U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Maternal and Child Health Bureau
Division of Maternal and Child Health Workforce Development

Developmental-Behavioral Pediatrics Training Program

Funding Opportunity Number: HRSA-18-075
Funding Opportunity Type(s): New, Competing Continuation
Catalog of Federal Domestic Assistance (CFDA) Number: 93.877

NOTICE OF FUNDING OPPORTUNITY

Fiscal Year 2018

Application Due Date: February 20, 2018

Ensure your SAM.gov and Grants.gov registrations and passwords are current immediately!
Deadline extensions are not granted for lack of registration.
Registration in all systems, including SAM.gov and Grants.gov,
may take up to 1 month to complete.

Issuance Date: December 21, 2017

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Authority: Section 399BB(e)(1) of the Public Health Service Act (42 U.S.C. § 280i-1(e)(1)), as amended by the Autism CARES Act of 2014 (Pub. L. 113-157)

EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB) is accepting applications for the fiscal year (FY) 2018 Developmental-Behavioral Pediatrics (DBP) Training Program. The purpose of this program is to enhance the behavioral, psychosocial, and developmental components of pediatric care by supporting DBP fellowship programs to prepare DBP fellows for leadership roles as teachers, investigators, and clinicians and to provide pediatric practitioners, residents, and medical students, with essential biopsychosocial knowledge and clinical expertise. This will result in advancing the field by training health care professionals to use valid and reliable screening and diagnostic tools, in addition to providing evidence-based interventions for children with autism spectrum disorder (ASD) and other developmental disabilities (DD).

The FY 2018 President's Budget does not request funding for this program. This notice is a contingency action taken to ensure that, should funds become available for this purpose, HRSA can process applications and award funds in a timely manner. You should note that this program may be cancelled prior to award recommendations.

Funding Opportunity Title:	Developmental-Behavioral Pediatrics Training Program
Funding Opportunity Number:	HRSA-18-075
Due Date for Applications:	February 20, 2018
Anticipated Total Annual Available FY18 Funding:	$1,906,150 (includes $35,000 for grantee meeting to be determined after award)
Estimated Number and Type of Award(s):	Up to 10 grants
Estimated Award Amount:	Up to $187,115 per year
Cost Sharing/Match Required:	No
Project Period/Period of Performance:	July 1, 2018 through June 30, 2023 (5 years)
Eligible Applicants:	Per § 399BB(e)(1)(A) of the Public Health Service Act, public or nonprofit agencies, including institutions of higher education, are eligible to apply. See Section III-1 of this notice of funding opportunity (NOFO), formerly known as the funding opportunity announcement (FOA), for complete eligibility information.

Application Guide

You (the applicant organization/agency) are responsible for reading and complying with the instructions included in HRSA's *SF-424 R&R Application Guide,* available online at http://www.hrsa.gov/grants/apply/applicationguide/sf424rrguidev2.pdf, except where

instructed in this NOFO to do otherwise. A short video explaining the *Application Guide* is available at http://www.hrsa.gov/grants/apply/applicationguide/.

Technical Assistance

HRSA has scheduled the following technical assistance webinar:

Webinar

Day and Date: Monday, January 8, 2018
Time: 2 p.m. – 3 p.m. ET
Call-In Number: 1-888-946-3803
Participant Code: 1492777
Weblink: https://hrsa.connectsolutions.com/dbp_training/
Playback Number: 1-866-410-5848
Passcode: 3622

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I. Program Funding Opportunity Description

1. Purpose

This notice solicits applications for the Developmental-Behavioral Pediatrics (DBP) Training Program. The purpose of the DBP Training Program is to enhance the behavioral, psychosocial, and developmental components of pediatric care by supporting DBP fellowship programs to train health care professionals to use valid and reliable screening and diagnostic tools, in addition to providing evidence-based interventions for children with autism spectrum disorder (ASD) and other developmental disabilities (DD).

Specific aims of the program are to support DBP fellowship programs to prepare fellows for leadership roles as teachers, investigators, and clinicians, and provide other trainees—including pediatric practitioners, residents, and medical students—with biopsychosocial knowledge and clinical expertise, including with ASD/DD. Awardees should ensure trainees in this program:

1. Receive an appropriate balance of academic, clinical, and community opportunities;
2. Demonstrate a capacity to evaluate, diagnose or rule out, develop, and provide evidence-based interventions to individuals with ASD/DD;
3. Demonstrate an ability to use a family-centered approach;
4. Are culturally competent; and
5. Are ethnically diverse.[1]

"Fellowships" refer to non-degree-related training and "traineeships" refer to degree-related training. As used elsewhere the term "trainee" is generic. Appendix A: Applicable Standards for Using Grant Funds to Support Trainees/Fellows defines trainees and fellows and provides guidelines for support. To be considered a long-term trainee, the trainee must complete 300 or more hours of DBP leadership, clinical, and didactic training.

2. Background

This training program is authorized by Section 399BB(e)(1) of the Public Health Service Act (42 U.S.C. § 280i-1(e)(1)), as amended by the Autism CARES Act of 2014 (Pub. L. 113-157). The "Purpose" section of this statute authorizes HRSA to increase awareness, reduce barriers to screening and diagnosis, promote evidence-based interventions and train professionals to utilize valid and reliable screening tools to diagnose or rule out and provide evidence based interventions for children with ASD/DD. See section 399BB(a) of the Public Health Service Act (42 U.S.C. § 280i-1(a).

[1] For the purposes of this notice of funding opportunity, grantees will meet the objective of ethnic diversity through recruitment of racially and ethnically diverse trainees. See Project Narrative, Methodology, Trainee Recruitment and Retention for additional information.

Need for the DBP Training Program

Children's developmental-behavioral health

Nationally, 26 percent of children are at moderate or high risk of developmental or behavioral problems and one in 68 children aged 8 has been diagnosed with ASD.[2,3] However, there is an unmet need for developmental pediatric evaluations for diagnosis and treatment due to a shortage of trained providers.[4] As of 2016, only 775 pediatricians were ever certified by the American Board of Pediatrics as DBPs, resulting in a national average of 109,427 children per DBP. Furthermore, there are significant geographic disparities in DBP with a range of one DBP per 23,307 children in one state to one per 456,248 in another and three states lacking even one DBP.[5]

Between 2001 and 2011 there was a 21 percent increase in neurodevelopmental or mental health conditions among children under 18 years old.[6] The shortage of trained subspecialty providers and insufficient training in DBP of general pediatricians results in an unmet need for developmental pediatric evaluations for diagnosis and treatment.[7,8] This likely contributes to the average age of ASD diagnosis of greater than age 4, even though children can be diagnosed as early as age 2.[4]

Addressing mental health conditions in childhood can play a key role in preventing risky health behaviors and chronic conditions in adulthood. This is particularly true for children with ASD who experience more adverse childhood experiences (ACES) than children without ASD, particularly among lower income families,[9] as well as high rates of mental and behavioral health comorbidities, such as ADHD.[10]

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[2] Child and Adolescent Health Measurement Initiative (2013). "Risk of Developmental or Behavioral Problems State Ranking Map." Available at www.childhealthdata.org. Accessed 9/15/17.

[3] Christensen DL, Baio J, Braun KV, et al. (2016) Prevalence and Characteristics of Autism Spectrum Disorder Among Children Aged 8 Years — Autism and Developmental Disabilities Monitoring Network, 11 Sites, United States, 2012. MMWR Surveill Summ. 65(No. SS-3):1–23.

[4] Autism Spectrum Disorder: Data and Statistics. https://www.cdc.gov/ncbddd/autism/data.html. Accessed 9/15/17.

[5] American Board of Pediatrics Inc., 2016-2017. Pediatric Physicians Workforce Data Book. https://www.abp.org/sites/abp/files/pdf/pediatricphysiciansworkforcebook2016-2017.pdf

[6] Houtrow AJ, Larson K, Olson LM, Newacheck PW, Halfon N. (2016) Changing Trends of Childhood Disability, 2001 – 2011. Pediatrics 134: 530-8.

[7] Jimenez ME, et. al. (2017) Access to Developmental Pediatrics Evaluations for At-Risk Children. J Dev Behav Pediatr. 1-7.

[8] Boat TF, et al. (2016) Workforce Development to Enhance the Cognitive, Affective, and Behavioral Health of Children and Youth: Opportunities and Barriers in Child Health Care Training. Discussion Paper, National Academy of Medicine, Washington DC. https://nam.edu/wp-content/uploads/2016/11/Workforce-Development-to-Enhance-the-Cognitive-Affective-and-Behavioral-Health-of-Children-and-Youth.pdf

[9] Kerns CM, Newschaffer CJ, Berkowitz S, Lee BK. (2017) Brief Report: Examining the Association of Autism and Adverse Childhood Experiences in the National Survey of Children's Health: The Important Role of Income and Co-occurring Mental Health Conditions. J Autism Dev Discord 47:2275-81.

[10] Simonoff E, Pickles A, Charman T, Chandler S, Loucas T, Baird G. (2008). Psychiatric Disorders in Children with Autism Spectrum Disorders: Prevalence, Comorbidity, and Associated Factors in a Population-derived Sample. J of the American Academy of Child and Adolescent Psychiatry, 47: 921–29.

Access to care for underserved

A lack of trained providers reduces access to care for children and youth with complex disabilities like ASD/DD and their families. Access to adequate health care is a significant problem for children with special health care needs, but is even more pronounced for those with ASD.[11] Caregivers of children with ASD report issues accessing services, such as inadequate insurance coverage, difficulty using services, lack of a usual source of care, as well as lower quality of care such as lack of shared decision making and lack of care coordination.[12] Further disparities in access to care can be found when looking by race and ethnicity, gender, language, and geography.[13]

Prevalence of ASD among non-Hispanic white children (15.5 per 1,000) is significantly higher than children who are non-Hispanic black (13.2 per 1,000), Asian/Pacific Islander (11.3 per 1,000), and Hispanic (10.1 per 1,000).[3] A later age of first evaluation for non-Hispanic black and Hispanic children also points to disparities by race and ethnicity. These disparities may be due to barriers in accessing services, such as services not available in the family's primary language, limited cultural and linguistic competence among providers and health systems, lack of awareness, and stigma.

According to one study, wait-time for developmental pediatric evaluations at US children's hospitals was nearly 6 months. This same study also found that many hospitals were unable to respond to a request for an appointment when the caller was speaking Spanish, indicating additional access issues for non-English speakers.[7]

Gender differences in the diagnosis of ASD with boys, being 4.5 times more likely to be diagnosed with ASD than girls, indicates a need for increased and earlier identification of ASD among girls. Furthermore, girls who are diagnosed with ASD have higher rates of co-occurring intellectual disability, suggesting that many girls with ASD go undiagnosed.[3]

Geography also impacts the access to care for both diagnostic and treatment services. This is evident by the variability in age of identification of ASD by state.[14] Rural communities also face disparities due to various factors such as distance to subspecialists and a lack of available services.[15]

[11] Kogan et al, (2008) A National Profile of the Healthcare Experiences and Family Impact of Autism Spectrum Disorder among Children in the United States, 2005 – 2006. Pediatrics 122(6):e1149-58.

[12] Vohra R, Madhavan S, Sambamoorthi U, St. Peter C. (2014) Access to Services, Quality of Care, and Family Impact for Children with Autism, Other Developmental Disabilities, and Other Mental Health Conditions. Autism 18(7): 815-826.

[13] Liptak et al. (2008) Disparities in Diagnosis and Access to Health Services for Children with Autism: Data from the National Survey of Children's Health Journal of Developmental and Behavioral Pediatrics 29(3):152-60.

[14] Shattuck PT. (2009). The Timing of Identification among Children with an Autism Spectrum Disorder: Findings from a Population-Based Surveillance Study. Am Acad Child Adolesc Psychiatry. 48(5): 474–483.

[15] Antezana L, Scarpa A, Valdespino A, Albright J, Richey JA. (2017) Rural Trends in Diagnosis and Services for Autism Spectrum Disorder. Frontiers in Psychology. 8:1-5.

Training

Increased developmental and behavioral health training is necessary at multiple levels, including in undergraduate medical education, residency programs, and subspecialty fellowships. While a 1-month—or 200-hour—experience in DBP is required by the American Board of Pediatrics during the pediatric residency,[16] surveys of practicing pediatricians indicate that they feel underprepared in these areas.[17,18]

Additional training in DBP is available for those interested in pursuing a 3-year subspecialty fellowship resulting in board certification. Increases in certified DBPs able to diagnose ASD/DD and provide effective treatment and interventions is a real need given the wait-time and access to care issues described. DBPs also work with the wider population as consultants to the systems of care, such as state Title V and other MCH agencies, and as researchers. Finally, because each pediatric residency program is required to have at least one faculty member who is certified in DBP, they also serve as faculty for medical schools.[16]

The DBP Training Program aims to increase the number of certified DBPs and support training in DBP for current and future pediatric practitioners. In FY 2015, the DBP Training Program prepared 50 long-term trainees, 441 medium-term trainees, and 2,454 short-term trainees to serve children with developmental and behavioral needs. Of the long-term trainees, over 22 percent were from underrepresented racial groups and 12 percent were Hispanic. These programs are supported by 136 DBP faculty members, representing 19 disciplines, to mentor fellows using innovative clinical and didactic curricula. They also reached 29,015 practicing providers through 519 continuing education events. All ten programs reported collaborating with state Title V (MCH) agencies or other MCH-related programs on over 177 activities in areas of service, training, continuing education, technical assistance, product development, and research. Illustrating their broad influence on the field, faculty, staff, and fellows successfully published 238 peer reviewed journal articles and 623 other documents and presentations.

[16] Accreditation council on Graduate Medical Education. (2017) ACGME Program Requirements for Graduate Medical Education in Pediatrics. http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/320_pediatrics_2017-07-01.pdf?ver=2017-06-30-083432-507. Accessed September 15, 2017.

[17] Horwitz SM, et al. (2015) Barriers to the Identification and Management of Psychosocial Problems: Changes from 2004 to 2013. *Academic Pediatrics* 2015:613-20.

[18] McMillan JA, Land M, Leslie LK. (2017) Pediatric Residency Education and the Behavioral and Mental Health Crisis: A Call to Action. Pediatrics. 139(1).

II. Award Information

1. Type of Application and Award

Type(s) of applications sought: New, Competing Continuation

HRSA will provide funding in the form of a grant.

2. Summary of Funding

HRSA expects approximately $1,906,150 (includes $35,000 for grantee meeting to be determined after award) to be available annually to fund 10 recipients. You may apply for a ceiling amount of up to $187,115 total cost (includes both direct and indirect, facilities and administrative costs) per year. The FY 2018 President's Budget does not request funding for this program. The actual amount available will not be determined until enactment of the final FY 2018 federal appropriation. This program notice is subject to the appropriation of funds, and is a contingency action taken to ensure that, should funds become available for this purpose, HRSA can process applications and award funds in a timely manner. The project period is July 1, 2018 through June 30, 2023 (5 years). Funding beyond the first year is dependent on the availability of appropriated funds for the DBP Training Program in subsequent fiscal years, satisfactory recipient performance, and a decision that continued funding is in the best interest of the federal government.

Five recipients awarded funds under this competition will be required to plan to develop and convene the DBP Training Program national grantee meeting during one of the years of the project period in the amount of $35,000, pending availability of funds. HRSA will provide funds on a rotating basis to one recipient each year to host this meeting. While only five grantees will host the meeting, all applicants should include a brief plan for fulfilling this responsibility along with the statement of willingness and capability. Internal planning for the annual meeting must remain consistent with a budget of $35,000, applicants must not include these annual meeting costs in the overall budget request. The budget must not exceed $187,115 per year, as annual meeting supplemental funding will not be finalized until post-award.

All HRSA awards are subject to the Uniform Administrative Requirements, Cost Principles and Audit Requirements at 45 CFR part 75.

The indirect cost rate for all MCH training programs is capped at 8 percent of modified total direct costs (MTDC) exclusive of tuition and related fees, direct expenditures for equipment, and subawards in excess of $25,000 (45 CFR § 75.414 Indirect (F&A) costs).

III. Eligibility Information

1. Eligible Applicants

Per § 399BB(e)(1)(A) of the Public Health Service Act, public or nonprofit agencies, including institutions of higher education are eligible to apply.

For the purposes of this NOFO, an “institution of higher education" is defined as any college or university accredited by a regionalized body or bodies approved for such purpose by the Secretary of Education, and any teaching hospital which has higher learning among its purposes and functions and which has a formal affiliation with an accredited school of medicine and a full-time academic medical staff holding faculty status in such school of medicine.

2. Cost Sharing/Matching

Cost sharing/matching is not required for this program.

3. Other

HRSA will consider any application that exceeds the ceiling amount non-responsive and will not consider it for funding under this notice.

HRSA will consider any application that fails to satisfy the deadline requirements referenced in *Section IV.4* non-responsive and will not consider it for funding under this notice.

NOTE: Multiple applications from an organization are not allowable.

If for any reason (including submitting to the wrong funding opportunity number or making corrections/updates) an application is submitted more than once prior to the application due date, HRSA will only accept your **last** validated electronic submission, under the correct funding opportunity number, prior to the Grants.gov application due date as the final and only acceptable application.

IV. Application and Submission Information

1. Address to Request Application Package

HRSA ***requires*** you to apply electronically through Grants.gov. You must use the SF-424 Research and Related (R&R) application package associated with this NOFO following the directions provided at http://www.grants.gov/applicants/apply-for-grants.html.

Effective December 31, 2017 - You **must** use the Grants.gov Workspace to complete the workspace forms and submit your application workspace package. After this date, you will no longer be able to use PDF Application Packages.

HRSA recommends that you supply an email address to Grants.gov on the grant opportunity synopsis page when accessing the notice of funding opportunity (NOFO) (also known as "Instructions" on Grants.gov) or application package. This allows Grants.gov to email organizations that supply an email address in the event the NOFO is changed and/or republished on Grants.gov before its closing date. Responding to an earlier version of a modified notice may result in a less competitive or ineligible application. *Please note you are ultimately responsible for reviewing the Find Grant Opportunities page for all information relevant to desired opportunities.*

2. Content and Form of Application Submission

Section 4 of HRSA's *SF-424 R&R Application Guide* provides instructions for the budget, budget justification, staffing plan and personnel requirements, assurances, certifications, and abstract. You must submit the information outlined in the *R&R Application Guide* in addition to the program-specific information below. You are responsible for reading and complying with the instructions included in HRSA's *SF-424 R&R Application Guide* except where instructed in the NOFO to do otherwise. You must submit the application in the English language and in the terms of U.S. dollars (45 CFR § 75.111(a)).

See Section 8.5 of the *SF-424 R&R Application Guide* for the Application Completeness Checklist.

Application Page Limit
The total size of all uploaded files may not exceed the equivalent of **80 pages** when printed by HRSA. The page limit includes the abstract, project and budget narratives, attachments including biographical sketches (biosketches), and letters of commitment and support required in HRSA's *SF-424 R&R Application Guide* and this NOFO. Standard OMB-approved forms that are included in the application package do not count in the page limitation. Biographical sketches **do** count in the page limitation. Indirect Cost Rate Agreement and proof of non-profit status (if applicable) do not count in the page limit. **We strongly urge you to take appropriate measures to ensure your application does not exceed the specified page limit.**

Applications must be complete, within the specified page limit, and validated by Grants.gov under the correct funding opportunity number prior to the deadline to be considered under this notice.

Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification

1) The prospective recipient certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
2) Failure to make required disclosures can result in any of the remedies described in 45 CFR § 75.371, including suspension or debarment. (See also 2 CFR parts 180 and 376, and 31 U.S.C. 3321).
3) Where the prospective recipient is unable to attest to the statements in this certification, an explanation shall be included in Attachment 8: Other Relevant Documents.

See Section 4.1 viii of HRSA's *SF-424 R&R Application Guide* for additional information on all certifications.

Temporary Reassignment of State and Local Personnel during a Public Health Emergency

Section 201 of the Pandemic and All-Hazards Preparedness Reauthorization Act of 2013 (PAHPRA), Public Law 113-5 amends section 319 of the Public Health Service (PHS) Act to provide the Secretary of the Department of Health and Human Services (HHS) with discretion to authorize the temporary reassignment of state, tribal, and local personnel during a declared federal public health emergency upon request by a state or tribal organization. The temporary reassignment provision is applicable to state, tribal, and local public health department or agency personnel whose positions are funded, in full or part, under PHS programs and allows such personnel to immediately respond to the public health emergency in the affected jurisdiction. Funds provided under the award may be used to support personnel who are temporarily reassigned in accordance with section 319(e). This authority terminates September 30, 2018. Please reference detailed information available on the Assistant Secretary for Preparedness and Response (ASPR) website via http://www.phe.gov/Preparedness/legal/pahpa/section201/Pages/default.aspx.

Program-Specific Instructions
In addition to application requirements and instructions in Section 4 of HRSA's *SF-424 R&R Application Guide* (including the budget, budget justification, staffing plan and personnel requirements, assurances, certifications, and abstract), include the following:

i. *Project Abstract*
See Section 4.1.ix of HRSA's *SF-424 R&R Application Guide*.

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

Successful applications will contain the information below. Please use the following section headers for the narrative.

- *INTRODUCTION -- Corresponds to Section V's Review Criterion (1) Need*

  Briefly describe the purpose of the proposed project. State concisely the importance of the project by relating the specific objectives to the potential of the project to meet the purposes of the grant program described in Section I.1. Purpose of this NOFO.

- *NEEDS ASSESSMENT -- Corresponds to Section V's Review Criterion (1) Need*

  Outline the needs of the community and organization. Use and cite demographic data whenever possible to support the information provided.

  - Document clearly the needs related to services and systems of care for individuals with neurodevelopmental and other related disabilities, including ASD.

  Describe and document the target population and its unmet health needs. This includes describing the social determinants of health and health disparities impacting the population or communities served. Consider disparities associated with a broad range of factors in assessing unmet health needs, including but not limited to race; ethnicity; gender identity; sexual orientation; religion; geography; socioeconomic status; mental health; cognitive, sensory, or physical disability; age; primary language; and health literacy; or other characteristics historically linked to discrimination or exclusion.

  - Discuss any relevant barriers in the service area that the project seeks to overcome. This section will help reviewers understand the community and/or organization that you will serve with the proposed project.

  - Evaluate critically the national, regional, state, and local demand for the training, and specifically identify issues the project will address and gaps that the project is intended to fill.

- *METHODOLOGY -- Corresponds to Section V's Review Criterion(a) (2) Response*

  Respond to the provisions in Section 399BB of the Public Health Service Act (42 U.S.C. § 280i-1, as amended by the Autism CARES Act of 2014 (Pub. L. 113-157) (hereafter referred to as Autism CARES or the Autism CARES Act of 2014) to increase awareness of ASD/DD and reduce barriers to screening and diagnosis by training professionals to utilize appropriate tools and interventions.

  Propose methods that you will use to address the stated needs and meet each of the program requirements and expectations described in this NOFO. Describe methods to recruit pediatricians to complete a 3-year DBP fellowship (long-term trainees). Describe efforts to increase the diversity of the trainees and, ultimately, the developmental-behavioral workforce. Describe plans to develop and/or update curriculum, as needed, and to include self-advocates and family members of children with ASD/DD as partners to enhance patient-centered and family-centered care principles into the DBPs' training. All fellows must be instructed on ASD/DD systems of care and services with particular emphasis on how to diagnose or rule out ASD/DD.

  Describe methods to train medium- and short-term trainees (including medical students, pediatric residents, and pediatric practitioners) to strengthen their ability to assess and address the developmental-behavioral needs of their patients. Describe development of effective tools and strategies for ongoing staff training, outreach, collaborations, communication, and information sharing/dissemination

with efforts to involve patients, families, and communities. Describe efforts to support strengthening the systems of care, such as in state Title V agencies.

Propose a plan for project sustainability after the period of federal funding ends. HRSA expects recipients to sustain key elements of their projects, such as strategies or services and interventions, which have been effective in improving practices and those that have led to improved outcomes for the target population.

1) Goals and Objectives

State the overall goal(s) of the project and list the specific objectives that respond to the stated need/purpose for this project. The objectives must be "SMART": specific, measurable, achievable, realistic and time-phased.[19] These outcomes are the criteria for evaluation of the program.

The DBP Training Program recipients should offer fellows a balance of interdisciplinary learning experiences, including clinical, didactic, mentoring, community-based practicums, research, and peer leadership in addition to required oral and written presentation experiences.

2) Curriculum

The DBP Training Program is designed to support high quality education for health professionals who will advance the field of MCH and enhance systems of care for children (infants through adolescents) with or at-risk of ASD/DD. The educational curricula, in addition to promoting excellence in scholarship and leadership, should emphasize the integration of services supported by states, local agencies, organizations, private providers, and communities. Understanding the multiple influences on the health status of children such as their families, the environment, lifestyle and cultural values, economic, legal and political conditions, and technical advances is vital. By focusing on the importance of health promotion, disease prevention, and the benefits of coordinated health care, families and practitioners can utilize evidence-based interventions and develop creative approaches for reaching the highest quality of life for children and families, particularly among vulnerable groups whose needs are not currently being met.

The curriculum must clearly define how the proposed training program content and structure ensures an adequate base of knowledge and experience. Programs must develop clear, measurable educational objectives for an interdisciplinary core curriculum, clinical and didactic, with a focus on ASD/DD and incorporate the acquisition of knowledge of:

- All aspects of DBP
- The social environment (e.g., family, community, school)
- Cultural competency
- Patient-centered services
- Family-centered services

[19] Logic Model Tip Sheet https://www.acf.hhs.gov/sites/default/files/fysb/prep-logic-model-ts.pdf

- Medical home
- Life course and social determinants of health
- Interdisciplinary team skills
- Leadership skills (e.g., team-building, conflict resolution)
- Communication skills (e.g., verbal, written)

The curriculum must prepare graduates to assume leadership roles in the development, improvement and integration of systems of care, especially in programs providing maternal and child health services. Such services include those for children with special health care needs, with special emphasis on ASD/DD, in community-based, patient/family-centered settings. Attention to the needs of children living in underserved communities is vital to increasing access to services for those children and families.

The curriculum must include acquisition of in-depth knowledge of the following: relevant psychosocial and biological sciences, growth and development, injury and disease prevention, and health promotion. The curriculum must include didactic content on the following: intellectual, social, and emotional functioning; psychological implications of physical illness; the child's environments (including, home, family, school, and community); interviewing children and family members; screening, assessment and treatment for all developmental domains; screening and treatment of physical, behavioral, and mental health comorbidities; public and private health resources; and formulating management and treatment plans.

The objective reviewers will evaluate projects on the strength of their 3-year fellowship program as described in clear educational objectives, the comprehensiveness of the curriculum, and productivity. The applicant institution must possess current accreditation for certification in DBP by the Accreditation Council for Graduate Medical Education (ACGME) (provide documentation in Attachment 6).

Include an outline of the curriculum, with descriptions of courses, workshops, seminars, and field experiences in Attachment 5. Identify the competencies expected of trainees and the required curriculum, including didactic and experiential components.

Additionally, the curriculum should address the elements of Healthy People 2020 National Health Promotion and Disease Prevention Objectives related to developmental and behavioral health.

a. Clinical Preparation

Training should be based on a comprehensive, exemplary, interdisciplinary clinical services model that is patient-centered, family-centered, and culturally and linguistically competent. Focus must be on prevention, early detection, assessment, care coordination, and treatment, including care at home and follow up, of children and youth with an emphasis on ASD/DD. Trainees should demonstrate a capacity to evaluate, diagnose or rule out, develop, and provide evidence-based interventions to individuals with ASD/DD. The intent is to

increase the number of individuals who are able to provide information and education on ASD/DD and to increase public awareness of developmental milestones.

It is essential for the program to provide a broad range of clinical experiences with all pediatric age groups, in all socioeconomic strata, and in multiple settings (inpatient, outpatient, office-based, community-based and, especially, primary care continuity clinics) emphasizing integration of services. Services should include health promotion, disease prevention and care coordination, as well as diagnosis and treatment of conditions that range from simple to highly complex. The curriculum must promote the medical home model.

Clinical preparation should be interdisciplinary and involve families, youth, and self-advocates, as appropriate. Programs must identify a mechanism to receive input from families who utilize health services, as well as involve them in the decision making process.

The curriculum must emphasize appropriate content relating to science-based judgment, evidenced-based practice and documentation of quality outcomes and performance within an established plan of care; expansion of the direct service roles to include consultation, collaboration, and supervision; and various service delivery models and approaches.

All fellows are expected to:

- work on the development of clinical communication and teaching skills.
- achieve communication and pedagogical skills appropriate for a variety of professional and community audiences.
- advance administrative and academic skills through assigned administrative/academic responsibility for at least one focused service or teaching activity.

b. Leadership

The curriculum must include content and experiences to foster development of leadership attributes. Leadership training prepares MCH health care professionals to move beyond excellent clinical or health administration to leading in the areas of practice, research, teaching, administration, and academia. Leadership in the area of policy development relates to the process of translating research to policy and training, as measured in Performance Measure Training 5.

The goal of leadership training is to prepare trainees who have shown evidence of leadership attributes and who have the potential for further growth and development as public health leaders. In order to accomplish this goal, trainees must achieve and excel in a variety of areas outlined in the Maternal and Child Health Leadership Competencies. A complete description of the competencies, including definitions, knowledge areas, and basic and advanced skills for each competence is included at http://leadership.mchtraining.net. Describe clearly how you will incorporate all of the MCH Leadership Competencies into the training

curriculum, including in didactic and experiential components, and how you will measure their attainment.

c. Interdisciplinary Training and Practice

Given the shortage of providers and the complexity of issues among the children seen by DBPs, interdisciplinary practice is vital for DBPs to expand their reach and deepen their care of patients. Interdisciplinary/interprofessional practice provides a supportive environment in which the skills and expertise of team members from different disciplines, including a variety of professionals, MCH populations, and community partners, are acknowledged and seen as essential and synergistic. Input from each team member is elicited and valued in making collaborative, outcome-driven decisions to address individual, community-, or systems-level problems. Promoting interdisciplinary care during training and in practice is vital to meet the various needs of children and their families. Additionally, promoting a broad understanding of disability is necessary in preparing clinicians to work with this population as is involving individuals who have lived experience with ASD/DD, both personally (self-advocates) and as family members.

The training curriculum must use an interdisciplinary approach to promote strong collaborations with other health professionals during and after training. Knowledge of interdisciplinary practice will enhance the individual skills needed to be a more successful team member, enhance the quality of care for children, and expand the limited reach of trained developmental and behavioral practitioners. Interdisciplinary training and practice should include professionals such as nurses, psychologists, child and adolescent psychiatrists, nutritionists, social workers, child neurologists, speech and language pathologists, educators, physical therapists, occupational therapists, and public health professionals. Family members of people with disabilities and self-advocates can also play key roles in interdisciplinary teams through roles such as patient navigation and policy development as well as serving as cultural brokers, when appropriate. You must describe the content and process that will ensure the interdisciplinary training and practice requirement is satisfied.

d. Cultural and Linguistic Competence

Training must be structured on a broad range of exemplary, interdisciplinary, comprehensive services that provide patient-centered and family-centered, coordinated care responsive to the cultural, social, and linguistic diversity of the community. You must demonstrate how the proposed training program will advance the cultural competence of fellows and other trainees, such as through the inclusion of cultural competency training in the curriculum, efforts to advance linguistic competence, administrative procedures, and faculty and staff development. Training should include strategies for approaching differing social, cultural, and health practices of various groups, and the implications of these relative to health status and the provision of health care. Recruiting culturally, racially, and ethnically diverse faculty and trainees is a key component of promoting cultural competence. Instruction on models of disability apart from the

medical model and the intersection of disability with other experiences, such as race/ethnicity, are an important way to increase cultural competence for professionals serving people with disabilities. Performance Measure Training 2 measures the extent cultural and linguistic competence is integrated into the grant's policies, guidelines, and training.

Cultural competence is a developmental process that occurs along a continuum and evolves over an extended period. It broadly represents knowledge and skills necessary to communicate and interact effectively with people regardless of differences, helping to ensure that the needs of all people and communities are met in a respectful and responsive way in an effort to decrease health disparities and lead to health equity. Health equity exists when challenges and barriers have been removed for those groups who experience greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender identity; sexual orientation; age; mental health; cognitive, sensory, or physical disability; geographic location; or other characteristics historically linked to discrimination or exclusion.

Linguistic competence is the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic competency requires organizational and provider capacity to respond effectively to the health literacy needs of populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity.[20]

A culturally and linguistically competent program is characterized by:

- Written strategies for advancing cultural competence
- Culturally and linguistically competent policies and practices
- Provision of knowledge and skill building efforts on cultural and linguistic competence for trainees, faculty, and staff
- Research data on populations served according to cultural groupings and historically underserved groups—racial, ethnic, linguistic, disability, etc.
- Faculty and instructors represent diverse backgrounds
- Periodic assessment of trainee, faculty, and staff progress in developing cultural and linguistic competence

Besides teaching concepts of cultural and linguistic competence, the intent is to ensure that project interventions are responsive to the cultural and linguistic needs of special populations, that services are accessible to consumers, and that the broadest possible representation of historically underrepresented groups. In order to ensure access and cultural and linguistic competence, you must demonstrate how projects will involve individuals from populations to be served,

[20] Health Resources and Services Administration, Maternal and Child Health Bureau. 2017. Discretionary Grant Performance Measures. https://perf-data.hrsa.gov/mchb/DgisApp/FormAssignmentList/Discretionary_Grant_Performance_Measures_Attachments_B_C_and_D.pdf

including those from historically underrepresented groups, in the planning and implementation of the project.

For additional resources and information, you are encouraged to refer to:

- The National Center for Cultural Competence at https://nccc.georgetown.edu/
- Documenting the Implementation of Cultural and Linguistic Competence, https://mchb.hrsa.gov/training/cultural-competence.asp
- The *Curricula Enhancement Module Series* created by the National Center for Cultural Competence, please visit https://nccc.georgetown.edu/curricula/resources.html.
- For information on various models of disability, please see *Including People with Disabilities Public Health Workforce Competencies*, http://www.aucd.org/docs/Competencies%20Draft_VERSION%201.8_updated%203.3.16.pdf

Plans for reporting on cultural competency as required in Section VI. 3. Reporting should be described.

e. Family-Centered Care, Patient-Centered Care, and Medical Home

The curriculum must include content about the provision of care that ensures the health and well-being of children and their families through a respectful family-professional partnership. Based on this partnership, family-centered care recognizes the importance of cultural diversity and family traditions; embraces community-based services; promotes an individualized and developmental approach to working with children and families; and ensures all policies, practices, and systems have the family in mind. Family-centered care honors the strengths, expertise, experiences, cultures, and traditions that everyone brings to this relationship. Patient-centered care is "providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions."[21] The American Academy of Pediatrics defines the pediatric medical home as being accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective.[22] Family-centered, patient-centered, and medical home concepts should be integral to the curriculum to facilitate care transitions and connection to community services, and ensure coordination amongst a wide range of disciplines in practice.

[21] Institute of Medicine (IOM). 2001. *Crossing the quality chasm: A new health system for the 21st century.* Washington D.C.: National Academy Press,
[22] National Center for Medical Home Implementation https://medicalhomeinfo.aap.org/Pages/default.aspx

f. Public Health, MCH/Title V and Related Legislation

The curriculum must address public health issues. It should emphasize, either as discrete topics or as topics integrated in other components, appropriate didactic and experiential content relative to MCH/Title V and related legislation, as well as to the development, implementation and evaluation of systems of health care. At a minimum, the curriculum should include analysis of core public health functions applied to DBP issues, such as community needs assessment, program planning and evaluation, public policy, financing, budgeting, and consultation. The curriculum must include theoretical and clinical components which provide students with working knowledge of the systems serving children with special health care needs, including Title V of the Social Security Act as amended, Autism CARES Act of 2014, and other relevant programs, such as Titles XIX (Medicaid/Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)), and XXI (State Children's Health Insurance Program) of the Social Security Act. The curriculum should reflect awareness of opportunities for coordination with Title V systems of care including developmental screening initiatives.

g. Research

Programs must provide for the conduct of collaborative research by fellows under joint supervision of faculty from relevant disciplines, e.g., contributing new knowledge, validating the effectiveness of intervention strategies, assessing quality, or linking intervention to functional outcomes and quality of life. HRSA expects all fellows to engage in one or more research projects during their tenure, and to seek to disseminate findings at scientific symposia, through published articles in peer-reviewed journals, and to practitioners and policymakers. You must document research and other scholarly activities of faculty and students relating to DBP, and must define the relevance of these activities to the training program.

h. Technology

The curriculum should incorporate the use of web-based technology for communication and information acquisition and processing, including distance learning modalities for lifelong learning, and continuing education. Programs should use principles of adult learning and effective education models utilizing available technologies such as e-learning systems, course management software, web-based conferencing, social media and social networking tools. Tele-health and tele-consultation are encouraged to expand the reach of the DBP Training Programs to practicing professionals in rural and underserved areas.

i. Innovation

You must clearly describe how the curricula and trainee experiences within the program ensure trainees are equipped to use multiple sources of information in their practices and leadership roles, and can synthesize, recognize and contribute to the MCH science. Program experiences should be designed to use new and

emerging technologies in clinical practice ensuring trainees can learn to use these technologies.

j. Emerging Issues

The curriculum must reflect awareness of ongoing and emerging health issues and practice challenges related to developmental-behavioral medicine and specifically, ASD/DD. Some examples include, congenital Zika virus infection, co-occurring mental health conditions, substance use, and suicide.

k. Life Course and Social Determinants of Health

The curriculum must address health promotion issues by emphasizing the life course development and socio-ecological framework. The life course approach to conceptualizing health care needs and services evolved from research documenting the important role of early life events in shaping an individual's health trajectory. The interplay of risk and protective factors, such as socioeconomic status, toxic environmental exposures, health behaviors, stress, and nutrition, influence health throughout one's lifetime.[23] The curriculum will prepare trainees to understand how systems interact with and influence each other to either decrease or increase risk factors or protective factors that affect a range of health and social outcomes for these children.

DBP Training Program grantees should incorporate transition topics into their curricula, including health care transition and transition from school-based services to those available during adulthood.

l. Community-Based Preparation

You must structure the training on exemplary, comprehensive, interdisciplinary service models in a variety of institutional and rural/urban community-based settings with an MCH client population representative of the cultural, linguistic, social, and ethnic diversity of the community. Examples include schools, community and migrant health centers (Federally Qualified Health Centers), and free clinics. Home visiting programs may provide opportunities for DBP Training Program grantees to collaborate, thereby enhancing and expanding services for children with neurodevelopmental disabilities and special health care needs. Working in an interdisciplinary program site is recommended.

3) Trainee Recruitment and Retention

The purpose of this grant is to enhance behavioral, psychosocial, and developmental aspects of pediatric care. This is to be accomplished through: 1) supporting fellows in DBP preparing for leadership roles as teachers, investigators, and clinicians advancing the field; and 2) providing pediatric practitioners, residents, and medical students with essential biopsychosocial

[23] Life Course Approach in MCH https://mchb.hrsa.gov/training/lifecourse.asp

knowledge and clinical expertise. You must present a plan to recruit and retain trainees committed to completing the purpose of this project.

The plan should include a description of methods of trainee recruitment for fellows as well as other long-, medium-, and short-term trainees. Include selection criteria for trainees whose career goals are consistent with the program objectives, including an interest in acquiring knowledge and skills to evaluate, diagnose or rule out, develop, and provide evidence-based interventions in ASD/DD. Include methods for retaining trainees through completion of the program.

Programs must provide evidence of the productivity of the existing training program in terms of the number of trainees who have completed training in DBP (fellows as well as other long-, medium-, and short-term) and their current professional activities.

Diversity in MCH Training

Consistent with statute, the program is focused on increasing the diversity of MCH faculty and students and incorporating efforts towards achieving cultural and linguistic competence and family-centered care into training programs. Over time, the program must evaluate whether the emphases on diversity, cultural and linguistic competence, and family centered care might also help to reduce health disparities. For more ideas and approaches to increasing diversity, see *Diversity and Health Equity in the Maternal and Child Health Workforce at* https://mchb.hrsa.gov/training/documents/MCH_Diversity_2016-05_RFS.pdf.

One aim of this program is to increase the diversity among trainee cohorts in accordance with the statutory requirement of increasing ethnic diversity and HRSA's goal to strengthen the health workforce by increasing the diversity of the health workforce including underrepresented racial and ethnic groups. Increased diversity among the MCH workforce will lead to increased access to care for underserved populations in an effort to address health disparities. You should describe the plan for recruiting trainees from diverse backgrounds and for evaluating the success of the recruitment efforts. Performance Measure Training 6 requires annual reporting on the percentage of trainees from underrepresented racial and ethnic groups.

a. Fellows

Fellowship training should be organized to meet the ACGME Program Requirements for Graduate Medical Education in Developmental-Behavioral Pediatrics (http://www.acgme.org/). The recruitment plan must include methods to recruit a *minimum* of one first-year fellow each year and a description of the anticipated challenges related to recruitment of DBP fellows and how you will address them.

During the course of their fellowship, fellows will be expected to meet eligibility requirements for the subspecialty certification in DBP as established by the American Board of Pediatrics (https://www.abp.org/abpwebsite/publicat/certboi.pdf*).*

b. Long-Term Trainees

As used in this section, “fellowships” refer to non-degree-related training and “traineeships” refer to degree-related training. As used elsewhere the term "trainee" is generic. Appendix A: Applicable Standards for Using Grant Funds to Support Trainees/Fellows defines trainees and fellows and provides guidelines for support. To be considered a long-term trainee, the trainee must complete 300 or more hours of DBP leadership, clinical, and didactic training.

There should also be a plan for tracking and reporting on former trainees after completing the training program in the areas of field leadership, work focused on MCH populations, and working in an interdisciplinary manner as well as graduates’ employment, research, programs initiated, publications submitted, etc. Recipients will report these data on the Former Trainee Information Form and under Performance Measures 10, 11, and 12. “Field leadership” refers to but is not limited to providing MCH leadership within the clinical, academic, research, public health, public policy or governmental realms. This plan should include longitudinal follow-up data about long-term trainees that the recipient will report on under Performance Measure Training 10, 2 and 5 years after completing the training program.

c. Other Trainees

Faculty time not required for training DBP fellows may be applied to other types of training related to the goals of the DBP Training Program. Programs are expected to develop exemplary, innovative models of education and training that may include, elective experiences for trainees not supported by the training grant, such as medical students, residents, practicing providers, psychologists, psychiatrists, social workers, educators, and others. Fellows should participate in these teaching activities, and serve as role models for students, residents, and other short- and medium-term trainees.

Plans for reporting on medium- and short-term trainees as required in Section VI. 3. Reporting should be described.

Medium-term

Medium-term trainees are trainees receiving equal to or more than 40 and less than 300 contact hours in a program.

Contact hours are defined as hours spent in didactic training (i.e., hours of course work or number of academic hours for which a trainee is registered); on site clinical work or hands-on, supervised clinical work; and experiential activities and projects conducted under the supervision of faculty (e.g., research, presentations,

proposal development). You should describe activities in which medium-term trainees will be engaged, and identify measurable training objectives, expected outcomes and outcome measures appropriate to the medium-term training activities conducted.

Short-term

Short-term trainees are trainees receiving less than 40 contact hours (as defined above) in a training program. Programs should identify specific short-term training objectives and the training activities in which short-term trainees are engaged. Continuing education students should not be included in this category.

4) Collaboration with Other Programs

Interchange with other programs is required. You should document how you will collaborate with other entities to enhance systems of care for children with ASD/DD. You are encouraged to coordinate activities and collaborate with other HRSA-supported training and research programs, including those listed at https://mchb.hrsa.gov/training/funded_projects.asp.

Programs must conduct continuing education activities for current providers to enhance their skills and to disseminate new information (a *minimum* of one activity per year). All programs should collaborate with State Title V or other MCH programs by providing consultation, in-service education, and continuing education. Performance Measure Training 4 measures the extent grantees collaborate with state Title V agencies, other MCH or MCH-related programs and other professional organizations.

Briefly describe:

- Existing or new partnerships with systems already serving children with ASD/DD such as Title V programs, Part C programs, home visiting programs and early childhood comprehensive systems programs.

- Coordination with other federal programs addressing ASD/DD such as the National Institutes of Health (NIH); the Centers for Disease Control and Prevention (CDC) (ADDM Network, Learn the Signs. Act Early. Campaign); the Administration for Community Living (ACL); and other relevant federal programs.

- Collaborations/partnerships with HRSA training and research investments, including, but not limited to, Autism CARES-funded programs in your region (state programs, research networks, and Leadership Education in Neurodevelopmental and Related Disabilities (LEND) grantees). This includes activities coordinated under the Autism CARES Act National Interdisciplinary Training Resource Center (ITAC).

a. MCH Network Development

You must articulate a plan for demonstrating and teaching others to promote enhanced access to MCH expertise, values, initiatives and products through increased visibility and outreach. Within this plan, emphasis must be placed on how you will connect MCH trainees and alumni to one another, adding to the network of MCH professionals working together to improve MCH. You must clearly describe efforts to ensure trainee involvement in wider MCH-related opportunities, along with other methods to develop the MCH identity amongst trainees.

b. DBP Training Program Grantee Meeting

Each DBP Training Program grantee is expected to send two faculty members to the DBP Training Program meeting which will be held once a year. A project director (PD) or other key staff are considered program representatives. The purpose of this meeting is to share fellows' research in progress, promote interchange, disseminate new information, and enhance national-level, long-term development in DBP with regard to training, health services, and research issues. It is expected that through these meetings, programs will coordinate their individual efforts and collaborate in the development of mutual efforts and projects.

Individual DBP Training Program grantees are responsible for transportation and other expenses to and from the meeting for their faculty and fellows. Grantees are also responsible for lodging costs for any faculty or fellows attending beyond the two faculty and three fellows paid for by the host program.

<u>Hosting the DBP Training Program Grantee Meeting</u>

Five of the programs awarded under this competition will be required to plan to develop and convene the DBP Training Program national grantee meeting during one of the years of the project period in the amount of $35,000, pending availability of funds. Funds will be made available on a rotating basis to one grantee each year to host this meeting. Responsibilities of the host program include agenda development, meeting logistics, meeting room rental and audiovisual support, arrangements, expenses, and payment for the program speakers. Include a statement of willingness and capability to plan, develop, convene, and manage the DBP Training Program grantee meeting. While only five grantees will host the meeting, all applicants are requested to include a brief plan for fulfilling these responsibilities along with the statement of willingness and capability.

- Describe a plan to develop and convene the DBP Training Program grantee meeting, 1 year during the 5-year project period.

- Outline host responsibilities to plan, make arrangements, and provide payment for the program, speakers, meeting logistics and lodging, plus meeting meals in lieu of one-half the per diem. The host program is

responsible for lodging and meeting meals in lieu of one-half the per diem, for approximately 50 participants—a minimum of two faculty and three fellows from each program.

- Your budget must not exceed $187,115 per year, as annual meeting supplemental funding will not be finalized until post-award.

IMPORTANT NOTES:

- Pending the availability of funds during each year of the project period, the one designated recipient will apply for an administrative supplement of up to $35,000 post-award, in additional funding to cover the costs of the annual meeting.

- The host should coordinate with the project officer in selecting both the date and location of the DBP annual meeting to facilitate coordination with other available meetings.

- While your internal planning for the annual meeting must remain consistent with a budget of $35,000, you must *not* include these annual meeting costs in the overall budget request.

c. Autism CARES Grantee Meeting

At least one program representative must attend the Autism CARES grantee meeting held every other year in Washington, DC. At a minimum, a PD or other key staff must attend. We anticipate these will occur the summer of 2019 and 2021.

d. HRSA Meeting

The HRSA meeting brings DBP Training Program grantees together with other HRSA-funded maternal and child health training programs in the DC area every other year. At least one program representative, either a PD or other key staff, is encouraged to attend. We anticipate these meetings will occur the fall of 2018, 2020, and 2022.

5) Continuing Education and Development

Although the primary purpose of this program is the long-term training of health professionals for leadership roles, as outlined above, each program must also conduct a minimum of one continuing education activity per year for the provider community to enhance skills or disseminate new information. Such programs should target health and related care providers and should be based on specific needs identified interactively with the group(s) to be served. Describe the plan for the conduct of such activities in the application.

Programs may wish to consider using the collaborative office rounds (COR) study group approach or similar models as a continuing education mechanism. See Appendix C for a list of the key elements of the COR model. HRSA expects that

the DBP Training Program grantees will consider collaborating in the development of projects of significance to the MCH community.

6) Technical Assistance/Consultation

The program should provide technical assistance (TA)/consultation to the field. TA refers to mutual problem solving and collaboration on a range of issues, which may include program development and evaluation; clinical services; needs assessment; policy and guideline formulation; site visits; and review/advisory functions. The TA effort may be a one-time encounter or on-going activity of brief or extended frequency depending on the needs of the state or organization, and may be geared to the needs of several states or a HRSA region. List the type of TA activities that you may be conducting and how you will market your capabilities. Of particular interest to HRSA is technical assistance to support the system of care for individuals with ASD/DD.

7) Development and Dissemination of Educational Resources

As programs revise and develop new curricular materials, teaching models, and other educational resources and references in DBP in response to new research findings and developments in the field, they must disseminate these products to other relevant programs in order to promote enhanced attention to this specialized area. Additionally, in the area of ASD/DD, programs should disseminate materials, models and resources with other stakeholders, in particular the research networks, training grants including DBPs, and the state demonstration grants funded under the Autism CARES Act of 2014. You must provide a plan for dissemination/sharing of program resources broadly.

- *WORK PLAN AND LOGIC MODEL -- Corresponds to Section V's Review Criterion(a) Response and Impact*

1) Work Plan

Describe the activities, methods, and techniques that you will use to achieve each of the objectives proposed during the entire project period in the Methodology section. Submit a time line (Attachment 1) that includes each activity and identifies responsible staff. As appropriate, identify meaningful support and collaboration with key stakeholders in planning, designing and implementing all activities, including development of the application. Indicate the extent to which these contributors reflect the diversity of the populations and communities served, including racial and ethnic minorities. The diversity plan referenced earlier in the methodology section can be separate or included as part of this work plan.

The plan must describe each type of training activity with regard to purpose, methodology, content, time commitment, and method of evaluation. The project plan must describe the patient population, diagnostic categories and services, and the various functions related to the provision of such services. The plan should include a description of trainee roles in provision of clinical services, extensiveness of clinical preparation, and clinical supervision.

Document in the work plan the extent and effectiveness of plans for dissemination of project results.

2) Logic Model

Submit a logic model (in Attachment 1) for designing and managing the project. A logic model is a one-page diagram that presents the conceptual framework for a proposed project and explains the links among program elements. While there are many versions of logic models, for the purposes of this notice, the logic model should summarize the connections between the:

- Goals and objectives.
- Assumptions, such as beliefs about how the program will work based on research, best practices, and experience.
- Inputs, including the organizational profile, collaborative partners, key staff, budget, and other resources.
- Target population (i.e., the individuals to be served).
- Activities.
- Outputs (i.e., the direct products or deliverables of program activities)
- Outcomes (i.e., the results of a program, typically describing a change in people or systems).

See Appendix B for the overall logic model for the DBP Training Program.

- *RESOLUTION OF CHALLENGES -- Corresponds to Section V's Review Criterion Response*

Discuss challenges that you are likely to encounter in designing and implementing the activities described in the work plan, and approaches that you will use to resolve such challenges.

- *EVALUATION AND TECHNICAL SUPPORT CAPACITY -- Corresponds to Section V's Review Criteria* Evaluative Measures and Resources/Capabilities

DBP Training Program grantees must evaluate their programs for both continuous quality improvement and to identify outcomes/impact of their efforts. A formal plan for evaluating the DBP program must address how you will achieve the major goals and objectives for each year of the project as well as track required annual performance data and measures. Monitoring and evaluation activities must be ongoing and, to the extent feasible, must be structured to gain information which is quantifiable and which permits objective rather than subjective judgments. Explain what data will be collected, the methods for collection by year and the manner in which data will be analyzed and reported. Data analysis and reporting must facilitate evaluation of the project outcomes. Describe any potential obstacles for

implementing the program performance evaluation and your plan to address those obstacles. Present a plan for collecting the data elements described in Section VI. 3. Reporting, including a method for tracking long-term trainees 2, 5 and 10 years after completing the training.

Describe the plan for the program performance evaluation that will contribute to continuous quality improvement. The evaluation should monitor ongoing processes and the progress towards the goals and objectives of the project. Include descriptions of the inputs (e.g., organizational profile, collaborative partners, key staff, budget, and other resources), key processes, and expected outcomes of the funded activities. Explain how you will use the data to inform program development and improvements, service delivery, and impact on different target populations.

Describe the systems and processes that will support meeting your proposed evaluation plan and performance measurement requirements. Include a description of how the organization will collect and manage data (e.g., assigned skilled staff, data management software) in a way that allows for accurate and timely reporting of performance outcomes. Describe who on the project will be responsible for refining, collecting, and analyzing data. Describe their current experience, skills, knowledge, materials published, and previous work of a similar nature.

The measurement of progress toward goals should focus on systems, health, and performance outcome indicators, rather than solely on intermediate process measures. Base the protocol on a clear rationale relating to the identified needs of the target population with project goals, grant activities, and evaluation measures.

Participation in HRSA's autism program evaluation activities, pending appropriation, is required. Participation may include responding to surveys, participating in interviews, and providing other reports.

If there is any possibility that the evaluation may involve human subjects research as described in 45 CFR part 46, you must comply with the regulations for the protection of human subjects as applicable.

- *ORGANIZATIONAL INFORMATION -- Corresponds to Section V's Review Criterion Resources/Capabilities*

  Succinctly describe your organization's current mission and structure, scope of current activities, including an organizational chart, and describe how these elements all contribute to the organization's ability to conduct the program requirements and meet program expectations.

  Briefly describe the administrative and organizational structure within which the program will function, including relationships with other departments, institutions, organizations, and agencies relevant to the program, and describe how these elements all contribute to the organization's ability to conduct the program requirements and meet program expectations. Organizational charts outlining

these relationships must be included in Attachment 4. Discuss how the organization will follow the approved plan, as outlined in the application, properly account for the federal funds, and document all costs to avoid audit findings.

Describe briefly the physical settings in which the program will take place. The primary program setting must provide sufficient and appropriate spaces for core faculty and trainee offices and for clinical and teaching activities. Physical, audiovisual, and computer resources must be available to the program and should be at least at the level available to other comparable programs in the institution. You must structure the training plan and settings to ensure sufficient formal and informal interaction amongst trainees and faculty across disciplines to accomplish and enhance the interdisciplinary process and practice on which the program is based. Maps, if needed, should be included in Attachment 9.

1) Partner Organizations

Describe organizations who will partner with yours to fulfill the goals of the program and meet the training objectives. Include in Attachment 3, noting overall page limitations, select copies of agreements, letters of understanding/commitment or similar documents from key organizations/individuals of their willingness to perform in accordance with the plan presented in the application.

Describe the practicum sites available for trainees completing clinical and community-based preparation. Practicum sites must provide exemplary, comprehensive, community-based services in a variety of institutional and rural/urban community-based settings focused on children with ASD/DD and other special health care needs representative of the cultural, social and ethnic diversity of the community. Practicum sites in underserved communities are especially recommended. If possible, you are encouraged to coordinate clinical training opportunities with HRSA-funded research sites and Title V programs. It is expected that the clinical component of the training will occur both within the primary program setting and in a variety of community settings.

2) Faculty

Describe briefly what additional resources, including personnel, are needed to accomplish the stated goals and objectives, i.e., what is requested through project support and why. The staffing plan and job descriptions for key faculty/staff must be included in Attachment 2.

Position descriptions should include the qualifications necessary to meet the functional requirements of the position, not the particular capabilities or qualifications of a given individual. A position description should not exceed one page in length, but can be as short as one paragraph in length due to page limitations.

Project Director

The role of project director (PD) shall constitute a major professional responsibility and time commitment of the person appointed to the position. The PD must be a board-certified pediatrician with subspecialty certification in DBP. The PD should be at the associate professor level or higher and have demonstrated leadership and expertise in the field of DBP, experience in post-graduate level teaching and demonstrated productivity in the conduct of scholarly research in DBP. The PD must be the person having direct, functional responsibility for the program for which support is directed. The PD must spend at least 20 percent effort on this project.

Family and Self-Advocate Partners

Promoting a broad understanding of disability is vital in preparing clinicians to work with this population. Therefore, key participants in the interdisciplinary team should be individuals who have lived experience with ASD/DD, both as personally (self-advocates) and as family members. Performance Measure Training 1 measures the extent programs ensure family/ youth/ community member participation in program and policy activities.

All grants *must* support involvement of at least one family member and one self-advocate to present the family and personal perspective to trainees. This could include teaching, mentoring, coordinating community experiences for trainees, advising other faculty on personal/family perspectives, planning training and developing curriculum, and serving as faculty. Individuals with disabilities or parents/siblings of individuals with disabilities who consult to your program or serve as faculty/staff members must be financially compensated.

Other Faculty Qualifications

Projects must have faculty with demonstrated leadership and appropriate education and experience in DBP necessary to fulfill the training goals and objectives. Outstanding faculty leadership—excellence in teaching, research, and community service—is expected.

The faculty must include not only well qualified professionals from pediatrics, including liaison faculty from community-based pediatric practices, but also representatives of other relevant disciplines to support and model interdisciplinary practice. Other disciplines may include, but are not limited to, MCH nursing, child development, psychology, child and adolescent psychiatry, nutrition, social work, child neurology, speech and language pathology, education, physical therapy, occupational therapy, and public health (e.g., health policy, organization and administration of services, program development, evaluation).

Core faculty must meet at least the minimum standards of education, experience and certification/licensure generally accepted by their respective professions. Each core faculty must demonstrate leadership and must have teaching and clinical experience in pediatrics and in providing health and related services to the

special health care needs of the population on which the program is focused. Core faculty must also be able to document cultural competency and knowledge and experience in patient-centered care, family-centered care, interdisciplinary teaming, and medical home or the project must provide appropriate continuing education for faculty to achieve these competencies.

Programs are expected to accord recognition for each core faculty, in the form of an academic appointment in the appropriate degree granting school or department of his/her profession in the grantee and/or an affiliated institution of higher learning. This appointment is in addition to the core faculty's appointment in the employing institute/center program. It shall be the responsibility of the appointing academic school or department to determine the basic faculty qualifications, and the responsibility of the employing program to determine and document the additional specialized pediatric training and clinical experience. Core faculty may be functionally, programmatically, or academically responsible to such positions as may be specified in the approved plan and position descriptions, but must be responsible to the DBP PD for the time allocated to the project. Core faculty members are the chief representatives of their respective professions in the program.

The purpose of providing grant support for faculty salaries is to ensure dedicated time for meeting the objectives of the training program. Core faculty must commit adequate time to participate fully in all components of the DBP Training Program grant. Deans, department chairs, and others in similar positions may not serve as PD or core faculty, or receive payment from project funds, unless special permission from your HRSA project officer is obtained.

Core faculty have the primary responsibility for planning, designing, implementing, supervising, and evaluating all training and service elements of the DBP Training Program grant. These responsibilities include definition of appropriate criteria for recruitment of trainees. Administrative responsibility must in all cases be to the PD. These requirements constitute the basis for development of the minimum qualifications section of the job description for each faculty position. Functional and program responsibilities should be specified in the narrative and position descriptions.

Biographical Sketches

Provide a biographical sketch for senior key professionals contributing to the project. The information must be current, indicating the individual's position and sufficient detail to assess the individual's qualifications for the position being sought and consistent with the position description. *Each biographical sketch must be limited to two pages or less as they count toward the overall page limit.* Include all degrees and certificates. When listing publications, list authors in the same order as they appear on the paper, the full title of the article, and the complete reference as it is usually cited in a journal. List the PD's sketch first then all other sketches must be arranged in alphabetical order, after the PD's sketch, and attached to SF-424 Senior/Key Person profile form.

It is strongly encouraged that biographical sketches follow the format described below:

- *Professional information.* At the top of page one, include name, position title, education/training including: institution and location, degree, month/year degree attained, field of study.

- *Personal statement*. Briefly describe why you are well-suited for your role(s) in the project described in this application.

- *Positions and honors*. List in chronological order previous positions, concluding with the present position. List any honors. Include present membership on any federal government public advisory committee.

- *Contribution to the field*. Reference up to five of your most significant contributions to the field, including peer-reviewed publications or other non-publication products).

- *Project support.* List both selected ongoing and completed research or training projects for the past 3 years (federal or non-federally-supported). *Begin with the projects that are most relevant to the research proposed in the application.*

When applicable, biographical sketches must include training, language fluency and experience working with populations that are culturally and linguistically different from their own.

NARRATIVE GUIDANCE

To ensure that you fully address the review criteria, this table provides a crosswalk between the narrative language and where each section falls within the review criteria.

Narrative Section	**Review Criteria**
Introduction	(1) Need
Needs Assessment	(1) Need
Methodology	(2) Response
Work Plan	(2) Response and (4) Impact
Resolution of Challenges	(2) Response
Evaluation and Technical Support Capacity	(3) Evaluative Measures and (5) Resources/Capabilities
Organizational Information	(5) Resources/Capabilities
Budget and Budget Justification Narrative (below)	(6) Support Requested – the budget section should include sufficient justification to allow reviewers to determine the reasonableness of the support requested.

iii. *Budget*

See Section 4.1.iv of HRSA's *SF-424 R&R Application Guide*. Please note: the directions offered in the *SF-424 R&R Application Guide* may differ from those offered by Grants.gov. Follow the instructions included in the *R&R Application Guide* and the additional budget instructions provided below. A budget that follows the *R&R Application Guide* will ensure that, if HRSA selects the application for funding, you will have a well-organized plan and by carefully following the approved plan can avoid audit issues during the implementation phase.

Reminder: The Total Project or Program Costs are the total allowable costs (inclusive of direct **and** indirect costs) incurred by the recipient to carry out a HRSA supported project or activity. Total project or program costs include costs charged to the award and costs borne by the recipient to satisfy a matching or cost-sharing requirement, as applicable.

The Consolidated Appropriations Act, 2017 (P.L. 115-31), Division H, § 202, states "None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II." See Section 4.1.iv Budget – Salary Limitation of HRSA's *SF-424 R&R Application Guide* for additional information. Note that these or other salary limitations may apply in FY 2018, as required by law.

iv. *Budget Justification Narrative*

See Section 4.1.v of HRSA's *SF-424 R&R Application Guide*. In addition, the DBP Training Program requires the following:

All budgets must provide satisfactory details to fully explain and justify the resources needed to accomplish the training objectives. This justification must provide explicit qualitative and quantitative documentation of required resources, productivity, and expected outcomes. Components to highlight include number of trainees expected each year (specifying the number short-, medium-, and long-term trainees) and how many of those will be DBP fellows, proposed program activities, Title V activities, and continuing education efforts.

Budget justification must document support provided to long-term trainees (fellows) either through this grant or through other sources.

You should budget funds for required meetings and include in the justification a description that includes:

- The annual DBP Training Program grantee meeting. At least two faculty members, the PD and other key staff, must attend the DBP Training Program meeting which will be held once a year. A PD or other key staff are considered program representatives.

- The Autism CARES grantee meeting which is held every other year in Washington, DC. At least one program representative must attend. At a

minimum, a PD or other key staff must attend. We anticipate these will occur the summer of 2019 and 2021.

- One HRSA meeting in the DC area every other year which brings DBP programs together with other HRSA-funded maternal and child health training programs. At least one program representative, either a PD or other key staff, is encouraged to attend. We anticipate these meetings will occur the fall of 2018, 2020, and 2022.

v. *Program-Specific Forms*

Program-specific forms are not required for application.

vi. *Attachments*

Provide the following items in the order specified below to complete the content of the application. **Unless otherwise noted, attachments count toward the application page limit.** Indirect cost rate agreements and proof of non-profit status (if applicable) will not count toward the page limit. **You must clearly label each attachment**.

Attachment 1: Work Plan and Logic Model, required

Attach the work plan and logic model for the project that includes all information detailed in Section IV. ii. Project Narrative. If you will make subawards or expend funds on contracts, describe how your organization will document the funds properly.

Attachment 2: Staffing Plan and Job Descriptions for Key Personnel (see Section 4.1.vi. of HRSA's *SF-424 R&R Application Guide), required*

Keep each job description to one page in length as much as is possible. Include the role, responsibilities, and qualifications of proposed project staff. Also, please include a description of your organization's time keeping process to ensure that you will comply with the federal standards related to documenting personnel costs.

Attachment 3: Letters of Agreement, Memoranda of Understanding, and/or Description(s) of Proposed/Existing Contracts (project-specific), required

Provide any documents that describe working relationships between your organization and other entities and programs cited in the proposal. Documents that confirm actual or pending contractual or other agreements should clearly describe the roles of the contractors and any deliverable. Ensure letters of agreement are properly signed and dated.

Attachment 4: Project Organizational Chart, required

Provide a one-page figure that depicts the organizational structure of the project.

Attachment 5: Curriculum, required

The required description of the curriculum should include descriptions of courses, workshops, seminars, and field experiences in Attachment 5. Identify the competencies expected of trainees.

Attachment 6: Documentation of ACGME Accreditation, required

Include documentation indicating current accreditation for a DBP fellowship program by ACGME.

Attachment 7: Tables, Charts, etc., optional

To give further details about the proposal include tables or charts (e.g., Gantt or PERT charts, flow charts, etc.) that show the program's curriculum, workshop descriptions, field placements and other elements of the training.

Attachments 8-15: Other Relevant Documents, optional

Include here any other documents that are relevant to the application, including letters of support. Letters of support must be dated and specifically indicate a commitment to the project/program (in-kind services, dollars, staff, space, equipment, etc.).

3. Dun and Bradstreet Data Universal Numbering System (DUNS) Number and System for Award Management

You must obtain a valid DUNS number, also known as the Unique Entity Identifier, for your organization/agency and provide that number in the application. You must also register with the System for Award Management (SAM) and continue to maintain active SAM registration with current information at all times during which you have an active federal award or an application or plan under consideration by an agency (unless the applicant is an individual or federal agency that is exempted from those requirements under 2 CFR § 25.110(b) or (c), or has an exception approved by the agency under 2 CFR § 25.110(d))**.**

HRSA may not make an award to an applicant until the applicant has complied with all applicable DUNS and SAM requirements and, if an applicant has not fully complied with the requirements by the time HRSA is ready to make an award, HRSA may determine that the applicant is not qualified to receive an award and use that determination as the basis for making an award to another applicant.

If you have already completed Grants.gov registration for HRSA or another federal agency, confirm that it is still active and that the Authorized Organization Representative (AOR) has been approved.

The Grants.gov registration process requires information in three separate systems:

- Dun and Bradstreet (http://www.dnb.com/duns-number.html)
- System for Award Management (SAM) (https://www.sam.gov)
- Grants.gov (http://www.grants.gov/)

For further details, see Section 3.1 of HRSA's *SF-424 R&R Application Guide*.

If you fail to allow ample time to complete registration with SAM or Grants.gov, you will not be eligible for a deadline extension or waiver of the electronic submission requirement.

4. Submission Dates and Times

Application Due Date
The due date for applications under this NOFO is *February 20, 2018 at 11:59 p.m. Eastern Time*.

See Section 8.2.5 – Summary of emails from Grants.gov of HRSA's *SF-424 R&R Application Guide* for additional information.

5. Intergovernmental Review

The Developmental-Behavioral Pediatrics Training Program is not subject to the provisions of Executive Order 12372, as implemented by 45 CFR part 100.

See Section 4.1 ii of HRSA's *SF-424 R&R Application Guide* for additional information.

6. Funding Restrictions

You may request funding for a project period of up to 5 years, at no more than $187,115 per year (inclusive of direct **and** indirect costs). Awards to support projects beyond the first budget year will be contingent upon Congressional appropriation, satisfactory progress in meeting the project's objectives, and a determination that continued funding would be in the best interest of the federal government.

See restrictions and non-allowable costs related to trainees in Appendix A: Applicable Standards for Using Grant Funds to Support Trainees/Fellows.

The General Provisions in Division H of the Consolidated Appropriations Act, 2017 (P.L. 115-31) apply to this program. Please see Section 4.1 of HRSA's *SF-424 R&R Application Guide* for additional information. Note that these or other restrictions will apply in FY 2018, as required by law.

You are required to have the necessary policies, procedures and financial controls in place to ensure that your organization complies with all legal requirements and restrictions applicable to the receipt of federal funding including statutory restrictions on use of funds for lobbying, executive salaries, gun control, abortion, etc. Like those for all other applicable grants requirements, the effectiveness of these policies, procedures and controls is subject to audit.

All program income generated as a result of awarded funds must be used for approved project-related activities. The program income alternative applied to the award(s) under the program will be the addition/additive alternative. Post-award requirements for program income can be found at 45 CFR § 75.307.

V. Application Review Information

1. Review Criteria

HRSA has instituted procedures for assessing the technical merit of applications to provide for an objective review of applications and to assist you in understanding the standards against which your application will be judged. HRSA has developed critical indicators for each review criterion to assist you in presenting pertinent information related to that criterion and to provide the reviewer with a standard for evaluation. See the review criteria outlined below with specific detail and scoring points.

These criteria are the basis upon which the reviewers will evaluate and score the merit of the application. The entire proposal will be considered during objective review, except for the competing continuations' progress report, which will be reviewed by HRSA program staff after the objective review process.

Review criteria are used to review and rank applications. The DBP Training Program has six review criteria:

Criterion 1: NEED (10 points) – Corresponds to Section IV's Introduction and Needs Assessment

The extent to which the application:

- Describes the target population and the social determinants of health impacting unmet health needs.
- Documents a strong knowledge of health and related issues for individuals with neurodevelopmental and related disabilities, including ASD.
- Documents the critical national, regional, and local needs that the proposed project will address.
- Specifically identifies problem(s) to be addressed and gaps which the proposed project is intended to fill.

Criterion 2: RESPONSE (35 points) – Corresponds to Section IV's Methodology, Work Plan and Logic Model

The extent to which the proposed project responds to the "Purpose" included in the program description. The strength of the proposed goals and objectives and their relationship to the identified project. The extent to which the activities (scientific or other) described in the application are capable of addressing the problem and attaining the project objectives.

Work Plan and Logic Model (5 points)

The extent to which the:

- The degree to which the project goals and objectives address the stated needs/purpose outlined in Section A and the objectives are time-framed and measurable (SMART).

- Work plan (Attachment 1) describes the activities or steps used to achieve each of the objectives proposed in the methodology section.

- Logic model (Attachment 1) demonstrates the relationship among resources, activities, outputs, target population, short and long-term outcomes.

Trainee Recruitment and Retention (5 points)

- The completeness, strength, and innovation of recruitment and retention plans and the strategies to attract trainees with training and career goals consonant with the purpose of the DBP Training Program.

- Strength of recruitment plans to attract trainees from diverse backgrounds, including from underrepresented racial and ethnic groups.

- Strength of methods to recruit a minimum of one first-year fellow each year, including a clear description of challenges related to recruiting DBP fellows and how they will be overcome.

- Strength of plans to increase the DBP workforce by offering medium-term and short-term trainee programs and activities.

Curricula and Training Elements (Training program design, clinical and didactic training): (15 points)

- The extent to which the curriculum, included in Attachment 5, has clear educational objectives and a comprehensive curriculum and presents course descriptions and planned activities, including a variety of clinical and research opportunities, for the full 3-year fellowship.

- The extent to which the approach to training is thoughtful, logical and innovative.

- Evidence that the curriculum will train providers to diagnose and treat ASD/DD.

- Evidence that the educational curricula will lead to in-depth knowledge of relevant psychosocial and biological sciences, growth and development, transition, injury prevention, and disease prevention and health promotion as components of DBP.

- The extent to which the curriculum addresses research, technology, innovation, and emerging issues.

- The extent to which interdisciplinary education about DBP, including clinical opportunities, is a clearly demonstrated method in the training.

- Evidence that the training promotes collaboration with families and self-advocates as members of interdisciplinary teams.

- Evidence that the curriculum and approach promotes patient-centered and family-centered care as well as the medical home.

- The extent to which the curriculum includes content relating to science-based judgment, evidenced-based practice and documentation of quality outcomes and performance within an established plan of care; expansion of the direct service roles to include consultation, collaboration, and supervision; and various service delivery models and approaches.

- The extent to which the clinical and community-based training clarifies the DBP's role in provision of clinical services through extensive clinical preparation and supervision in diverse service settings.

- The extent to which the curriculum addresses social determinants of health and provides an understanding of the influences of family; environment; lifestyle; cultural values; economic; legal and political conditions; and technological advances on the health of children.

- Evidence that the curriculum aims to develop cultural and linguistic competence among the trainees.

- Evidence that the curriculum presents alternative models of disability.

- The extent to which the application incorporates MCH life course framework into the curriculum.

- The extent to which the curriculum emphasizes the systems of care and integration of services supported by states, local agencies, organizations, private providers, and communities.

- The extent to which the project integrates a public health perspective in the planned curriculum and incorporates trainee interactions with MCH professionals in various settings.

- The extent to which the curriculum, didactic and experiential, prepares graduates to assume leadership roles and incorporates the MCH Leadership Competencies framework into the training, including the development of strong communication skills.

- The extent to which the application provides evidence of a collaborative research approach for trainees in partnership with the faculty.

- Demonstration that fellows will participate in teaching activities and serve as role models for students, residents, and other short- and medium-term trainees.

Strengthening Systems of Care (10 points)

- The effectiveness and strength of the collaboration with those outside of the university (families, state Title V agencies, MCH or other appropriate agencies, other MCH partners) to strengthen systems of care.

- Strength of the outcomes and activities described for medium- and short-term trainees.

- The strength of plans to provide continuing education, consultation and technical assistance to those practicing in the field, including a minimum of one continuing education activity per year for current providers.

- Demonstration of an effective use of technology to increase reach of DBP training to practitioners in underserved areas.

- Extent of plans to collaborate with research networks, state demonstration projects, and/or LEND programs funded under the Autism CARES Act of 2014.

Criterion 3: EVALUATIVE MEASURES (15 points) – Corresponds to Section IV's
Evaluation and Technical Support Capacity

The strength and effectiveness of the method proposed to monitor and evaluate the project results.

- The degree to which the proposal presents evidence that the evaluative measures will be able to assess: 1) to what extent the program objectives have been met, and 2) to what extent these can be attributed to the project.

- The strength of the methods for data collection and the manner in which it will be analyzed and reported, including plans to ensure data collection quality.

- The strength of the plan to track required annual performance data and measures.

- The completeness of plans for tracking trainee field leadership after graduation.

- The completeness of plans to document the research and scholarly activities of faculty and students.

- The strength of the project plan to use evaluation findings for continuous quality improvement.

- The strength of the plans to measure TA recipient, and medium- and short-term trainee experiences and the impact of the training/TA on their practice.

- A description of plans to participate in HRSA's autism program evaluation activities as required, pending appropriation.

Criterion 4: IMPACT (10 points) – Corresponds to Section IV's Response, Work Plan and Logic Model

- The extent to which the proposed impact of the program is outlined in the logic model and proposed activities are tied to the intended impact.

- The extent to which the proposed project will result in increased access to care for children currently underserved.

- The extent to which project results may be national in scope and the degree to which the project activities are replicable.

- The strength of the plans to sustain key parts of the program beyond the federal funding.

- The feasibility and effectiveness of the dissemination plan to share curricula, assessment and other tools, training approaches, research findings, and successes.

- Effectiveness of the plan to strengthen the MCH network through connections of program faculty, staff, trainees, and alumni with the broader MCH network.

- Effectiveness of the planned TA activities to strengthen the system of care.

Criterion 5: RESOURCES/CAPABILITIES (20 points) – Corresponds to Section IV's Evaluation and Technical Support Capacity and Organizational Information

Organizational (10 points):

- Evidence that the DBP fellowship program is accredited by ACGME.

- Evidence of productivity of the existing DBP fellowship program in terms of the number of fellows who have completed training in DBP and their current professional activities.

- The strength of the plan to meaningfully involve individuals from populations to be served, including those from historically underrepresented groups, in the planning and implementation of the project with appropriate compensation.

- The extent to which the applicant organization provides the quality and availability of facilities and personnel to fulfill the needs and requirements of the proposed project.

- The extent to which the described physical and virtual resources are adequate to perform the training and facilitate full participation of primary care providers and other clinicians serving youth in continuing education and TA activities.

- The administrative and organizational structure will provide an adequately supportive environment for faculty, staff, and trainees.

- Evidence of formal affiliation agreements with institutions and programs outside of the university that are contributing to the training program, such as those serving as practicum sites (Attachment 3).

- The extent that the organization has the capacity to enable faculty and trainee interaction in order to facilitate interdisciplinary discussions and experiences.

- Evidence of planned collaboration within the university (through shared courses, curriculum innovations, and collaborative research).

Faculty and Staff (10 points):

The extent to which the application:

- Demonstrates that the proposed PD is a board-certified pediatrician with subspecialty certification in DBP with demonstrated academic and scholarly leadership in the field.

- Demonstrates that project personnel are qualified by training and/or experience to implement and carry out the project.

- Demonstrates that faculty members are effective in recruiting, teaching, collaborating with, and mentoring students as well as leading in the field of DBP.

- Presents an effective plan for recruiting a racially, ethnically, and culturally diverse team of faculty.

- Demonstrates that key personnel have adequate time devoted to the project to achieve project objectives (use of funds other than grant funds is permitted) , including that the proposed PD has devoted at least 20 percent effort on this project.

- Demonstrates that a minimum of one self-advocate and one family member will be involved in the project and describes their roles, including mentoring the trainees.

- Demonstrates that the person identified on the project as responsible for refining, collecting, and analyzing data for evaluation is qualified by training and/or experience to fulfill these data-related activities.

Criterion 6: SUPPORT REQUESTED (10 points) – Corresponds to Section IV's Budget and Budget Justification Narrative

The reasonableness of the proposed budget for each year of the project period in relation to the objectives, the complexity of the research activities, and the anticipated results.

- The extent to which costs for all 5 years of the project period, are reasonable given the scope of work and links to the proposed project activities.
- The extent to which budget line items are well described and justified in the budget justification.
- The extent to which funds are allocated for two key staff and all fellows to attend the annual DBP Training Program grantee meeting.
- The extent to which funds are allocated for the PD or one key faculty member to attend the Autism CARES and HRSA meetings throughout the 5-year project period.
- The extent to which the number of trainee stipends are described in the budget.
- The extent to which the budget and justification demonstrates commitment to innovative national efforts, with an emphasis on developmental-behavioral health.
- The extent to which the budget narrative (not the line item budget) outlines adequate costs and justification for managing the DBP annual meeting for 1 year during the 5-year grant period.

2. Review and Selection Process

The independent review process provides an objective evaluation to the individuals responsible for making award decisions. The highest ranked applications receive consideration for award within available funding ranges. In addition to the ranking based on merit criteria, HRSA approving officials may also apply other factors in award selection, (e.g., geographical distribution), if specified below in this NOFO. HRSA may also consider assessment of risk and the other pre-award activities described in Section 3 below.

See Section 5.3 of HRSA's *SF-424 R&R Application Guide* for more details.

3. Assessment of Risk and Other Pre-Award Activities

HRSA may elect not to fund applicants with management or financial instability that directly relates to the organization's ability to implement statutory, regulatory or other requirements (45 CFR § 75.205).

HRSA reviews applications receiving a favorable objective review for other considerations that include past performance, as applicable, cost analysis of the project/program budget, assessment of your management systems, ensuring continued applicant eligibility, and compliance with any public policy requirements, including those requiring just-in-time submissions. HRSA may ask you to submit additional programmatic or administrative information (such as an updated budget or "other support" information) or to undertake certain activities (such as negotiation of an indirect cost rate) in anticipation of an award. However, even at this point in the process, such requests do not guarantee that HRSA will make an award. Following review of all applicable information, HRSA's approving and business management officials will determine whether HRSA can make an award, if special conditions are required, and what level of funding is appropriate.

Award decisions are discretionary and are not subject to appeal to any HRSA or HHS official or board.

Effective January 1, 2016, HRSA is required to review and consider any information about your organization that is in the Federal Awardee Performance and Integrity Information System (FAPIIS). You may review and comment on any information about your organization that a federal awarding agency previously entered. HRSA will consider any of your comments, in addition to other information in FAPIIS in making a judgment about your organization's integrity, business ethics, and record of performance under federal awards when completing the review of risk posed as described in 45 CFR § 75.205 HHS Awarding Agency Review of Risk Posed by Applicants.

HRSA will report to FAPIIS a determination that an applicant is not qualified (45 CFR § 75.212).

4. Anticipated Announcement and Award Dates

HRSA anticipates issuing/announcing awards prior to the start date of July 1, 2018.

VI. Award Administration Information

1. Award Notices

HRSA will issue the Notice of Award prior to the start date of July 1, 2018. See Section 5.4 of HRSA's *SF-424 R&R Application Guide* for additional information.

2. Administrative and National Policy Requirements

See Section 2.2 of HRSA's *SF-424 R&R Application Guide*.

Human Subjects Protection:
Federal regulations (45 CFR part 46) require that applications and proposals involving human subjects must be evaluated with reference to the risks to the subjects, the adequacy of protection against these risks, the potential benefits of the research to the

subjects and others, and the importance of the knowledge gained or to be gained. If you anticipate research involving human subjects, you must meet the requirements of the HHS regulations to protect human subjects from research risks as specified in the Code of Federal Regulations, Title 45 – Public Welfare, Part 46 – Protection of Human Subjects (45 CFR part 46), available online at http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.html.

3. Reporting

The new Discretionary Grant Information System (DGIS) reporting system will continue to be available through the Electronic Handbooks (EHBs). HRSA enhanced the DGIS and these improvements are available for recipient reporting as of October 1, 2017. HRSA will communicate with recipients and provide instructions on how to access the system for reporting. HRSA will also provide technical assistance via webinars, written guidance, and one-on-one sessions with an expert, if needed.

The updated and final reporting package incorporating all OMB accepted changes can be reviewed at (OMB Number: 0915-0298 Expiration Date: 06/30/2019): https://mchb.hrsa.gov/data-research-epidemiology/discretionary-grant-data-collection.

Award recipients must comply with Section 6 of HRSA's *SF-424 R&R Application Guide* **and** the following reporting and review activities:

1) **Progress Report(s)**. The recipient must submit a progress report to HRSA on an **annual** basis. Among other items, the report will ask for progress against program activities and outcomes proposed in the application. Further information will be available in the award notice.

2) **Final Report Narrative.** The recipient must submit a final report narrative to HRSA after the conclusion of the project.

3) **Performance Reports.** HRSA has modified its reporting requirements for Special Projects of Regional and National Significance (SPRANS) projects, Community Integrated Service Systems (CISS) projects, and other grant/cooperative agreement programs administered by HRSA to include national performance measures that were developed in accordance with the requirements of the Government Performance and Results Act (GPRA) of 1993 (Public Law 103-62). GPRA requires the establishment of measurable goals for federal programs that can be reported as part of the budgetary process, thus linking funding decisions with performance. Performance measures for states have also been established under the Block Grant provisions of Title V of the Social Security Act.

   a) Performance Measures and Program Data

   To prepare successful applicants for their reporting requirements, the listing of administrative forms and performance measures for this program can be found at https://perf-data.hrsa.gov/mchb/DgisApp/FormAssignmentList/T77_3.HTML.

Administrative Forms
Form 1, Project Budget Details Form 2, Project Funding Profile Form 4, Project Budget and Expenditures Form 6, Maternal & Child Health Discretionary Grant Form 7, Discretionary Grant Project
MCH Workforce Development Training Forms
Faculty and Staff Information Trainee Information (Long-Term Trainees Only) Former Trainee Information Medium-Term Trainees Short-Term Trainees Continuing Education
Updated DGIS Performance Measures, Numbering by Domain *(All Performance Measures are revised from the previous OMB package)*

Performance Measure	**New/Revised Measure**	**Prior PM Number (if applicable)**	**Topic**
Core			
Core 1	New	N/A	Grant Impact
Core 2	New	N/A	Quality Improvement
Core 3	New	N/A	Health Equity – MCH Outcomes
Capacity Building			
CB 2	New	N/A	Technical Assistance
CB 3	New	N/A	Impact Measurement
CB 5	Revised	3, 4	Scientific Publications
CB 6	New	N/A	Products
Child Health			
CH 3	New	N/A	Developmental Screening
Children and Youth with Special Health Care Needs			
CSHCN 3	New	N/A	Transition to Adult Health Care

DIVISION OF MCH WORKFORCE DEVELOPMENT:

Performance Measure	New/Revised Measure	Prior PM Number (if applicable)	Topic
Training 01	New	N/A	MCH Training Program and Healthy Tomorrows Family Member/Youth/Community Member participation
Training 02	New	N/A	MCH Training Program and Healthy Tomorrows Cultural Competence
Training 04	Revised	59	Title V Collaboration
Training 05	Revised	85	Policy
Training 06	Revised	09	Diversity of Long-Term Trainees
Training 10	Revised	08	Leadership
Training 11	Revised	84	Work with MCH Populations
Training 12	Revised	60	Interdisciplinary Practice

b) Performance Reporting Timeline

Successful applicants receiving HRSA funds will be required, within 120 days of the project start date, to register in HRSA's EHBs and electronically complete the program-specific data forms that are required for this award. This requirement entails the provision of budget breakdowns in the financial forms based on the award amount, the project abstract and other grant/cooperative agreement summary data as well as providing objectives for the performance measures.

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

c) Project Period End Performance Reporting

Successful applicants receiving HRSA funding will be required, within 90 days from the end of the project period, to electronically complete the program-specific data forms that appear for this program. The requirement includes providing expenditure data for the final year of the project period, the project abstract and grant/cooperative

agreement summary data as well as final indicators/scores for the performance measures.

4) **Integrity and Performance Reporting.** The Notice of Award will contain a provision for integrity and performance reporting in FAPIIS, as required in 45 CFR part 75 Appendix XII.

VII. Agency Contacts

You may request additional information regarding business, administrative, or fiscal issues related to this NOFO by contacting:

Hazel N. Booker
Grants Management Specialist
Division of Grants Management Operations, OFAM
Health Resources and Services Administration
5600 Fishers Lane, Mailstop 10SWH03
Rockville, MD 20857
Telephone: (301) 443-4236
Email: NBooker@hrsa.gov

You may request additional information regarding the overall program issues and/or technical assistance related to this NOFO by contacting:

Rita Maldonado, MPH
Project Officer, Division of MCH Workforce Development
Attn: Developmental-Behavioral Pediatrician Training Program
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane, Room 18W17C
Rockville, MD 20857
Telephone: (301) 443-3622
Email: rmaldonado@hrsa.gov

You may need assistance when working online to submit your application forms electronically. Always obtain a case number when calling for support. For assistance with submitting the application in Grants.gov, contact Grants.gov 24 hours a day, 7 days a week, excluding federal holidays at:

Grants.gov Contact Center
Telephone: 1-800-518-4726 (International Callers, please dial 606-545-5035)
Email: support@grants.gov
Self-Service Knowledge Base: https://grants-portal.psc.gov/Welcome.aspx?pt=Grants

Successful applicants/recipients may need assistance when working online to submit information and reports electronically through HRSA's Electronic Handbooks (EHBs). For assistance with submitting information in HRSA's EHBs, contact the HRSA Contact Center, Monday-Friday, 8 a.m. to 8 p.m. ET, excluding federal holidays at:

HRSA Contact Center
Telephone: (877) 464-4772
TTY: (877) 897-9910
Web: http://www.hrsa.gov/about/contact/ehbhelp.aspx

VIII. Other Information

Needs Assessment Resource:

A SUMMARY of Current Title V Workforce Needs" 2014 published by the National MCH Workforce Development Center is available at http://www.mchb.hrsa.gov/training/documents/NMCHWDC_Summary-2014-09-11.pdf

Logic Models

Additional information on developing logic models can be found at the following website: http://www.acf.hhs.gov/sites/default/files/fysb/prep-logic-model-ts.pdf.

Although there are similarities, a logic model is not a work plan. A work plan is an "action" guide with a time line used during program implementation; the work plan provides the "how to" steps. Information on how to distinguish between a logic model and work plan can be found at the following website: http://www.cdc.gov/healthyyouth/evaluation/pdf/brief5.pdf.

Technical Assistance

HRSA has scheduled the following technical assistance webinar:

Webinar

Day and Date: Monday, January 8, 2018
Time: 2 p.m. – 3 p.m. ET
Call-In Number: 1-888-946-3803
Participant Code: 1492777
Weblink: https://hrsa.connectsolutions.com/dbp_training/
Playback Number: 1-866-410-5848
Passcode: 3622

Helpful Resources and Informational Websites

1. Division of Maternal and Child Health Workforce Development https://mchb.hrsa.gov/training/about.asp

2. *Bright Futures (American Academy of Pediatrics)* https://brightfutures.aap.org/Pages/default.aspx

3. *Healthy People 2020* http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx

4. Institute of Medicine (IOM). *"In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce."* http://www.nap.edu/catalog/10885/in-the-nations-compelling-interest-ensuring-diversity-in-the-health

5. *MCH Leadership Competencies* http://leadership.mchtraining.net/

6. National Center for Cultural Competence http://nccc.georgetown.edu/

7. *Diversity and Health Equity in the Maternal and Child Health Workforce* https://mchb.hrsa.gov/training/documents/MCH_Diversity_2016-05_RFS.pdf

8. Surgeon General's Health Reports http://www.surgeongeneral.gov/library/

9. Discretionary Grant Information System (DGIS) https://mchdata.hrsa.gov/dgisreports/

10. Title V Maternal and Child Health Services Block Grant Program https://mchb.hrsa.gov/maternal-child-health-initiatives/title-v-maternal-and-child-health-services-block-grant-program

11. Title V Information System (TVIS) https://mchb.tvisdata.hrsa.gov/

12. *Including People with Disabilities Public Health Workforce Competencies* http://www.aucd.org/docs/Competencies%20Draft_VERSION%201.8_updated%203.3.16.pdf

IX. Tips for Writing a Strong Application

See Section 4.7 of HRSA's *SF-424 R&R Application Guide*

Appendix A: Applicable Standards for Using Grant Funds to Support Trainees/Fellows

A. Definitions

1. A trainee is an individual whose activities within the training program are directed primarily toward achieving an advanced degree.
2. A fellow is an individual who has met at least the minimum standards of education and experience accepted by his/her respective profession and whose activities within the training program are for the primary purpose of obtaining or enhancing particular skills or knowledge.

B. Qualifications for receiving stipends/tuition/salary support under this program.

1. A trainee must have at least a baccalaureate degree and be enrolled in a graduate program.
2. A fellow must have achieved the academic degree and completed requisite training which constitutes the basic professional level training for his/her field.
3. A post-doctoral fellow must have an earned doctorate and must have completed any required internship.
4. A post-residency fellow must have an earned medical degree and must have satisfied requirements for certification in a specialty relevant to the purpose of the proposed training.
5. A special trainee or fellow may be approved, upon request to your HRSA project officer, only in those unusual circumstances where particular needs cannot be met within the categories described above.
6. Citizenship – The trainee or fellow receiving a stipend must be a citizen or a non-citizen national of the United States or have been lawfully admitted for permanent residence, as evidenced by a currently valid Permanent Resident Card [USCIS Form I-551] or other legal verification of such status, by the start of the training grant, fellowship or traineeship, or award. A non-citizen national is a person who, although not a citizen of the United States, owes permanent allegiance to the United States.
7. Licensure – For any profession for which licensure is a prerequisite, the trainee/fellow must also be licensed by one of the states, or, in the case of foreign graduates, meet other requirements which legally qualify him/her to practice his/her profession in the United States.

C. Restrictions

1. Concurrent Support

   Trainees/fellows receiving stipends under this program will generally be full time, long term trainees. Stipends generally will not be made available under this program to persons receiving a salary, fellowship or traineeship stipend, or other financial support related to his/her training or employment for the same hours counted toward his/her HRSA-funded traineeship/fellowship. Exceptions to these

restrictions may be requested to your HRSA project officer and will be considered on an individual basis. Tuition support may be provided to full-time or part-time students

2. Non-Related Duties

   The funding recipient shall not use funds from this award to require trainees or fellows to perform any duties which are not directly related to the purpose of the training for which the grant was awarded.

3. Field Training

   Funding recipients may not utilize grant funds to support field training, except when such training is part of the specified requirements of a degree program, or is authorized in the approved application.

4. Grant funds may <u>not</u> be used:

   a) for the support of any trainee who would not, in the judgment of the awardee, be able to use the training or meet the minimum qualifications specified in the approved plan for the training.
   b) to continue the support of a trainee who has failed to demonstrate satisfactory participation in the training program.
   c) for support of candidates for undergraduate or pre-professional degrees, or the basic professional degree.

D. Trainee Costs

1. Allowable Costs

   a) Stipends (except as indicated above)
   b) Tuition and fees, including medical insurance
   c) Travel related to education/training and field placements
   d) For a few institutions, it may be beneficial to support trainees through tuition remission and wages. Tuition remission and other forms of compensation paid as, or in lieu of, wages to students (including fellows and trainees) performing necessary work are allowable provided that there is a bona fide employer-employee relationship between the student and the institution for the work performed, the tuition or other payments are reasonable compensation for the work performed and are conditioned explicitly upon the performance of necessary work, and it is the institution's practice to similarly compensate students in non-sponsored as well as sponsored activities.

2. Non-Allowable Costs

   a) Dependent/family member allowances
   b) Travel between home and training site
   c) Fringe benefits or deductions which normally apply only to persons with the status of an employee

3. Stipend Levels

All approved stipends indicated are for a full calendar year, and must be *prorated for an academic year or other training period of less than 12 months*. The stipend levels may, for this program, be treated as ceilings rather than mandatory amounts, i.e., stipends may be less than *but may not exceed the amounts indicated*. However, where lesser amounts are awarded, the awarding institution must have established, written policy which identifies the basis or bases for such variation and which ensures equitable treatment for all eligible trainees/fellows. These stipend levels apply to the National Institutes of Health, the Agency for Healthcare Research and Quality, and the Health Resources and Services Administration training grantees and were updated on June 27, 2017, https://grants.nih.gov/grants/guide/notice-files/NOT-OD-17-084.html (predoctoral) and December 15, 2016, https://grants.nih.gov/grants/guide/notice-files/NOT-OD-17-003.html (post doctoral). *Dollar amounts indicated in this NOFO are subject to update by the agency as reflected in this issuance.*

a) Pre-Doctoral
One stipend level is used for all pre-doctoral candidates, regardless of the level of experience.

Career Level	Years of Experience	Stipend for FY 2017	Monthly Stipend
Predoctoral	All	$23,844	$1,987

b) Post-Doctoral
The stipend level for the entire first year of support is determined by the number of full years of relevant post-doctoral experience** when the award is issued. Relevant experience may include research experience (including industrial), teaching assistantship, internship, residency, clinical duties, or other time spent in a health-related field beyond that of the qualifying doctoral degree. Once the appropriate stipend level has been determined, the fellow must be paid at that level for the entire grant year. *The stipend for each additional year of support is the next level in the stipend structure and does not change mid-year*.

Career Level	Years of Experience	Stipend for FY 2017	Monthly Stipend
Postdoctoral	0	$47,484	$3,957
	1	$47,844	$3,987
	2	$48,216	$4,018
	3	$50,316	$4,193
	4	$52,140	$4,345
	5	$54,228	$4,519
	6	$56,400	$4,700
	7 or More	$58,560	$4,880

**Determination of the “years of relevant experience” shall be made in accordance with program guidelines and will give credit to experience gained prior to entry into the grant-supported program as well as to prior years of participation in the grant-supported program. The appropriate number of “years” (of relevant experience) at the time of entry into the program will be determined as of the date on which the individual trainee begins his/her training rather than on the budget period beginning date of the training grant. Stipends for subsequent years of support are at the next level on the stipend chart.

4. Supplements to Stipends

Stipends specified above may be supplemented by an institution from non-federal funds. *No federal funds may be used for stipend supplementation unless specifically authorized under the terms of the program from which the supplemental funds are derived*.

Appendix B: DBP Training Program Logic Model

Purpose: To enhance the behavioral, psychosocial, and developmental aspects of pediatric care.

Objectives:

- To advance the field of developmental-behavioral pediatrics (DBP) by supporting and preparing fellows for leadership roles as teachers, investigators, and clinicians.
- To provide other trainees, including pediatric practitioners, residents, and medical students, with biopsychosocial knowledge and clinical expertise, including with autism spectrum disorder (ASD) and other developmental disabilities.

INPUTS	OUTPUTS		OUTCOMES	IMPACT
	ACTIVITIES	PRODUCT/SYSTEMS		
Partners and resources	Activities to create/improve health/service systems and infrastructure	Health/service systems and infrastructure created to support desirable systems behaviors	Health/service systems behaviors that lead to improved health outcomes	Improved health and wellness outcomes for population/ sub-population
Grantee Org. • Public or nonprofit agencies, including institutions of higher education Other Key Stakeholders • Academic medical centers • State Title V and other state agencies • Community and clinical-based providers and organizations Other Key Partners • Assoc. of University Centers on Disabilities (AUCD) • Medical and Graduate Schools Key Tools, guidelines • *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents* • Virtual meeting technology	• Recruit fellows with commitment to obtaining the DBP certification, and serving children with autism spectrum disorder (ASD) and other developmental disabilities (DD). Recruitment efforts will have a special emphasis on recruiting from underrepresented groups. • Develop/update curriculum, as needed • Recruit and maintain self-advocate(s) to mentor trainees, provide personal perspective, and serve as faculty members • Recruit and maintain family member(s) to mentor trainees, provide family perspective, and serve as faculty members • Instruct trainees on ASD/DD systems of care and services (e.g., leadership, policy, clinical, community, public health, cultural competency, interdisciplinary teamwork) • Instruct trainees to diagnose or rule out	• Increased number of developmental-behavioral pediatricians providing services to children and youth demonstrating knowledge/skills: o to use valid screening tools to diagnose and rule out ASD/DD o to treat ASD/DD and to work in an interdisciplinary manner o in systems of care for children and youth with ASD/DD o of community engagement o in research and leadership • Evaluation process operational • Increased collaboration and partnerships between HRSA training program grantees and Title V/other MCH programs that support comprehensive, coordinated and family-centered systems of care	• Increased number of professionals trained to provide services to ASD/DD populations • Improved diagnosis and treatment of ASD/DD using valid tools • Improved delivery of care for children and youth with ASD/DD • Increased interdisciplinary teams within healthcare system to address complex ASD/DD issues • Enhanced multidisciplinary workforce capable and available to address children's developmental-behavioral health issues • Increased number of professionals trained in developmental-behavioral pediatrics, thus reducing the wait time to receive services • Increased number of leaders in the field at	• Improved access to developmental-behavioral health care for children • Improved behavioral health for children • Improved health and well-being for children and youth with ASD/DD • Reduced health and healthcare disparities in ASD/DD populations • Increased quality of life (e.g., fewer missed school days, reduced hospitalizations) • Improved early identification of developmental-behavioral manifestations

	ASD/DD • Conduct continuing education activities for provider community to enhance skills or disseminate new information (a minimum of 1 per year) • Collaborate with state Title V MCH programs including consultation, in-service education, and continuing education • Develop evaluation process and plan to assess program activities	• Increased representation of underrepresented groups working in the field of ASD/DD • Increased research outputs and advances	local, state and national levels (e.g., those working in a capacity to make decisions or implement programs/ policies) • Improved pediatric practices that facilitate a more comprehensive approach to health supervision in regards to developmental and behavioral services, such as outlined in *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents*	
Measures of success with timeline	• Number of DBP fellows recruited each year • Evaluation plan in place • Number of trainees recruited from underrepresented groups (PM Training 6) • Extent of family and self-advocate involvement in training fellows recruited/ retained (PM Training 1) • Number of short, medium and long-term trainees, including participants in continuing education and technical assistance • Extent to which cultural competence incorporated into training (PM Training 2) • Extent to which grantees partner with State Title V agencies and other MCH programs (PM Training 4)	• Data collected, analyzed and reported annually per the grantee's evaluation plan • Percent change in trainees pre/post-test • Self-efficacy of trainees to apply knowledge/skills learned as measured in the grantee's evaluation plan • Increased collaborations as measured via performance measures (PM Training 4) • Number of publications and research advances	• Number of trainees that demonstrate field leadership (PM Training 10) • Percent of trainees who work with ASD/DD/MCH populations post graduation (PM Training 11) • Number of trainees engaged in activities to inform policy and improve health outcomes for ASD/DD populations (PM Training 5) • Percent change and/or number of infants/children who receive interdisciplinary diagnostic services to confirm or rule out ASD/DDs by year among grantees • Percent trainees work in interdisciplinary manner to serve MCH population (PM Training 12)	

Appendix C: Key Elements of Collaborative Office Rounds

Collaborative Office Rounds (COR) utilizes a study group approach that emphasizes the practical challenges confronted by community-based practitioners. The approach is directed primarily to fellows and practitioners and emphasizes material linked to clinical situations. Other characteristics of the COR approach include: a small group experience, an atmosphere promoting the free exchange of ideas, and a continuing relationship with resource faculty and other group members.

Projects can cosponsor, with child psychiatry, an ongoing COR group designed to be a training experience for fellows and a continuing education experience for community providers. This is in addition to any COR groups supported by separate COR grants to some departments of pediatrics.

Specific objectives must include, but are not limited to, the following:

- Enhance understanding of psychosocial aspects of pediatrics and increase ability to help children and families deal with these issues
- Expand power to discriminate between transient disturbances and more serious psychiatric disorders
- Heighten awareness of the scope of participants' competencies and strengthen orientation to consult with or refer to other professionals as appropriate
- Promote collaboration among primary care providers with developmental-behavioral pediatricians and child psychiatrists
- Facilitate a more comprehensive approach to health supervision, such as envisaged in Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents

COR Program Features

Faculty Composition and Qualifications—Faculty must include at least one pediatrician with demonstrated expertise and experience in the field of DBP and one child psychiatrist as moderators. Substitute moderators should be designated so that both a pediatrician and a child psychiatrist are present consistently in moderator roles. Visiting faculty may be brought in as consultants or speakers.

Members—Members of the group should ideally be limited to ten or twelve, including the two moderators. DBP Training Program grantee COR groups are expected to include their fellows as well as others, such as primary care pediatricians, fellows in child psychiatry, and community child psychiatrists. Regular attendance should be the norm. Visitors/auditors might attend for education or training proposes as long as their numbers and pattern of attendance are not disruptive.

Meetings—Meetings should be at regular intervals, e.g., monthly, and for set periods of time. Meetings must be at least one hour long.

Format—Format should be a case-oriented approach to pursue the COR group's objectives. In addition to case material, the focus may also be on consultative activities to community agencies, including activities that deal with systems and facilities. Case material may be supplemented with didactic material.

Location and Timing—Location and timing of the meetings need to be sufficiently convenient to facilitate sustained participation. COR groups that are primarily concerned with issues that arise in a particular area, e.g., the inner city, are encouraged to meet in the area if it meets the test of convenience.

Evaluation— Evaluation of all COR groups is expected to include monitoring of process and assessment of impact in relation to goals.

Confidentiality—All COR group participants must adhere fully to the highest professional standards with regard to confidentiality.

Exclusively Educational Activity—Grant funds awarded for a COR group program may be used only for expenses clearly related to and necessary for the educational activity. COR funds may be used for continuing medical education (CME) credit required of practitioners. Funds may not be used to support service delivery and research. It is hoped that those brought together will be inspired in the direction of collaborative research.

Application—The program description should include the following information about the COR component in their application:

- The proposed group composition in terms of level and specialization
- Objectives, such as those suggested above, to illustrate the goals of the COR group
- Explanation of each of the requirements outlined above, with appropriate description and/or assurance provided for each
- Information that might assist in getting a picture of how the COR group could be expected to function and what educational accomplishments could be anticipated.