U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Maternal and Child Health Bureau
Division of Child, Adolescent, and Family Health

Networks for Oral Health Integration within the Maternal and Child Health Safety Net

Funding Opportunity Number: HRSA-19-053
Funding Opportunity Type(s): New
Catalog of Federal Domestic Assistance (CFDA) Number: 93.110

NOTICE OF FUNDING OPPORTUNITY

Fiscal Year 2019

Letter of Intent Requested By: February 25, 2019

Application Due Date: April 29, 2019

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

Issuance Date: January 28, 2019

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Authority: Social Security Act, Title V, § 501(a)(2) (42 U.S.C. 701(a)(2))

EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA) is accepting applications for fiscal year (FY) 2019 Networks for Oral Health Integration within the Maternal and Child Health Safety Net. The purpose of this program is to improve access to and delivery of comprehensive, quality oral health care for children, 0–17 years of age, by testing and establishing models of care utilizing three collective strategies: 1) enhanced integration of oral health care into Maternal and Child Health (MCH) safety net services; 2) increased knowledge and skills among health care providers (including dental, non-dental clinical, and non-dental support service providers) for delivering optimal dental services; and 3) increased knowledge and awareness of preventive oral health practices among parents/caregivers to increase adoption of these behaviors including use of needed dental services.

Funding Opportunity Title:	Networks for Oral Health Integration within the Maternal and Child Health Safety Net
Funding Opportunity Number:	HRSA-19-053
Due Date for Applications:	April 29, 2019
Anticipated Total Annual Available FY 2019 Funding:	$3,850,000
Estimated Number and Type of Award(s):	Up to three cooperative agreement(s)
Estimated Award Amount:	Up to $1,283,333 per year subject to the availability of appropriated funds
Cost Sharing/Match Required:	No
Period of Performance:	September 1, 2019 through August 31, 2024 (5 years)
Eligible Applicants:	Any domestic public or private entity, including an Indian tribe or tribal organization (as those terms are defined at 25 U.S.C. 450b) is eligible to apply. See 42 CFR 51a.3(a). Domestic faith-based and community-based organizations are also eligible to apply. See Section III-1 of this notice of funding opportunity (NOFO) 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 Application Guide,* available online at http://www.hrsa.gov/grants/apply/applicationguide/sf424guide.pdf, except where instructed in this NOFO to do otherwise.

Technical Assistance

HRSA has scheduled the following technical assistance:

Webinar

Day and Date: Thursday, February 7, 2019
Time: 2 p.m. – 3:30 p.m.
Call-In Number: 1-888-603-9071
Participant Code: 4095307
Weblink: https://hrsa.connectsolutions.com/network_oral_integration_maternal/
Playback Number: 1-866-448-4808 | Password: 1234

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APPENDIX 32

I. Program Funding Opportunity Description

1. Purpose

This notice announces the opportunity to apply for funding under the Networks for Oral Health Integration within the Maternal and Child Health (MCH) Safety Net Program (referred to here as the NOHI Program). The purpose of this program is to improve access to and delivery of comprehensive, quality oral health care[1] for children, 0–17 years of age, by testing and establishing models of care utilizing three collective strategies: (1) enhanced integration of oral health care within MCH safety net services (Section IV, Table 1); (2) increased knowledge and skills among health care providers (including dental, non-dental clinical, and non-dental support service providers) for delivering optimal dental services; and (3) increased knowledge and awareness of preventive oral health practices among parents/caregivers to increase adoption of these behaviors including use of needed dental services.

Achieving the program purpose requires testing and validating replicable models of care to integrate oral health into MCH safety net services. The MCH safety net services are comprised of providers, payment programs (e.g., Medicaid and the State Children's Health Insurance Program) and facilities that provide clinical, nonclinical and support services. A “model of care” [2] broadly defines the delivery of health services, outlining best care practices and services for a person, population group, or patient cohort as they progress through the stages of a condition, injury, or event. It aims to ensure people get the right care, at the right time, by the right team, and in the right place.

The NOHI Program will provide funding to three distinct Networks that will each develop, implement, and evaluate a model of care that enables the integration of optimal oral health services within one of the MCH safety net settings specified in Table 1 (Section IV). Oral health integration in a clinical MCH safety net setting should include each of the following components:

- anticipatory guidance[3],
- oral health education to children and their families,
- oral health risk assessment of children or adolescents[4,5],

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[1] Quality oral health care includes preventive oral health services, diagnostic follow-up, and treatment. Comprehensive delivery ensures continuity of care and integration between primary care and oral health care.

[2] A Practical Guide on How to Develop a Model of Care at the Agency for Clinical Innovation, May 2013, last accessed on July 23, 2018 at: https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0009/181935/HS13-034_Framework-DevelopMoC_D7.pdf

[3] “Anticipatory Guidance” is a proactive, developmentally based counseling technique that focuses on the needs of a child at each stage of life. (Anticipatory Guidance. Performing Preventive Services: A Bright Futures Handbook, 2018, last accessed on August 28, 2018 at: https://brightfutures.aap.org/Bright%20Futures%20Documents/Anticipatory%20Guidance.pdf)

[4] American Academy of Pediatrics. Bright Futures, 4th edition, 2018, last accessed on August 7, 2018 at: https://www.aap.org/en-us/Documents/oralhealth_RiskAssessmentTool.pdf

[5] American Academy of Pediatrics. Oral Health Risk Assessment tool. American Academy of Pediatric: Elk Grove, IL: 2011.

- structured referrals for appropriate oral health services,
- tracking of referrals to determine receipt of needed oral health services,
- provision of preventive oral health services[6] by dental or non-dental personnel, and referrals for restorative dental services, if needed.

Program Objectives

For the purpose of the program objectives: 1) a dental provider is a dentist, dental hygienist or dental assistant, 2) a non-dental clinical provider is a physician, nurse practitioner, physician assistant or medical assistant and 3) a non-dental support service provider is a community health educator, "promotora", health navigator or individual with a similar role.

Applications should propose integrated models of care to meet all the following program objectives by August 31, 2024:

1) 90 percent of providers participating in training organized by the Network will increase their knowledge of oral preventive care and the key components of oral health integration,
2) 90 percent of providers participating in training organized by the Network will deliver preventive oral health care services,
3) 35 percent of parents/caregivers of pediatric patients in MCH safety net setting participating in the Network will increase their knowledge/awareness about preventive oral health practices,
4) 75 percent of children and adolescents in the MCH safety net setting(s) participating in the Network will be referred for dental services (preventive and/or restorative), as appropriate,
5) 50 percent of children and adolescents in MCH safety net setting participating in the Network will receive preventive oral health services,
6) All three cooperative agreement recipients will identify and define components of successful interventions to implement a model of care that successfully integrates oral health into a MCH safety net setting, aimed at increasing access and delivery of dental services.

Program Description

For a detailed description of the program, please go to Section IV, page 9.

[6] Preventive oral health services are activities that aim to improve and maintain good oral health and function by reducing the onset and/or development of oral diseases or deformities and the occurrence of orofacial injuries. Examples of preventive oral health services include, but are not limited to, oral hygiene instruction, fluoride treatment, and dental sealants. (Title V MCH Health Services Block Grant to States Program, Appendix H, last accessed on August 7, 2018 at: https://mchb.tvisdata.hrsa.gov/Home/Glossary).

2. Background

This program is authorized by the Social Security Act, Title V, § 501(a)(2) (42 U.S.C. 701(a)(2)).

Children's Oral Health

Oral disease has an impact on physical, psychological, social, and economic health and well-being, often resulting in pain, diminished function, and reduced quality of life. The 2000 Surgeon General's report, *Oral Health in America*, referred to oral health as a "silent epidemic" of dental and oral diseases that burden children and adults throughout the United States (U.S.).[7] The National Health and Nutrition Examination Survey from 2011–2014 reported that 23 percent of preschool children (0–5 years of age) had early childhood caries and that 18 percent of children 5–18 years of age had untreated caries.[8] Dental caries are among the most prevalent health problems facing children and adolescents in the U.S.[7]

Poor oral health has a negative influence on children's speech, growth and function, and social development. Missing teeth, pain, and infection resulting from oral diseases can limit food choices and worsen nutrition.[9] If the infection is untreated, oral disease can result in death.[10]

There are inequalities in the number of dental visits children receive in 1 year based on income level. According to the 2014 Medical Expenditures Panel Survey, only 37 percent of low-income children ages 2 through 18 had a preventive dental visit during the past year.[11] Overall, children from high-income groups were twice as likely to have a dental visit as children from low-income groups. Among children with private insurance, 58 percent received dental care at least once a year. Rates were lower for children with Medicaid (44 percent), particularly for the very young.[12]

[7] U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research. Oral Health in America. A Report of the Surgeon General. NIH publication no. 00-4713. Rockville, MD: U.S. Public Health Service, Department of Health and Human Services; services;2000.

[8] Dye BA, Mitnik GL, Iafolla TJ, Vargas CM. Trends in dental caries in children and adolescents according to poverty status in the United States from 1999 through 2004 and from 2011 through 2014. *Journal of the American Dental Association*. 2017;148(8):550-565.e7.

[9] Ramos-Jorge J, Pordeus IA, Ramos-Jorge ML, Marques LS, Paiva SM. Impact of untreated dental caries on quality of life of preschool children: different stages and activity. *Community Dent oral Epidemiol* 2014 42:311-32222.

[10] Tragic Results When Dental Care is Out of Reach, last accessed on August 7, 2018 at: https://www.pbs.org/wgbh/frontline/article/tragic-results-when-dental-care-is-out-of-reach/

[11] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Healthy People; 2020 Topics and Objectives. Oral Health (Access to Preventive Services, OH-8).2018; https://www.healthypeople.gov/2020/topic-objectives/topic/oral-health/objectives, accessed on September 10, 2018.

[12] Nasseh K, Aravamudhan K, Vujicic M, Grau B. Dental Care Use among Children Varies Widely across States and between Medicaid and commercial plans within a State. Health Policy Institute Research Brief. American Dental Association. October 2013. Last accessed on August 7, 2018 at: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1013_5.ashx

To improve oral health and reduce oral health care inequalities among the U.S. population, the U.S. Department of Health and Human Services (HHS) Oral Health Strategic Framework proposes five overarching goals, which the NOHI Program incorporates:

1) integrate oral health and primary health care,
2) prevent disease and promote oral health,
3) increase access to oral health care and eliminate disparities,
4) increase the dissemination of oral health information and improve health literacy, and
5) advance oral health in public policy and research.[13]

Oral Health Systems in the U.S.

Two Institute of Medicine reports released in 2011, *Advancing Oral Health in America* and *Improving Access to Oral Health Care for Vulnerable and Underserved Populations,* reiterated the oral health burden in the U.S. and the need for improvements within the health care system. [14,15]

The current oral health care system is a loosely organized network of private practices and the oral health safety net.[16] The oral health safety net comprises of providers, payment programs and facilities that provide clinical, nonclinical and support services. It includes Medicaid and the State Children's Health Insurance Program (SCHIP), federally qualified health centers (FQHCs), school-based health centers and academic dental institutions, among other entities. This system fails to adequately reach those populations with the highest burden of oral disease contributing to significant oral health disparities for low-income, minority, rural, and other underserved populations.[14] The private practice network primarily consists of solo and small group practices, and serves about two-thirds of the U.S. population, (most of which has commercial dental benefits or the ability to pay out-of-pocket).[17] The oral health safety net serves the remaining one-third of the U.S. population.

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[13] U.S. Department of Health and Human Services Oral Health Strategic Framework, 2014–2017, U.S. Department of Health and Human Services Oral Health Coordinating Committee, last accessed on August 7, 2018 at: https://www.uclachatpd.org/uploads/1/4/9/1/14918002/u.s._department_of_health_and_human.pdf
[14] Institute of Medicine and National Research Council. 2011. Advancing Oral Health in America. Washington DC: The National Academies Press.
[15] Institute of Medicine and National Research Council. 2011. Improving Access to Oral Health Coral health are for Vulnerable and Underserved Populations. Washington DC: The National Academies Press.
[16] Tomar SL, Cohen LK. Attributes of an ideal oral health care system. Journal of Public Health Dent 70(2010):S6-S14.
[17] ADA, Health Policy Institute 2017. 2016 Characteristics of Private Dental Practices, last accessed on July 31, 2018practices at: https://www.ada.org/en/science-research/health-policy-institute/data-center/dental-practice

MCH Oral Health

HRSA aims to increase access to comprehensive, quality oral health care services for those most at risk for oral diseases[18] among the MCH populations. Quality oral health care includes the provision of preventive oral health services, diagnostic follow-up, and treatment. Comprehensive delivery ensures continuity of care and appropriate integration between primary medical care and oral health care.

The provision of preventive oral health services, early detection, and appropriate management of dental caries and oral diseases and conditions are critical to improving the health of children and adolescents. There is little peer-reviewed literature showing the impact of enhancing oral health integration within the health care system on the utilization of preventive oral health services among children and adolescents.[19] Some evidence suggests that certain interventions can increase the percentage of children and adolescents who receive a preventive dental visit. These include school/preschool-based interventions (e.g., school-based dental services[20]) and Medicaid reforms (e.g., increased provider reimbursement, enhanced benefits). Components of successful interventions included infrastructure enhancements (e.g., training for providers and program support staff, use of one enrollment form for medical and dental care, integrated electronic health records), community systems development (e.g., structured referrals, engaging parents and community stakeholders), and policies to address barriers (e.g., reimbursement and payment issues).

One challenge to integrating oral health services within a MCH safety net setting is determining the most effective ways to optimize the workforce in the delivery of oral health care, while minimizing disruption to other health care priorities managed at the site. This remains a significant challenge to integrating oral health services within MCH safety net settings. The NOHI Program helps address this challenge by identifying, implementing, and evaluating models of care within specific MCH safety net settings. This includes the role of primary care services and health care providers in increasing utilization rates of preventive oral health services among children.

HRSA has two primary mechanisms for increasing access to oral health care among MCH populations: 1) administering support for programs (i.e., NOHI Program) designed to implement innovations and build the evidence base around specific strategies for improving oral health, and 2) providing oral health-focused technical assistance to national, state, and local stakeholders such as Title V MCH Programs.

[18] HRSA, Oral Health, https://www.hrsa.gov/oral-health/index.html, accessed on September 10, 2018.
[19] Gauger TL, Prosser LA, Fontana M, Polverinin PJ. Integrative and collaborative care modles between pediatric oral health and primary care providers: a scoping review of literature. Journal of Public Health Dentistry 78 (2018) 246-256.
[20] Trudnak Fowler T, Matthews G, Black C, Crosby Kowal H, Vodicka P, Edgerton E. Evaluation of a Comprehensive Oral Health Services Program in School-Based Health Center. Matern Child Health J.2018 Jul;22(7):998-1007.

II. Award Information

1. Type of Application and Award

Type(s) of applications sought: New.

HRSA will provide funding in the form of a cooperative agreement. A cooperative agreement is a financial assistance mechanism where substantial involvement is anticipated between HRSA and the recipient during performance of the contemplated project.

HRSA Program involvement will include:
- Assuring the availability of HRSA personnel or designees to participate in the planning and development of all phases of this activity;
- Assisting in establishing, reviewing, and updating priorities for activities conducted under this cooperative agreement;
- Participating in planning any meetings, as appropriate, including those conducted long-distance, virtually, or in-person as part of project activities;
- Reviewing documents developed by award recipients, such as operating procedures, audiovisuals, other materials produced, and meetings planned under this cooperative agreement; and
- Assisting in the dissemination information on project activities and products.

Each cooperative agreement recipient's responsibilities will include:
- Engaging with and ensuring the participation of the HRSA Project Officer in revisions to the work plan;
- Providing the HRSA Project Officer with the opportunity to review and provide input on materials produced and meetings/conferences planned under this cooperative agreement;
- Assuring that the HRSA Project Officer will be provided an electronic copy of, or electronic access to, each product developed under this cooperative agreement;
- Developing a schedule for on-going communication among the Network members, and with the HRSA Project Officer;
- Assuring that all products developed or produced, either partially or in full, under this cooperative agreement are made fully accessible and available for free to members of the public;
- Establishing a Steering Committee (SC) that will include key individuals who can provide subject matter expertise and represent the caregivers/family members of the NOFO's target population;
- Retaining personnel in key positions and with sufficient time commitment to successfully perform the full functions of their position.
- Developing and implementing a plan to disseminate Network findings through publications and other dissemination activities such as webinars, annual Network meetings, conference presentations, and other related activities;
- Participating in the learning collaborative, virtual and annual face-to-face meeting organized by Center for Oral Health System Integration and Improvement (COHSII);
- Collaborating with COHSII in other activities outlined in this NOFO's "Purpose" section; and

- Working with the HRSA Project Officer in the collection and reporting of ongoing data such as number of participating sites,relevant outcomes.

2. Summary of Funding

HRSA expects approximately $3,850,000 to be available annually to fund three recipients. You may apply for a ceiling amount of up to $1,283,333 total cost (includes both direct and indirect, facilities and administrative costs) per year. The period of performance is September 1, 2019 through August 31, 2024 (5 years). Funding beyond the first year is subject to the availability of appropriated funds for the NOHI within the Maternal and Child Health Safety Net in subsequent fiscal years, satisfactory recipient performance, and a decision that continued funding is in the best interest of the Federal Government.

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

III. Eligibility Information

1. Eligible Applicants

Any domestic public or private entity, including an Indian tribe or tribal organization (as those terms are defined at 25 U.S.C. 450b) is eligible to apply. See 42 CFR 51a.3(a). Domestic faith-based and community-based organizations are also eligible to apply.

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. HRSA encourages you to apply through Grants.gov using the SF-424 workspace application package associated with this NOFO following the directions provided at http://www.grants.gov/applicants/apply-for-grants.html.

If you're reading this notice of funding opportunity (NOFO) (also known as "Instructions" on Grants.gov) and reviewing or preparing the workspace application package, you will automatically be notified in the event HRSA changes and/or republishes the NOFO 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 For Applicants page for all information relevant to desired opportunities.*

2. Content and Form of Application Submission

Section 4 of HRSA's *SF-424 Application Guide* provides instructions for the budget, budget narrative, staffing plan and personnel requirements, assurances, certifications, and abstract. You must submit the information outlined in the 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 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 *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, and letters of commitment and support required in the *Application Guide* and this NOFO. Standard OMB-approved forms that are included in the workspace application package do not count in the page limit. 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.

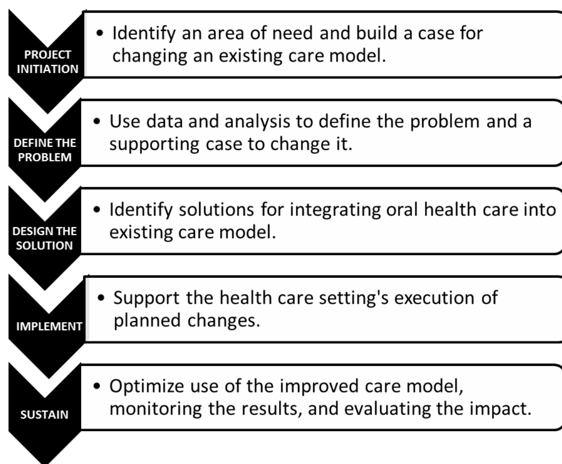
2) Failure to make required disclosures can result in any of the remedies described in 45 CFR § 75.371, including suspension or debarment. (See also 2 CFR parts 180 and 376, and 31 U.S.C. 3321).
3) Where the prospective recipient is unable to attest to the statements in this certification, an explanation shall be included in Attachments 9 - 15: Other Relevant Documents.

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

Program Description

Recipients have the latitude to use a planning framework of their choice embodying the principles, approaches, and sequencing of program activities illustrated in Figure 1[21] to guide the integration of oral health care within a MCH safety net setting. Recipients, before and during program implementation, will identify organizational and community facilitators and barriers to effectiveness, examine costs and other factors influencing decisions to adopt the model of care, and identify facilitators or barriers to widespread adoption of the model of care implemented. At the end of the funding period, recipients will have defined and fully implemented models of care that successfully integrate oral health care into MCH safety net settings - increasing access to and delivery of comprehensive, quality oral health services (preventive and/or restorative) to children and adolescents.

Figure 1: Process Flow Chart for Developing a Model of Care



Network Description

To achieve the program purpose and objectives, each recipient will establish a Network comprised of the recipient and MCH safety net sites located across four different states or jurisdictions as described in Figure 2. Each Network will select one MCH safety net setting and one target population group (specified in Table 1).

[21] A Practical Guide on How to Develop a Model of Care at the Agency for Clinical Innovation, May 2013, last accessed on July 23, 2018 at: https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0009/181935/HS13-034_Framework-DevelopMoC_D7.pdf

Each Network must have the capacity to develop, implement, and evaluate a model of care that demonstrates the integration of oral health care into a MCH safety net setting. A fully integrated model of care will exhibit the following core characteristics:

- is patient-centric;
- has localized flexibility and considers equity of access;
- supports efficient utilization of resources;
- supports safe, quality care for patients;
- has a robust and standardized set of outcome measures and evaluation processes; and
- is innovative and considers new ways of organizing and delivering care. [22]

Table 1. MCH Health Care Safety Net Settings and Target Population

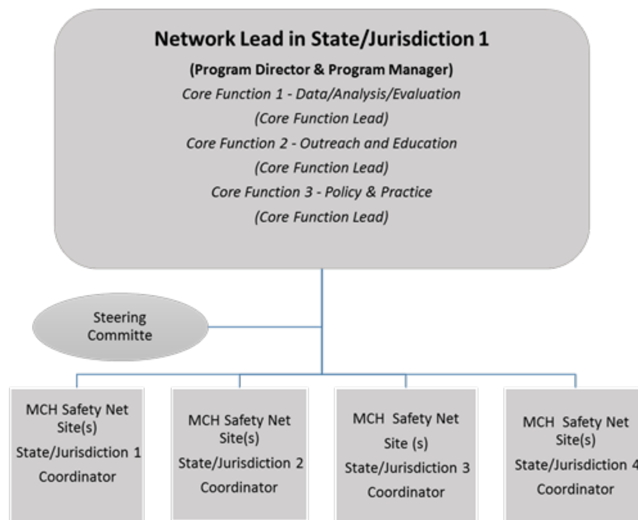
MCH Safety Net Settings	• Community health centers • Migrant health centers • School-based health centers • Rural health clinics • Tribally operated health clinics • Local health department clinics • Community and teaching hospitals • Medicaid managed care organizations
Target Population	• Infants and Toddlers (0 - 2 years) • Early childhood (3 - 5 years) • Middle childhood (6 - 11 years) • Adolescents (12 - 17 years) • Children and Youth with Special Health Care Needs

Network Core Functions

Each Network will assure the ongoing implementation of three Core Functions, each with a designated leader (i.e., the Core Function Lead):
1) Data, Analysis, and Evaluation, 2) Outreach and Education, and 3) Policy and Practice.

[22] A Practical Guide on How to Develop a Model of Care at the Agency for Clinical Innovation, May 2013,: https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0009/181935/HS13-034_Framework-DevelopMoC_D7.pdf

Figure 2 – Network Description



Core Function 1 (CF1): Data, Analysis, and Evaluation – CF1 will provide services and resources for the design of the demonstration project and plans for data collection, analysis, and evaluation.

Specifically, CF1 will facilitate each Network's expertise and assistance for:

- Developing implementation plans for demonstration project and for capturing the appropriate data,
- Identifying survey instruments that may be used across all participating sites,
- Identifying and establishing common data definitions, data methodologies, and data analyses among demonstration sites across the four states/jurisdictions,
- Identifying and selecting common measurement tools for assessing providers' knowledge and skills about the delivery of optimal oral health services,
- Identifying and selecting common measurement tools for assessing parents/caregivers knowledge and awareness about preventive oral health practices, and
- Developing evaluation plans for the Network and for documenting and reporting on the impact of the demonstration project on access and actual delivery of oral health services and the resulting oral health outcomes.

Core Function 2 (CF2): Outreach and Education – coordinates provider and parents/caregivers engagement and outreach across all sites. The aim of providers' engagement and outreach is transforming the workforce to target the population's oral health needs. Specifically, CF2 will ensure expertise and assistance for:

- Developing clear and detailed plans to identify gaps in knowledge and practices among providers and this NOFO's target population and their families related to preventive oral health services,
- Indicating how to address gaps identified related to preventive oral health services,
- Designing and implementing provider trainings that include the five domains and associated core clinical competencies for non-dental providers that HRSA published

and tested in the 2014 report, *Integration of Oral Health and Primary Care Practice*,[23] and
- Designing and implementing patient and parent/caregiver educational sessions to raise their awareness about the importance of oral health to their children's overall health and best ways to maintain a healthy mouth.

Core Function 3 (CF3): Policy and Practice - addresses policies related to oral health services at the MCH safety net setting and/or state/jurisdiction level, to improve practice standards related to services delivery and leverage Medicaid's coverage to assure mechanisms to provide reimbursement for oral health services. Required activities in support of CF3 will include:
- Conducting an environmental scan to identify factors that influence the target population's oral health at the state/jurisdiction level;
- Producing reports from the environmental scan that provide options and strategies to address access to and delivery of oral health services at the state/jurisdiction level;
- Implementing new or revised policies within participating sites to facilitate appropriate referrals between MCH safety net settings and dental care systems;
- Implementing new or revised policies within participating sites to deliver preventive oral health services in a non-dental setting; and
- Creating proposals for addressing oral health services and coverage for the target population within participating states' Medicaid system.

The Role of the State/Jurisdiction Coordinator
Each Network recipient will designate four State/Jurisdiction Coordinators to lead and monitor activities of the demonstration project across all participating MCH safety net sites in their state/jurisdiction. While this NOFO does not prescribe a specific number of MCH safety net sites to be included within each state/jurisdiction, applicants should design the project to represent a sufficient volume of pediatric patients to produce conclusive (representative) results through the demonstration project. State/Jurisdiction Coordinators, together with their Network key staff will plan, design, implement, and evaluate the demonstration project at participating sites.

Learning Collaborative Requirements
This NOFO is designed to test, evaluate and establish replicable models of care that effectively integrate the delivery of patient-centered, quality oral health services within MCH safety net settings. Therefore, all three Networks will collaborate to identify common metrics across the three demonstration projects. Each Network will also identify additional common metrics unique to their specific MCH safety net setting. These metrics will determine the model of care's effectiveness in improving access to and delivery of oral health care to the target population.

[23] U.S. Department of Health and Human Services, Health Resources and Services Administration. February 2014. *Integration of Oral Health and Primary Care*, last accessed on July 20, 2018 at: https://www.hrsa.gov/sites/default/files/hrsa/oralhealth/integrationoforalhealth.pdf

To accomplish this vision, the Networks will participate in a learning collaborative organized by the Center for Oral Health System Integration and Improvement (COHSII), which is separately funded by HRSA. Networks will agree to:

- Participate in all virtual and face-to-face sessions among the three Network recipients, focusing on building capacity around the three Core Functions.
- Participate in all virtual and face-to-face sessions among the States/Jurisdiction Coordinators, focusing on implementation of their demonstration projects.
- Provide data biannually to the collaborative on the following metrics: referrals to oral health services, types of preventive oral health services provided in clinical sites, and utilization of preventive oral health services by the target population. Test the feasibility of the MCH Oral Health Quality Indicators. These indicators, identified by COHSII, will enable the monitoring of oral health services delivered in public health programs and systems of care. The set of quality indicators are located on pages 17–19 of the document entitled, Oral Health Quality Improvement for the Maternal and Child Health Population: Identifying a Set of Quality Indicators. [24]

Steering Committee
Each Network Lead will establish a Steering Committee (SC) made up of at least five but no more than 10 members. The SC will provide input on the project direction and will participate in discussions related to the implementation of the demonstration project. The SC will meet at least annually (virtual or face-to-face) to review structure and progress of the Network and provide recommendation to the Network's Program Director. The SC will include key individuals who can provide subject matter expertise and represent the NOFO's target population and their families.

Collaboration with Other Partners
Recipients are encouraged to collaborate with other relevant programs:
1) HRSA-funded programs: Healthy Start, Maternal, Infant and Early Childhood Home Visiting, Early Childhood Comprehensive Systems, Family-to-Family Health Information Centers, the Title V Block Grant, Community Health Centers, Oral Health Workforce Development, and Rural Health Care Services Outreach.
2) HHS-funded programs: Head Start and Early Head Start.
3) Other federally funded programs: Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Award Categories
HRSA expects the NOHI Program to build the evidence base for effective, replicable models of care across diverse geographic and demographic areas. To achieve diversity in the settings included through this NOFO, HRSA will review ranked application and make one award to the top-scored application from each cluster category listed below:

Category 1
HRSA Region 1: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont
HRSA Region 2: New Jersey, New York, Puerto Rico, and Virgin Islands

[24] National Maternal and Child Center for Oral Health System Integration and Improvement (COHSII), last accessed on August 6, 2018 at:
https://www.mchoralhealth.org/PDFs/COHSII_QualityIndicatorsReport.pdf

HRSA Region 3: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia
HRSA Region 4: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee

Category 2
HRSA Region 5: Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin
HRSA Region 6: Arkansas, Louisiana, New Mexico, Oklahoma, and Texas
HRSA Region 7: Iowa, Kansas, Missouri, and Nebraska

Category 3
HRSA Region 8: Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming
HRSA Region 9: Arizona, American Samoa, California, Federated States of Micronesia, Guam, Hawaii, Nevada, Republic of Marshall Islands, Republic of Palau, and The Commonwealth of the Northern Marianna Islands
HRSA Region 10: Alaska, Idaho, Oregon, and Washington

Program-Specific Instructions
In addition to application requirements and instructions in Section 4 of HRSA's *SF-424 Application Guide* (including the budget, budget narrative, 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 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, consistent with forms and attachments, 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(a) 1 (Need)*

  1) Briefly describe the purpose of the proposed project.
  2) Describe the target population, oral health needs, problems addressed, major goals, and objectives for the project.

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

  This section will help application reviewers understand the population, MCH safety net setting, and local sites selected. Use and cite demographic data whenever possible to support the information provided.

  1) Describe and document the selected target population and its unmet oral health needs. Clearly outline the oral health needs and barriers to access in

oral health care for the group selected specific to the participating states/jurisdictions.
2) Describe the reasons for selecting the MCH safety net setting from Table 1.
3) Describe the reasons for selecting the safety net sites for the demonstration project.
4) Describe each of the participating MCH safety net sites, including how many children from the target population (Table 1) are served.
5) Describe and identify the barriers in the MCH safety net setting that the project will work to overcome.
6) Describe how the demonstration project will build upon ongoing efforts within the MCH safety net setting selected.

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

  This section will help application reviewers understand how you plan to accomplish the goals and objectives of the cooperative agreement.

  1) Describe the proposed methods that will address the stated needs and achieve the program requirements and expectations, as outlined in the Program Description above. Address how the proposed approach reflects the factors listed in the Appendix.
  2) Describe strategies to achieve the goals and objectives of this NOFO for the selected MCH safety net setting and target population group.
  3) Indicate how the size of the population served by the sites selected is robust enough to draw data-driven recommendations for replicating the model of care by the end of the project.
  4) Organize the Methodology narrative around the development and establishment of: a) the three CFs described in the Program Description above; and b) demonstration project in the four states/jurisdictions that will implement fully integrated models of care, as stated in the Program Description above.
  5) Provide a detailed description for how you intend to establish:
     - CF1: Data, Analysis, and Evaluation – include a plan for common definitions, data collection, methodologies, and analyses common to the four states/jurisdictions. You must include expertise in program evaluation and clearly detail how you will develop and support a data system, which will allow the Network to measure its progress and address the six program objectives listed in Section I of this NOFO.
     - CF2: Outreach and Education – include a description of assessments, effective tools, and strategies for outreach to providers and children's parents and families.
     - CF3: Policy and Practice – include a plan to conduct an environmental scan on oral health policies at the state/jurisdiction and local level. You should include expertise in the Medicaid system and information on Medicaid coverage for the target population in the participating states.
     - Participating MCH safety net sites – describe the administrative and program implementation relationships between the Network's three CFs and the MCH safety net sites. Describe the selection process for the MCH safety net sites and the demonstration project in the four

states/jurisdictions. Include your plan for implementation of the demonstration project at the participating sites.

- Participation in the COHSII Learning Collaborative – describe collaboration and participation in the learning collaborative organized by COHSII with the purpose of establishing common data elements across the three Networks, sharing best practices, and addressing challenges and barriers encountered by the Networks. Discuss plans to test the MCH Oral Health Quality Indicators developed by COHSII and collaborate with COHSII to achieve their program objectives listed in Section IV of this NOFO.
- Steering Committee (SC) – discuss plans for the SC to provide input to the Network. You should: 1) delineate the anticipated roles of the SC, and 2) provide a plan to select SC members after funding of the project.

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

- *WORK PLAN -- Corresponds to Section V's Review Criterion (a) 2 (Response),and 4 (Impact)*

1) Describe the activities or steps that you will use to achieve each of the objectives proposed during the entire period of performance in the Methodology section, including collaboration among all three Networks post-award.
2) Develop a timeline that links each activity to the program expectations, identifies responsible staff, and indicates progress milestones across the 5-year period of performance.
3) Identify meaningful support and collaboration with key stakeholders in planning, designing, and implementing all activities (including development of the application).
4) Submit the work plan in table format as Attachment 1. Your work plan should be operational 9 months after the initial award date.
5) Submit a logic model for designing and managing the project as Attachment 2. See Section VIII of this NOFO for guidance on designing logic models.

- *RESOLUTION OF CHALLENGES -- Corresponds to Section V's Review Criterion(a) 2 (Response)*

1) Discuss the 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.
2) Address how you intend to resolve any challenges related to selection of metrics for the project and collection of related data.
3) Address how you intend to resolve any challenges related to the level of readiness of your organization and expected partners at the state/jurisdiction level to work together to achieve the project's goal and objectives. Cite specific examples of your organization's experience in resolving such challenges, whenever possible.

- *EVALUATION AND TECHNICAL SUPPORT CAPACITY -- Corresponds to Section V's Review Criterion(a) 3 (Evaluation Measures) and 5 (Resources/Capabilities)*

  1) Describe your measurement and data strategy for collecting, analyzing, and tracking data to measure project performance, outcomes, and impact.
  2) Describe your use of data collected to inform program development and service delivery.
  3) Identify key personnel with adequate knowledge and technical capacity to perform the data collection and analysis described.
  4) Identify key personnel with adequate knowledge and expertise in program performance evaluation.
  5) Describe current experience, skills, and knowledge of staff that will implement the performance evaluation of the Network and provide technical support to participating MCH safety net sites for implementation of data collection and evaluation.
  6) Describe the systems and processes that will support your organization's performance measurement requirements through effective tracking, including a description of how your organization will collect and manage data in a way that allows for accurate and timely reporting of performance outcomes.
  7) Describe any potential obstacles for implementing the program performance evaluation and technical support to MCH safety net sites, and your plan to address these obstacles.
  8) Describe how you will collect data to report on the objectives listed in the "Purpose" section of this NOFO and those that are relevant for the integrated model of care selected.

- *ORGANIZATIONAL INFORMATION -- Corresponds to Section V's Review Criterion(a) 5 (Resources/Capabilities)*

  You will categorize the Organizational Information section of your Project Narrative into three sub-sections: Applicant Organization: Organizational Structure and Resources, State/Jurisdiction Partners, and Personnel Capacity.

  1) Applicant Organization: Organizational Structure and Resources

- Succinctly describe your organization's current mission, structure, and scope of activities. Describe how these contribute to the ability of the organization to conduct the project requirements and meet project goal and objectives.
- Demonstrate how your organization has an appropriate infrastructure to successfully implement the three (3) Core Functions of the Network Lead, as well as assure sustained engagement of the local safety net sites for the duration of the project.
- Discuss how your 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 the resources available for carrying out the project and conducting activities, including your organization's facilities and physical space,

equipment, and information technology resources.

- Submit a project organizational chart that summarizes the relationship between your organization, CFs and participating MCH safety net sites within selected states/jurisdictions as Attachment 3.

2) Local MCH Safety Net Site Partners

- Describe the administrative and organizational structure within the MCH safety net settings and its relationship to the applicant organization and CFs.
- Describe the oversight plan and frequency of communication with partners.
- Submit Letters of Agreement from the MCH safety net sites that will participate in the Network as Attachment 4, specifying the nature of their commitment to the project and indicating their ability to collect the data elements required by the project.

3) Personnel Capacity

- Submit a Staffing Plan and Job Descriptions for key personnel as Attachment 5, describing the roles and responsibilities of key personnel including, but not limited to, the Project Director, CF Leads, State/Jurisdiction Coordinators.
- Describe the function of each role represented in the project organizational chart, submitted as Attachment 5
- Demonstrate that the Project Director exhibits proven executive and leadership experience; effective management skills of multi-site project and subcontract teams; strong oral and written communication skills for a variety of audiences (professional and public); and collaborative work among peers representing a variety of organizations and disciplines.
- Demonstrate how key personnel have the required skills and expertise to perform their role effectively.
- Demonstrate significant experience with data collection and evaluation, survey methodology, and policy related to health and oral health care at the federal and state level.
- Demonstrate significant experience in running multi-site grants and/or cooperative agreements.
- Submit biographical sketches as attachment 6 for all key personnel identified in Attachment 5.

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 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 Application Guide*. Please note: the directions offered in the SF-424 Application Guide may differ from those offered by Grants.gov. Follow the instructions included in the Application Guide and the additional budget instructions provided below. A budget that follows the 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 Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019 (P.L. 115-245), Division B, § 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 Application Guide* for additional information. Note that these or other salary limitations may apply in the following FY, as required by law.

iv. Budget Narrative

See Section 4.1.v. of HRSA's *SF-424 Application Guide*.

In addition, the NOHI Program requires the following to ensure adequate staffing to manage the project.

<u>Network Level</u>

- At least 1.0 full-time equivalent (FTE) of project leadership, which can be shared between the Project Director and Project Manager with the following roles and responsibilities: 1) implementation and oversight of the Network as described in the project narrative, and 2) maintaining collaboration with the SC, key project personnel selected to lead CFs, state/jurisdiction demonstration projects, and COHSII.

- Funding for travel to:
  1) one annual learning collaborative meeting with COHSII and all Networks in the Washington DC area, to include cost of travel and lodging for Project Director, CF Leads, and State/Jurisdiction Coordinators; and
  2) one annual conference for one Network member to share accomplishments (such as National Oral Health Conference, Association of Maternal and Child Health Programs, American Public Health Association).
- Funding to host a virtual Network meeting in the second, third, and fourth year period of performance.

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
Attach the work plan for the project that includes all information detailed in Section IV. ii. Project Narrative. If you make subawards or expend funds on contracts, include in your work plan tasks to ensure proper documentation of funds.

Attachment 2: Logic Model
Attach a one-page Logic Model for the project that includes all information detailed in Section IV. ii - Project Narrative. Additional resources are in Section VIII – Other Information.

Attachment 3: Project Organizational Chart
Provide a one-page figure that depicts the organizational structure of the project.

Attachment 4: Letters of Agreement, Memoranda of Understanding, Letter of Support and/or Description(s) of Proposed/Existing Contracts (project-specific).
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. Letters of agreement need a date and signature. Letters of support must be dated and specifically indicate a commitment to the project/program (in-kind services, dollars, staff, space, equipment, etc.).

Attachment 5: Staffing Plan and Job Descriptions for Key Personnel (see Section 4.1. of HRSA's *SF-424 Application Guide)*
Limit each job description to one page in length as much as possible. Include the role, responsibilities, and qualifications of proposed project staff. Also include a description of your organization's timekeeping process to ensure that you will comply with the federal standards related to documenting personnel costs.

Attachment 6: Biographical Sketches of Key Personnel
Include biographical sketches for persons occupying the key positions described in Attachment 5, not to exceed two pages in length per person. In the event that a biographical sketch is included for an identified individual not yet hired, include a letter of commitment from that person with the biographical sketch.

Attachment 7: Tables, Charts, etc.
Include any additional tables, charts, or figures to give further details about the proposal (e.g., Gantt or PERT charts, flow charts).

Attachment 8: For Multi-Year Budgets--5th Year Budget (NOT counted in page limit),
After using columns (1) through (4) of the SF-424A Section B for a 5-year period of performance, submit the budget for the 5th year as an attachment. Use the SF-424A Section B. See Section 4.1.iv of HRSA's *SF-424 Application Guide.*

Attachments 9 – 15: Other Relevant Documents
Include any other documents that are relevant to the application.

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 the registration 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 Application Guide*.

UPDATED SAM.GOV ALERT: For your SAM.gov registration, you must submit a notarized letter appointing the authorized Entity Administrator. The review process changed for the Federal Assistance community on June 11, 2018. Read the updated FAQs to learn more.

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 *April 29, 2019 at 11:59 p.m. Eastern Time*. HRSA suggests submitting applications to Grants.gov at least **3 days before the deadline** to allow for any unforeseen circumstances. See Section 8.2.5 – Summary of emails from Grants.gov of HRSA's *SF-424 Application Guide* for additional information.

5. Intergovernmental Review

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

6. Funding Restrictions

You may request funding for a period of performance of up to 5 years, at no more than $1,283,333 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.

The General Provisions in Division B of the Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019 (P.L. 115-245) apply to this program. Please see Section 4.1 of HRSA's *SF-424 Application Guide* for additional information. Note that these or other restrictions will apply in the following FY, as required by law.

You cannot use funds under this notice for the following purposes:

Shared Staffing: If you are proposing to utilize the same director, project staff, or contractual staff across multiple awards/programs (e.g., SPRANS, Healthy Start, State Title V block grant, WIC), you must assure that the combined funding for each position does not exceed 1.0 FTE. If such an irregularity is found, funding for the Networks for Oral Health Integration within the Maternal and Child Health Safety Net will be reduced accordingly.

Shared Equipment: If you are proposing to purchase equipment which will be used across multiple awards/programs (e.g., SPRANS, Healthy Start, State Title V block

grant, WIC), you must pro-rate the costs of the equipment across programs and show the calculation in the budget justification. If an irregularity is found where the Networks for Oral Health Integration within the Maternal and Child Health Safety Net program equipment is being used by other programs without reimbursement, funding for the Networks for Oral Health Integration within the Maternal and Child Health Safety Net funding will be reduced accordingly.

Purchase of Vehicles: Projects should not allocate funds to buy vehicles for the transportation of clients, but rather to lease vehicles or contract for these services.

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. You can find post-award requirements for program income at 45 CFR § 75.307.

7. Other Submission Requirements,

Letter of Intent to Apply

The letter should identify your organization and its intent to apply, and briefly describe the proposal. HRSA will ***not*** acknowledge receipt of letters of intent. Send the letter via email by *February 25, 2019* to:

HRSA Digital Services Operation (DSO)
Please use the HRSA opportunity number as email subject (HRSA-19-053)
HRSADSO@hrsa.gov

Although HRSA encourages letters of intent, they are not required. You are eligible to apply even if you do not submit a letter of intent.

V. Application Review Information

1. Review Criteria

HRSA has 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 reviewed. HRSA has 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.

Review criteria are used to review and rank applications. The Networks for Oral Health Integration within the Maternal and Child Health Safety Net program has six review criteria:

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

1) The extent to which the application demonstrates understanding of the problem and associated contributing factors to the problem. Focus should be on the applicant's understanding of unmet oral health needs of the target population and the barriers to oral health care services.
2) The extent to which the application demonstrates the importance of the selection of states/jurisdictions and the specific MCH safety net setting.
3) The extent to which the application shows feasibility of the demonstration project to address the oral health needs of the target population.
4) The extent to which the application shows how the demonstration project builds upon ongoing efforts within the MCH safety net setting.

Criterion 2: RESPONSE (30 points) – Corresponds to Section IV's Methodology, Work Plan and Resolution of Challenges

1) Methodology (15 points)
    - The extent to which the proposed project responds to the "Purpose" section and Section IV of this NOFO.
    - The extent to which the proposed project describes the methodology to develop and implement a model of care that integrates oral health care in a MCH safety net setting.
    - *The extent to which the applicant demonstrates that the MCH safety net sites selected represent a large segment of the target population to allow for data-driven recommendations at the end of the period of performance*
    - *The extent to which the logic model presents a clear and reasonable conceptual framework for the proposed project.*
2) Work Plan (5 points)
    - The strength, completeness and clarity of the following:
        - the activities of each Core Functions,
        - oversight of the demonstration project in the states/jurisdictions
        - engagement in the learning collaborative
        - collaborations with COHSII, and
        - plans to select members of the Steering Committee.
    - The extent to which the applicant demonstrates feasibility of the work plan including experienced staff and measurable outcomes.
3) Resolution of Challenges (10 points)
    - The degree to which the applicant describes an innovative approach to address new and emerging challenges likely to be encountered in designing and implementing the model of care.

Criterion 3: EVALUATIVE MEASURES (20 points) – Corresponds to Section IV's Evaluation and Technical Support Capacity

These criteria assess the strength and effectiveness on the proposed methods to monitor performance and evaluate the project processes, performance, outcomes/results and impact. Specifically the applicant should describe:
1) The strength and effectiveness of the methods proposed to monitor and evaluate project activities, objectives, and outcomes.
2) The extent to which plans and methodology for evaluating the Network performance clearly include collection, analysis, and tracking of data to measure process and outcomes/impact.
3) The degree to which the Network Program Director demonstrates the organizational experience for data gathering procedures and analysis as they relate to a collaborative, multi-site project as required by this NOFO.
4) The degree to which the key staff involved in evaluating the Network performance demonstrates the required knowledge, skill, and experience to complete the data collection and analysis, including the provision of technical support to the participating MCH safety net sites.
5) The extent to which the performance evaluation plan uses data collected and analysis to inform program development and service delivery, including how this plan contributes to continuous quality improvement.

Criterion 4: IMPACT (10 points) – Corresponds to Section IV's Work Plan

The extent to which the proposed project has a public health impact, based on:

1) The quality of the applicant's plan for the establishment of the Network and the nature and quality of activities proposed.
2) The significance of the project in identifying a model of care in a MCH safety net setting to integrate oral health care for the target population.
3) The feasibility and effectiveness of plans for dissemination of project results.

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

The strength and completeness of the description of the applicant's ability to implement the Network, as evidenced by:

1) The organizational structure and resources that contribute to the administration of the Network and capacity for effectively testing changes to practice within the MCH safety net setting of focus.
2) The appropriateness of the project staff and proposed partners based on their training, expertise, and/or experience in running multi-site grants and/or cooperative agreements.
3) The team experience in data collection and evaluation, survey methodology, and policy related to health and oral health care at the federal and state levels.
4) The relationship between the Network and proposed partners, based on commitment from partner organization (i.e., letter of agreement).

5) The commitment from local MCH safety net sites to assure engagement throughout the duration of the demonstration project, including the ability of the safety net sites to provide data elements required by the project.

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

1) The reasonableness of the proposed budget for each year of the period of performance in relation to the objectives, the complexity of the activities, and the anticipated results.
2) The reasonableness of the proposed budget regarding travel and funding to host the virtual Network meeting.
3) The extent to which key personnel have adequate time devoted to the project to assure the Network's operation and achievement of project objectives.
4) The extent to which key staff developing and directing the program performance evaluation has adequate time devoted to this task.

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. 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 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 September 1, 2019.

VI. Award Administration Information

1. Award Notices

HRSA will issue the Notice of Award prior to the start date of September 1, 2019. See Section 5.4 of HRSA's *SF-424 Application Guide* for additional information.

2. Administrative and National Policy Requirements

See Section 2.1 of HRSA's *SF-424 Application Guide*.

Requirements of Subawards
The terms and conditions in the Notice of Award (NOA) apply directly to the recipient of HRSA funds. The recipient is accountable for the performance of the project, program, or activity; the appropriate expenditure of funds under the award by all parties; and all other obligations of the recipient, as cited in the NOA. In general, the requirements that apply to the recipient, including public policy requirements, also apply to subrecipients under awards. See 45 CFR § 75.101 Applicability for more details.

3. Reporting

The 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. The agency 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: **https://mchb.hrsa.gov/data-research-epidemiology/discretionary-grant-data-collection** (OMB Number: 0915-0298 Expiration Date: 06/30/2019).

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

1) **Progress Report(s)**. The recipient must submit a progress report to HRSA on a **biannual** basis, which should address progress toward program outcomes. 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 projects, Community Integrated Service Systems projects, and other grant/cooperative agreement programs 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 are at https://perf-data.hrsa.gov/mchb/DgisApp/FormAssignmentList/UK7_2.HTML and below.

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 Products, Publications, and Submissions Data Collection Form TA/Collaboration Form			
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 1	New	N/A	State Capacity for Advancing the Health of MCH Populations
CB 2	New	N/A	Technical Assistance
CB 3	New	N/A	Impact Measurement
CB 4	Revised	5	Sustainability
CB 5	Revised	3, 4	Scientific Publications
CB 6	New	N/A	Products
CB 7	New	N/A	State Capacity for Accessing Electronic Health Data
Life Course/ Cross Cutting			
LC 3	New	N/A	Oral Health

b) Performance Reporting Timeline

Successful applicants receiving HRSA funds will be required, within 120 days of the period of performance 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 period of performance. 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) Period of Performance End Performance Reporting

Successful applicants receiving HRSA funding will be required, within 90 days from the end of the period of performance, 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 period of performance, 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 and/or technical assistance regarding business, administrative, or fiscal issues related to this NOFO by contacting:

Ms. Ernsley P. Charles
Grants Management Specialist
Division of Grants Management Operations, OFAM
Health Resources and Services Administration
5600 Fishers Lane, Mailstop 10N146A
Rockville, MD 20857
Telephone: (301) 443-8329
Email: echarles@hrsa.gov

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

Maria Teresa Canto, DDS, MS, MPH
Dental Officer, Division of Child, Adolescent and Family Health
Attn: Funding Program
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane, Room 18N39
Rockville, MD 20857
Telephone: (301) 443-3183
Email: MCanto@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

Logic Models

You can find additional information on developing logic models 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. You can find information on how to distinguish between a logic model and work plan at the following website: http://www.cdc.gov/healthyyouth/evaluation/pdf/brief5.pdf.

Technical Assistance

HRSA has scheduled following technical assistance:

Webinar

Day and Date: Thursday, February 7, 2019
Time: 2 p.m. – 3:30 p.m.
Call-In Number: 1-888-603-9071
Participant Code: 4095307
Weblink: https://hrsa.connectsolutions.com/network_oral_integration_maternal/
Playback Number: 1-866-448-4808 | Password: 1234

Tips for Writing a Strong Application

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

APPENDIX

Factors to strengthen the MCH oral health system identified by a MCHB key stakeholder meeting held on May 30–31, 2018.

CONTEXTUALIZED INTEGRATION

- MCH oral health system and models for integration need to consider the context of an evolving healthcare system.
- Positioning oral health within primary care would ensure that oral health is a component of the overall healthcare system as that system evolves and focus concentrates on accountable care organizations.

CULTURAL COMPETENCE

- Conducting cultural assessments to ensure cultural competence, understanding the population's needs and its perspective.
- Incorporating flexibility and use of community specific approaches and strategies with involvement of key community businesses (e.g., beauty shops, barbershops) and organizations (e.g., churches).

WORKFORCE DEVELOPMENT

- PRACTICE STRUCTURE. Understanding the implications of dentists moving from individual practices into group and community practices (e.g., increasing importance of community outreach.)
- DIVERSITY. More emphasis on building a diverse practitioner workforce and developing a system where the practitioners look like and are people from the community. This should include looking at the structure of the workforce, billing processes, and who can be reimbursed (e.g., engaging alternative providers).
- EDUCATION. Curriculum reform to ensure that providers are equipped to meet the needs of their client population and understand the challenges of their clients' communities.
- CAPACITY. Increased educational debt for new providers is a significant challenge. Dental students are choosing their type of practice with debt repayment in mind (i.e., choosing fields like corporate practice where income is typically higher). This is influencing the pool of providers willing to serve patients with Medicaid and children with special needs.

BROAD ELECTRONIC HEALTH RECORD (EHR) CONNECTIVITY

- Establish an interconnected system of EHRs with common language, enabling the education and connection of providers through billing and referrals. This would include integration at hospital and emergency care centers as well.

DATA AND EVALUATION

- Improve the evidence base and mechanisms available to look at efficiency of care as well as effectiveness.
- Include a focus on developing quality improvement metrics that are tangible and easy to measure.