 12.9. Health Start Community Health Worker Core Curriculum.
- 12.10. Other Provider Resources as available.
- 12.11. Exhibit One (1) - Contractors Expense Reports
- 12.12. Exhibit Five (5) – Needs Assessment Report.
- 12.13. Exhibit Six (6) – MIECHV Service Utilization by Primary Care Area.
- 12.14. Exhibit Seven (7) - List of eligible PCAs with associated zip codes.
- 12.15. Exhibit Eight (8) – The ADHS Guidance for Federal Award Management.
- 12.16. Exhibit Nine (9) - Quarterly and Annual Site Visit Documentation.

### **13. Notices, Correspondence, and Reports**

- 13.1. Notices, correspondence, reports, supporting documentation, and invoices/CERs from the Subrecipient to ADHS shall be sent to:

Kristin Spevak, Health Start Manager  
Office of Children's Health  
Arizona Department of Health Services  
150 N 18th Avenue, Suite 310  
Phoenix, AZ 85007-3242  
Email: [Kristin.Spevak@azdhs.gov](mailto:Kristin.Spevak@azdhs.gov)  
Phone: 602-316-336

- 13.2. CERs and all supporting documentation shall be emailed to: [healthstartinvoices@azdhs.gov](mailto:healthstartinvoices@azdhs.gov)

13.2.1 AUTOMATED CLEARING HOUSE. ADHS may pay invoices for some or all Orders through an Automated Clearing House (ACH). In order to receive payments in this manner, the Contractor must complete an ACH Vendor Authorization Form (form GAO-618) within thirty (30) days after the effective date of the Contract. The form is available online at: <https://gao.az.gov/sites/default/files/2023-05/GAO-618.pdf>

13.2.1.1 ACH Vendor Authorization Form shall be emailed to [Vendor.Payautomation@azdoa.gov](mailto:Vendor.Payautomation@azdoa.gov).

**COST REIMBURSEMENT LINE ITEM BUDGET  
PIMA COUNTY HEALTH DEPARTMENT  
RFGA2025-013-009**

**COST REIMBURSEMENT LINE ITEM BUDGET**

<b>ACCOUNT CLASSIFICATION</b>	<b>AMOUNT</b>
Personnel	\$171,375.00
ERE	\$63,409.00
Professional & Outside Services	\$500.00
Travel Expense (In-State)	\$8,425.00
Out of State Travel	\$0.00
Occupancy	\$0.00
Operating Expenses/ Other Operating	\$11,300.00
Capital Outlay Expense	\$0.00
Indirect (if authorized)	\$37,501.00
Other	\$0.00
<b>TOTAL</b>	<b>\$292,510.00</b>

With prior written approval from the Program Manager, the Contractor is authorized to transfer up to a maximum of ten percent (10%) of the total budget amount between funded line items. Transfers of funds are only allowed between funded line items. Transfers exceeding ten percent (10%) or to a non-funded line item shall require an amendment.

Authorization for purchase of services under this Contract shall be made only upon ADHS issuance of a Purchase Order that is signed by an authorized agent. The Purchase Order will indicate the Contract number and the dollar amount of funds authorized. The Contractor shall only be authorized to perform services up to the amount on the Purchase Order. ADHS shall not have any legal obligation to pay for services in excess of the amount indicated on the Purchase Order. No further obligation for payment shall exist on behalf of ADHS unless a.) the Purchase Order is modified with an official ADHS Procurement Change Order, and/or b.) an additional Purchase Order is issued for purchase of services under this Contract.