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

Maternal and Child Health Bureau
Division of Services for Children with Special Health Needs

Health Care Delivery System Innovations for Children with Medical Complexity

Announcement Type: New
Funding Opportunity Number: HRSA-17-100

Catalog of Federal Domestic Assistance (CFDA) No. 93.110

FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2017

Letter of Intent Due Date: December 2, 2016

Application Due Date: February 27, 2017

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Deadline extensions are not granted for lack of registration.
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may take up to one month to complete.*

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Anna Maria Padlan
Public Health Analyst
Division of Services for Children with Special Health Needs
E-mail: APadlan@hrsa.gov
Telephone: (301) 443-1737
Fax: (301) 594-0878

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

EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB) is accepting applications for fiscal year (FY) 2017 Health Care Delivery System Innovations for Children with Medical Complexity. The purpose of this funding initiative is to improve the quality of life for children with medical complexity (CMC), the wellbeing of their families, and the cost-effectiveness of their care, through development and implementation of innovative care and payment models using a Collaborative Improvement and Innovation Network (CoIIN) approach. A CoIIN is made up of teams of self-motivated individuals/organizations with a shared vision, collaborating to achieve a common goal by sharing ideas, information, and quality improvement (QI) work.

Funding Opportunity Title:	Health Care Delivery System Innovations for Children with Medical Complexity
Funding Opportunity Number:	HRSA-17-100
Due Date for Applications:	February 27, 2017
Anticipated Total Annual Available Funding:	$3,200,000
Estimated Number and Type of Award(s):	Up to one (1) cooperative agreement
Estimated Award Amount:	Up to $3,200,000 per year
Cost Sharing/Match Required:	No
Project Period:	August 1, 2017 through July 31, 2021 (four (4) years)
Eligible Applicants:	As cited in 42 CFR § 51a.3(a), any public or private entity, including an Indian tribe or tribal organization (as those terms are defined at 25 U.S.C. 450(b) is eligible to apply). Faith-based and community-based organizations are also eligible to apply. [See Section III-1 of this 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 Application Guide,* available online at http://www.hrsa.gov/grants/apply/applicationguide/sf424guide.pdf, except where instructed in this FOA to do otherwise. A short video explaining the *Application Guide* is available at http://www.hrsa.gov/grants/apply/applicationguide/.

Technical Assistance

A pre-submission technical assistance call will be held for all prospective applicants. The call will be on:
Day/Date/Time: Monday, November 28, 2016 from 2:00 – 3:00 pm ET
Call-in Number: 1-888-677-1801
Passcode: 5206602
Webinar link: https://hrsa.connectsolutions.com/cmcfoa2017/

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I. Program Funding Opportunity Description

1. Purpose

This announcement solicits applications for the 2017 Health Care Delivery System Innovations for Children with Medical Complexity cooperative agreement. Children with medical complexity (CMC), a subgroup of children and youth with special health care needs (CYSHCN), have generally been characterized as "children with substantial family-identified needs, characteristic chronic and severe conditions, functional limitations, and high health care use" (Cohen et al. Pediatrics 2011). The purpose of this initiative is to develop and implement innovative care and payment models for such children and youth using a Collaborative Improvement and Innovation Network (CoIIN) approach, which is adapted from Peter Gloor's collaborative innovation network (COIN) model (Gloor, 2006). Through collaborative learning, a CoIIN made up of teams of families of CMC, pediatric primary and specialty care clinicians, leaders of integrated health care delivery systems and/or freestanding children's hospitals, state Title V CYSHCN and Medicaid leaders, and other relevant stakeholders from participating states will work together to test strategies and build evidence for optimizing high quality, cost-effective, family-centered care for CMC.

Program Goal: The overall goal of this program is to improve the quality of life for CMC, the wellbeing of their families, and the cost-effectiveness of their care. The CoIIN model provides an infrastructure based on collaborative learning, QI, and innovation for increasing the sharing of best practices and lessons learned among a peer-to-peer framework, including stakeholders that can impact policy and practice to show measureable outcomes in a short time.

Program Objectives:
- By July 2021, increase by 50 percent from baseline (the total number of CMC in the cohort), the number of CMC reporting a single point/locus of management in a patient/family centered medical home.

- By July 2021, increase by 50 percent from baseline (the total number of CMC in the cohort), the number of CMC with shared plan of care (McAllister, J.W. 2014) due to CoIIN activities as described further down in this section.

- By July 2021, decrease by 25 percent from baseline, the number of unscheduled hospitalizations of CMC in the cohort due to CoIIN activities as described further down in this section.

- By July 2021, increase by 25 percent from baseline, the number of families of CMC in the cohort reporting unmet needs are being met due to CoIIN activities as listed further down in this section.

- By July 2021, 25 percent of participating teams will have piloted an innovative payment model.

Program Requirements:

To accomplish the program objectives, it is expected the awardee will:

- Sustain a QI quality improvement learning community to test innovative care delivery system models, develop strategies for dissemination and spread, and formulate new policies for sustaining gains attained during the project period.

- Achieve collective impact among the participating states with establishment of common aims, shared metrics and measurement systems, coordinated strategies, and continuous communication at the state level in the care and management of CMC.

The awardee of this cooperative agreement must have or demonstrate immediate capability to implement formal partnerships with organizations that represent health professionals or organizational entities that provide health care to infants, children, and adolescents; advance child health; and/or set the standards for quality child health care.

The awardee will be expected to perform the following activities:

- Establish and convene, within three (3) months of the project start date, an external advisory committee of CMC family representatives, representatives of national pediatric health professional and maternal and child health state membership organizations, national child health leaders and stakeholders with subject matter expertise to advise the awardee on technical matters relating to this funding opportunity. Areas of subject matter expertise should include patient- and family-centered care (PFCC), children with medical complexity, quality improvement (QI), systems of care for CYSHCN (*National Consensus Framework for Systems of Care for CYSHCN*, AMCHP, 2014), health care financing, health care delivery system transformation, health disparities, and evaluation. The advisory committee will provide guidance to the awardee and participating CoIIN teams on project activities, including identification of relevant standards and indicators, development of CoIIN aims, and technical content references and materials. The awardee will support the travel of the advisory committee members to at least one face-to-face meeting per year during the project period. Identify at least ten and up to twelve teams, one team per state, to participate in the CoIIN. Teams should have an identified lead and include families of CMC, pediatric primary and specialty care clinicians, leaders of integrated health care delivery systems and/or freestanding children's hospitals, state Title V CYSHCN and Medicaid leaders, and other relevant stakeholders and demonstrate readiness to implement the activities outlined within the FOA. Each participating team should target 150-300 CMC as part of their state CoIIN activities. The cohort of participating teams should reflect diversity in population, health care system structures, and geographic representation, as much as feasible.
- Funds (at least 50 percent of the annual award) will be provided by the awardee to the participating CoIIN teams to support their work, including data collection, facilitation of communication and participation of specific team members, and financial assistance for CMC family engagement and participation.
- Propose for HRSA approval potential topic areas that the teams could consider for improvement during the project period, as well as a methodology to assist the

teams in implementing/creating strategies to address the specific topics. In addition to innovative financing approaches and payment models that support integrated care systems for CMC, other potential topics include:

- o Identification of CMC and their risk stratification based on medical, psycho-social, and functional needs into criteria-based clinical groups;
- o Engagement of CMC and their families and their incorporation into meaningful partnerships and shared decision-making;
- o Mental/behavioral health care integration;
- o Information sharing across providers and care settings;
- o Use of health information technology, e.g. registry, electronic health records, m-health (using mobile devices to support medicine and public health) to facilitate coordinated care;
- o Co-management and team-based care;
- o Tracking of CMC service utilization and cost trends over time;
- o Transition of youth with medical complexity into adult care settings.

- Provide ongoing technical assistance and coaching to teams on QI and innovation through learning collaboratives. There should be an emphasis on rapid cycle testing, such as the Institute for Healthcare Improvement's Breakthrough Series (Institute for Healthcare Improvement, 2003), including demonstration of understanding the challenges teams will face in implementing rapid change, and identifying the specific technical assistance needs required to address them. The technical assistance should include how to apply QI methodologies through a CoIIN framework, the implementation of CoIIN strategies/change concepts defined by the teams, ensuring effective data collection and real-time documentation reporting on CoIIN measures, and sustaining CoIIN activities and practices. The QI methodologies should ensure effective data collection and real-time documentation of progress made through the effort.

- Convey CMC systems content and procedural expertise to the CoIIN participants.

- Assist teams with the development of proposed aims, change packages, and measures to track progress (i.e., outcome and process measures). The teams will: 1) identify achievable aims; 2) track measurable outcomes over time through the creation of run charts based on the reports fed back to them by the awardee staff; 3) identify key operational changes on site that permit the improvement in these tracking measures; and 4) test their strategies through a series of iterative plan-do-study-act (PDSA) cycles.

- Provide a web-based collaborative workspace for online communication, virtual training, data submission, and data and information sharing.

- Conduct a minimum of four in-person learning sessions for teams to share achievements and challenges with one another. Awardee will support the travel of five to seven members, including at least one family representative from each team, to attend the learning sessions.

- Support spread of successful innovation tools, processes, and models among CoIIN participants.

- Develop, propose for HRSA approval, and implement a plan to evaluate CoIIN processes.

- Provide to HRSA reports summarizing achievements of the CoIIN, detailing processes and elaborating on tools and strategies that can be supported by public/private insurance and sustained in the health care delivery system.
- Develop and propose for HRSA approval a plan for dissemination of successful innovations to other states and jurisdictions and stakeholders.

Benchmarks:
The benchmarks that the awardee should meet during the project period include:

Year 1
1. Convene an expert committee of national stakeholders.
2. Orient teams to CoIIN and QI methodologies.
3. Develop collaborative charter, change package(s), CoIIN aims.
4. Identify shared measures and methods for collection and analysis of data, including financing data.
5. Establish evaluation criteria for CoIIN processes.

Years 2 and 3
1. Establish enhanced and improved partnerships, coordination, and communication among members of the teams and their respective entities.
2. Develop measurement system and participant tracking, coordination, and integration.
3. Develop QI systems and protocols.
4. Develop internal data system to track participant progress and activities.
5. Conduct ongoing monitoring on CoIIN process.
6. Evaluate improvements in participant QI skills, data reporting timelines, and structural/process measures.

Year 4
1. Implement changes in policy/procedures/processes among the participating state entities and organizations for facilitating a cost-effective system of care for CMC.
2. Identify successful innovations (e.g. tools and mechanisms to facilitate real-time communication with families and all providers and transition across settings; appropriate transfer of information and accountability among providers).
3. Disseminate and make available information (e.g., "Playbook", technical content, PDSA cycle reports, and webinars).
4. Identify strategies for sustaining and scaling of successful changes.
5. Increase understanding of the unique challenges and care delivery approaches that result in improved health and cost savings for CMC.
6. Increase knowledge of how value can be defined and measured for CMC.
7. Develop a review of the innovative payment models piloted by the participating teams and an economic assessment of the payment models that can support integrated care for CMC.

2. Background

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

The Population: Approximately 3 million of the 76 million children in the United States are considered to be CMC; this number is increasing at a rate of about 5 percent annually (Children's Hospital Association, 2016). While their number is small, CMC have disproportionately high acute care utilization and account for as much as one-third of health care spending for all children (Olson, LPFCH 2015). "In children's hospitals, CMC account for 55 percent of hospital cost for all admissions and 85 percent of cost for 30-day unplanned hospital admissions" (Olson, LPFCH 2015). An increasingly larger number of CMC rely on the Medicaid and CHIP programs for insurance coverage. The latest data indicate two-thirds of CMC currently are insured by Medicaid. They constitute 6 percent of the total number of children on Medicaid while accounting for 40 percent of Medicaid's total spending on children (Children's Hospital Association, 2016) and 50 percent of Medicaid's spending on hospital care for all children (Berry et al, Health Affairs 2014).

Multiple studies of CMC indicate that these are the children most likely to have unmet healthcare needs as well as being at greater risk for adverse medical, developmental, psychosocial, and familial outcomes (Kuo et al, Health Affairs 2014). In addition, the responsibility of caring for CMC has been noted to adversely impact the health, employment, finances, and relationships of families and/or caregivers of CMC (Kuo et al, Pediatr Adolesc Med 2011). Families of CMCs desire access to effective and timely medical care, including rehabilitation and palliative services; care coordination; communication between providers with the aim of reducing travel and duplicative services and appointments; navigation through different components of the health care system, support for multiple community-based therapists; and access to specialized community services (Olson, LPFCH 2015). Beside the need for access to coordinated care, families also want family-centered care in a setting where the family's expertise is respected, they are treated as an active member of the care team, and are engaged as full partners with shared decision-making that addresses their child's and family's needs (Olson, LPFCH 2015).

The System of Care: The current health care system is not necessarily designed to serve the growing number of children with medical complexity. CMC frequently require services that extend beyond what is covered by Medicaid. Even when the services are covered, the payments for delivered care may not be adequate (Berry, JAMA Pediatrics 2013; Olson, LPFCH 2015). At the same time, the patient/family-centered medical home model of accessible, comprehensive, and coordinated care promoted for all children is not necessarily available to CMC because of 1) acute shortages of community-based pediatric clinicians to provide home and post-acute care (Berry et al, Health Affairs 2014); 2) limited time and capacity on the part of pediatric primary care clinicians (Agrawal R, Shah P, et al. Clin Pediatr. 2012; 51(1):39-45); and 3) limited experience on the part of clinicians in managing the variety and complexity of health issues of CMC (VanCleave et al, Acad Pediatr 2015).

Fee-for-service payment models that have traditionally financed care for this population are likely not sustainable due to the increased number of CMC and the increased expenditure associated with the population. As recent health care payment and policy initiatives such as moving CMC into Medicaid managed care arrangements and health care value-based purchasing continue to gain momentum, they have the potential to significantly impact the structure and quality of care for this population of children. At the same time, value-based purchasing models advanced by the Affordable Care Act and the Medicare Access and CHIP Reauthorization Act offer opportunities for investments in system improvement and capacity building, including registries to track population health, QI strategies, team-based care, and alignment of payments around shared accountability for outcome and cost.

Interventions: Interventions that decrease the costs associated with avoidable health care utilization and improved care management for this vulnerable group of children are now emerging. For example, some children's hospitals have developed dedicated structured clinical programs to meet the need for coordinated care management for CMC. For the most part these programs offer intensive case management and care coordination to connect these children with the requisite services, e.g. pharmacy and home health care supplies, rehabilitation services (Cohen et al, Arch Pediatr Adolesc Med 2011). While these hospital structured care programs have the advantages of dedicated medical expertise in complex care and proximity to subspecialists, they have not yet consistently assumed the responsibility for the child's primary care needs or provide services in a location that is easily accessible to families.

Other models of care coordination and/or case management exist, including state-level case management provided by state Title V CYSHCN programs or Medicaid managed care contracts, onsite care coordinators in pediatric primary care and specialty practices, or care coordination provided by an integrated healthcare delivery system (Olson S, LPFCH 2015).

The Approach: What CMC need is a more robust model of care embracing a system of care approach that organizes services into a "coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life" (Stroul, B., Blau, G., & Friedman, R. 2010). The systems of care approach should be comprehensive: addressing the physical, emotional, and social needs of the child, providing developmentally appropriate services, coordinating care across health settings and disciplines, and effecting successful transition from pediatric to adult care. Such a model would facilitate meaningful family engagement at all levels of the health and health care system – from direct care, organizational design and governance, to policymaking. Implementing the appropriate level of family engagement for CMC and their families could result in improved health outcomes, increased physical and emotional function, a smoother transition from pediatric to adult health care system, cost savings, etc., and improved care coordination across systems.

The innovative care model would facilitate access to and coordination of the full array of multi-disciplinary services, including mental and behavioral health services, and cultivate family support required to meet the extensive needs of CMC. This can be accomplished through the patient/family-centered medical home or health home

approach to comprehensive care that aims to integrate care vertically in order to coordinate providers across settings and disciplines with horizontal integration, i.e. connecting the health care system with other systems that interact with the child and family, e.g. child care, schools, social services, and public health agencies.

Ideally, the cross-systems model should effect positive family-provider relations, meet the medical and psychosocial needs of child and family in a timely manner, and result in positive family/child outcomes. For example, models utilizing tertiary care community based partnerships in care coordination/care integration have demonstrated positive effects, including decreased hospital admissions and shorter inpatient stays, improved family well-being, and cost savings (Cohen et al, BMC 2012) (Palfrey et al, Pediatrics 2004) (Gordon et al, Arch Pediatr Adolesc Med 2007). Additional assessment of integrated care models is currently underway in a Center for Medicare and Medicaid Innovation demonstration project involving multiple children's hospitals across the nation (Children's Hospital Association, 2016).

We propose to utilize the Collaborative Innovation and Improvement Network (CoIIN) methodology to convene teams of families of CMC, pediatric clinicians, state Title V CYSHCN program and Medicaid leaders, and leaders from integrated care delivery systems and freestanding children's hospitals, to work together to test and adopt innovative models to drive improvements in the health care system serving CMC. By bringing together public and private stakeholders involved in the care of CMC, it is anticipated this funding opportunity will identify strategic approaches and develop resources useful for improving the quality and experience of care for CMC and their families. The focus of the CoIIN on the development of models rooted in a foundation of family-centered care will ideally result in approaches for more effective utilization of health care resources for CMC.

Maternal and Child Health Bureau
MCHB is a component of HRSA within the U.S. Department of Health and Human Services (HHS). Since its inception, Maternal and Child Health (MCH) services awards have provided a foundation for ensuring the health of our nation's mothers and children. The mission of MCHB is to provide national leadership in partnership with key stakeholders, to reduce disparities, assure availability of quality care, and strengthen the nation's MCH/public health infrastructure in order to improve the physical and mental health, safety and well-being of the MCH population. MCHB recently revised its national performance measure (NPM) framework that focuses on the establishment of a set of population-based measures. The 15 NPMs address key national MCH priority areas that represent the following six MCH population domains:
(1) Women/Maternal Health; (2) Perinatal/Infant Health; (3) Child Health; (4) Children and Youth with Special Health Care Needs (CYSHCN); (5) Adolescent Health; and
(6) Cross-cutting or Life Course. Learn more about the MCHB and the six MCH population domains at http://mchb.hrsa.gov.

The Division of Services for Children with Special Health Needs
The Omnibus Budget Reconciliation Act of 1989, Public Law 101-239 amended Title V of the Social Security Act to extend the authority and responsibility of MCHB to address the core elements of community-based systems of services for CYSHCN and their families. With this amendment, state Title V programs under the MCH Services Block

Grant program were given the responsibility to provide and promote family-centered, community-based, coordinated care for CYSHCN and facilitate the development of community-based systems of services for such children and their families. CYSHCN are defined as "those children and youth who have or are at increased risk for chronic physical, developmental, behavioral or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally." (McPherson, et al, 1998)

According to the National Survey of Children with Special Health Care Needs (2009/2010), 15.1 percent of children under 18 years of age in the United States, or approximately 11.2 million children, are estimated to have special health care needs. Overall, 23 percent of U.S. households with children have at least one child with special health care needs.

Through award initiatives, DSCSHN works to achieve the following six critical systems outcomes:
1) Family/professional partnership at all levels of decision making.
2) Access to coordinated ongoing comprehensive care within a medical home.
3) Access to adequate private and/or public insurance and financing to pay for needed services.
4) Early and continuous screening for special health needs.
5) Organization of community services for easy use.
6) Youth transition to adult health care, work, and independence.

II. Award Information

1. Type of Application and Award

Type(s) of applications sought: New

Funding will be provided in the form of a cooperative agreement. A cooperative agreement, as opposed to a grant, is an award instrument of financial assistance where substantial involvement is anticipated between HRSA and the recipient during performance of the contemplated project.

As a cooperative agreement, **HRSA Program involvement will include**:
- Making available the services of MCHB personnel as participants in the planning and development during the period of the cooperative agreement;
- Continuous review of the activities, data, measures, and tools designed and implemented to accomplish this initiative;
- Participating, when appropriate, in meetings, conference calls, and learning sessions conducted during the period of the cooperative agreement;
- Participating in all major areas of the CoIIN – selection and development of teams, coordination and alignment, training and facilitation, QI processes, development of indicators, and dissemination and spread;

- Participating in reviewing topic areas for targeted improvement, planning for the project, facilitating collaboration with successful applicants and selected teams, and facilitating involvement of expert faculty and partner organizations;
- Reviewing and editing, as appropriate, written documents developed by the recipient including documentation of pre-work, learning sessions, white papers and evaluation reports;
- Participating with the recipient in the dissemination of project findings, best practices, and lessons learned from the CoIIN, and in producing and jointly reviewing reports, articles, and/or presentations developed under this FOA; and
- Assisting in the establishment of federal and state interagency partnerships, collaboration, and cooperation that may be necessary for carrying out the project.

The cooperative agreement recipient's responsibilities will include:
- Producing, including publishing articles, and disseminating materials; and adhering to HRSA guidelines pertaining to acknowledgement and disclaimer on all products produced by HRSA award funds (see Acknowledgement of Federal Funding in Section 2.2 of HRSA's *SF-424 Application Guide*);
- Completing activities proposed in response to the project requirements and scope of work;
- Developing and maintaining a website;
- Providing leadership, in collaboration with MCHB, in data collection;
- Analyzing evidence-based data, impact and QI data, and any relevant data trends;
- Collaborating with MCHB on ongoing review of activities, budget items, procedures, information/publications prior to dissemination, contracts and interagency agreements through conference calls and/or face-to-face meetings;
- Convening and leading a minimum of four face-to-face sessions during the project period for the participating teams;
- Planning and implementing the CoIIN processes among teams, including the provision of technical assistance, coaching, and learning sessions; and
- Participating in face-to-face meetings and conference calls with HRSA conducted during the period of the cooperative agreement.

2. Summary of Funding

Approximately $3,200,000 is expected to be available annually to fund one (1) recipient. You may apply for a ceiling amount of up to $3,200,000 per year. The actual amount available will not be determined until enactment of the final FY 2017 federal budget. This program announcement is subject to the appropriation of funds, and is a contingency action taken to ensure that, should funds become available for this purpose, applications can be processed, and funds can be awarded in a timely manner. The project period is August 1, 2017 through July 31, 2021 (four (4) years). Funding beyond the first year is dependent on the availability of appropriated funds for the Health Care Delivery System Innovations for Children with Medical Complexity program in subsequent fiscal years, satisfactory recipient performance, and a decision that continued funding is in the best interest of the Federal Government.

Effective December 26, 2014, all administrative and audit requirements and the cost principles that govern federal monies associated with this award are subject to the Uniform Guidance 2 CFR part 200 as codified by HHS at 45 CFR part 75, which supersede the previous administrative and audit requirements and cost principles that govern federal monies.

III. Eligibility Information

1. Eligible Applicants

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

Foreign entities are not eligible for HRSA awards, unless the authorizing legislation specifically authorizes awards to foreign entities or the award is for research. This exception does not extend to research training awards or construction of research facilities.

2. Cost Sharing/Matching

Cost sharing/matching is not required for this program.

3. Other

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

Any application that fails to satisfy the deadline requirements referenced in *Section IV.4* will be considered non-responsive and will not be considered for funding under this announcement.

NOTE: Multiple applications from an organization are not allowable. However, organizations have the ability to come together as a consortium to submit a joint application for this cooperative agreement. The application must identify the lead organization as the proposed award recipient, and additional information on the partner organization(s) must be included in the Work Plan, Evaluation, and Technical Capacity, and Organizational Information sections of the Project Narrative. Each consortium member must demonstrate substantial involvement in the project and contribute significantly to the goals of the project. The roles and responsibilities of each consortium member must be clearly defined in a proposed Memorandum of Understanding/Agreement (MOU/A). The proposed MOU/A must be supported in writing by all consortium members and submitted as Attachment 4.

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* applicants for this FOA to apply electronically through Grants.gov. You must download the SF-424 application package associated with this FOA following the directions provided at http://www.grants.gov/applicants/apply-for-grants.html.

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 FOA to do otherwise.

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 FOA. Standard OMB-approved forms that are included in the application package are NOT included in the page limit. Indirect Cost Rate Agreement and proof of non-profit status (if applicable) will not be counted 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 the announcement.

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) Where the prospective recipient is unable to attest to any of the statements in this certification, such prospective recipient shall attach an explanation to this proposal.

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

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), please 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 and well organized so that reviewers can understand the proposed project.

Use the following section headers for the Narrative:

- *INTRODUCTION -- Corresponds to Section V's Review Criteria 1 (Need) and 5 (Resources/Capabilities)*
  This section should briefly describe the purpose of the proposed project. Clearly identify the target population of children with medical complexity as a distinct subgroup of CYSHCN and the system of care which serves these children. Include a discussion that exhibits a solid understanding of the CoIINs. Demonstrate understanding of CMC issues, population health, child health care delivery system, the QI processes, different QI models, and the principles of collaborative learning.

- *NEEDS ASSESSMENT -- Corresponds to Section V's Review Criterion 1 (Need)*
  The target population and its unmet health needs must be described and documented in this section. You must demonstrate your understanding of the population of CMC and their families as well as the current system of care for CMC, including the structure and financing of the current child health care delivery system as well as the barriers to integrated service delivery. Demonstrate knowledge of current strategies and investments at the federal, state and foundation level in this population, as well as relevant and available system process and outcome measures for assessing the value of care for CMC. Please discuss any relevant barriers and gaps in the health care delivery system for CMC that the project hopes to overcome. This section will help reviewers understand the health care delivery system for CMC that the project proposes to impact. Address socio-cultural determinants of health and health disparities impacting the population or communities served and unmet needs. Data should be used and cited whenever possible to support the information provided.

- *METHODOLOGY -- Corresponds to Section V's Review Criteria 2 (Response), 3 (Evaluative Measures) and 4 (Impact)*
  Propose methods that will be used to address the stated needs and meet each of the previously described program requirements and expectations in this FOA. Any innovative approaches should be included in the methods. The description of the project methodology should extend across the four years of the project effort. Account for the differences in teams participating in the CoIIN who represent distinct state or territory based ecosystems, with variations in managed care

penetration, availability of specialty care, family engagement, Medicaid and CHIP coverage, as well as differing demographics, resources, and geography.

The CoIIN model provides an infrastructure based on collaborative learning, QI, and innovation for increasing the sharing of best practices and lessons learned among a peer-to-peer framework, including stakeholders that can impact policy and practice to show measureable outcomes in a short time.

Describe the methods for addressing collaborative learning, innovation, and QI aspects of the CoIIN project as requested below:

Method #1 – Collaborative Learning: Identify, Scale, and Spread What Works The CoIIN will scale-up and/or spread interventions or strategies that will improve care by providing opportunities for collaborative learning and action across states, across sectors, and among many partners.

Describe in detail how you will:
1) Identify and convene an external advisory committee of CMC family representatives, representatives of national pediatric health professional and maternal and child health state membership organizations, national child health leaders and stakeholders with subject matter expertise for the project within three (3) months of the project start date. The advisory committee will review progress and provide guidance to the awardee and participating teams throughout the course of the project period on matters including: the identification of relevant standards and indicators, the development of CoIIN aims, and technical content references and materials. Areas of expertise must include: patient- and family-centered care (PFCC), CMC, quality improvement, systems of care for CYSHCN (ref National Consensus Framework for Systems of Care for CYSHCN, AMCHP), health care financing, health care delivery system transformation, health disparities, and evaluation. Convene at least one face-to-face meeting for the expert committee per year during the project period.
2) Identify one cohort of at least ten and up to twelve teams, one team per state, to participate in the CoIIN. Teams should have an identified lead and include families of CMC, pediatric primary and specialty care clinicians, leaders of integrated health care delivery systems and/or freestanding children's hospitals, state Title V CYSHCN and Medicaid leaders, and other relevant stakeholders, including public/private insurance. Each selected team should target 150-300 CMC as part of their state CoIIN activities. The cohort of teams selected should reflect diversity in population, health care system structures and geographic representation, as much as feasible. Submit proposed MOUs, or at a minimum letters of intent, from the selected states as Attachment 4.
3) Provide details on the recruited teams, including funding arrangements and a proposed timeline for working with the teams. In the work plan section, indicate what the role will be for each of the different team members. Discuss who was recruited for the teams, each team members' role (i.e. fiduciary, leader, etc.), and how to ensure buy-in from the team members to

remain engaged in the CoIIN throughout the project period (i.e., MOUs verses letters of support, tangible evidence of participation, etc.).

4) Describe a plan to dedicate at least 50 percent of the annual funding to the participating teams to support the work of the teams, including data collection, facilitation of communication and participation of specific team members, and financial assistance for CMC family/caregiver involvement/engagement.

5) Describe a plan to conduct and share an environmental scan of the system of care for CMC in the participating states which identifies common and unique strengths and challenges among the cohort.

6) Support the spread of successful innovation tools, processes, and models among CoIIN participants, and develop a plan for dissemination of successful innovations to other non-participating states/territories, jurisdictions and stakeholders. All awardee products including, but not limited to, guidelines, publications, books, pamphlets, slide sets, CD ROMS, curricula, assessment tools, videos, toolkits, and guidance documents, will be coordinated by the program coordinating center and made available to the general public.

Data Rights

All publications the cooperative agreement recipient develops or purchases with funds awarded under this announcement must be consistent with the requirements of the program. Pursuant to 45 CFR § 75.322(b), the cooperative agreement recipient owns the copyright for materials that it develops under this cooperative agreement, and HHS reserves a royalty-free, nonexclusive, and irrevocable right to reproduce, publish, or otherwise use those materials for federal purposes, and to authorize others to do so. In addition, pursuant to 45 CFR § 75.322(d), the Federal Government has the right to obtain, reproduce, publish, or otherwise use data produced under this cooperative agreement and has the right to authorize others to receive, reproduce, publish, or otherwise use such data for federal purposes, e.g., to make it available in government-sponsored databases for use by other researchers. The specific scope of HRSA rights with respect to a particular grant award-supported effort will be further addressed in the Notice of Award (NoA). Data and copyright-protected works developed by a sub-recipient also are subject to the Federal Government's copyright license and data rights.

7) Assist teams with developing a plan to sustain the key elements which have been effective in improving practices and those that have led to improved outcomes for children with medical complexity, after the period of federal funding ends.

Method #2 – Innovation: Build/Refine the Evidence, and Quality Improvement: Close the Gap Between What We Know Works and What We Do

The CoIIN will support innovation and promote/facilitate the development of strategies that will improve the quality of life for CMC (i.e., building the evidence of what works; discovering if known interventions work in all communities/populations, etc. – "precision public health"). The CoIIN will support QI efforts by providing guidance, training, and technical assistance to the teams on the effective use of collaborative learning approaches as well as QI principles and practices.

Describe in detail how you will:
1) Provide training, guidance, technical assistance, and coaching to teams on innovation, as necessary.
2) Develop a plan for conducting in-person learning sessions, including a budget for travel stipends for five to seven members including at least one family member, from each participating team.
3) Develop a plan to provide ongoing technical assistance and coaching to teams on QI and innovation. There should be an emphasis on rapid cycle testing, including demonstration of understanding the challenges teams will face in implementing rapid change, and identifying the specific technical assistance needs required to address them. This technical assistance should include how to apply QI methodologies through a CoIIN framework, the implementation of CoIIN strategies/change concepts defined by the teams, ensure effective data collection and real-time documentation reporting on CoIIN measures, and sustaining CoIIN activities and practices. Strategies in the work plan should reflect the needs and challenges that have been identified.
4) Provide assistance to the teams with the development of aims, change packages, and measures to track progress (i.e. outcome and process measures) on potential topic areas, in addition to innovative financing approaches and payment models, such as identification of CMC and their risk stratification based on medical and psycho-social needs, engagement of CMC and their families and their incorporation into meaningful partnerships and shared decision making, transition from pediatric to adult care systems, and information sharing across providers and care settings. The work of the teams should align with the objectives of the Medicare Access and CHIP Reauthorization Act of 2015. The teams should identify achievable aims, track measurable outcomes over time, identify key operational changes, and test strategies through a series of plan-do-study-act cycles.
5) Develop and implement a measurement system to evaluate CoIIN processes, QI, and performance measures, including describing data sources, evaluation methods, and how the evaluation findings will be shared throughout the project. Performance measures used should be meaningful to patients, families, providers, and public/private insurance (e.g. use of services, cost date). Explain how the data will be used for QI, inform program development and service delivery, and influence policy changes. You must describe any potential obstacles for implementing the program performance evaluation and how those obstacles will be addressed.
6) Discuss how data will be collected at the family, provider, and plan levels.

7) Propose a plan identifying, selecting, and managing a web-based collaborative workspace to facilitate the collaboration of participating teams. This web based collaborative workspace must have the capabilities for virtual training, data submission and management, and data and information sharing among the teams. Teams should be permitted to conduct QI in different ways as long as they are using real-time data, and the data can be evaluated similarly across all teams.

▪ *WORK PLAN -- Corresponds to Section V's Review Criteria 2 (Response) and 4 (Impact)*
Describe the activities or steps that will be used to achieve each of the activities proposed in the Methodology section over the entire project period. Use a timeline 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.

Submit a logic model for designing and managing the project (Attachment 1). 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 announcement the logic model should summarize the connections between the:
  • Goals of the project (e.g., objectives, reasons for proposing the intervention, if applicable);
  • Assumptions (e.g., beliefs about how the program will work and is supporting resources. Assumptions should be based on research, best practices, and experience.);
  • Inputs (e.g., organizational profile, collaborative partners, key staff, budget, other resources);
  • Target population (e.g., the individuals to be served);
  • Activities (e.g., approach, listing key intervention, if applicable);
  • Outputs (i.e., the direct products or deliverables of program activities); and
  • Outcomes (i.e., the results of a program, typically describing a change in people or systems).

▪ *RESOLUTION OF CHALLENGES -- Corresponds to Section V's Review Criterion 2 (Response)*
Discuss challenges that are likely to be encountered in designing and implementing the activities described in the work plan, and approaches that will be used to resolve such challenges. In particular, discuss challenges with processes for maintaining engagement of CoIIN participants, and how to evaluate various team QI processes using the same measures.

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

Describe the plan for the program performance evaluation that will assess whether the proposed project activities were implemented and improvements occurred as intended. The program performance evaluation should monitor ongoing processes and the progress towards the goals, objectives, and benchmarks of the project as listed under the Purpose section, including how to address the system, clinic, and family level indicators listed below.

System Level
- Increases in partnerships/collaborations among stakeholders across groups, organizations, systems
- Increases in QI processes
- Increases in knowledge and incorporation of evidence-based interventions and system standards
- Increases in sharing of resources and data across systems

Clinic Level
- Increases in number of CMC with shared plan of care (McAllister, J.W. 2014)
- Increases in number of co-management arrangements between the CMC's medical home and subspecialists
- Increases in number of CMC with identified single point/locus of management
- Decreases in number of unscheduled hospitalizations of CMC

Family Level
- Decreases of family/caregiver burden
- Increases in number of families of CMC reporting unmet needs are being met
- Increases in family/caregiver participation in QI processes
- Increases in level of engagement of CMC and their families and their incorporation into meaningful partnerships and shared decision making

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. Emphasis should be on experience related to managing collaboratives, data collection, providing technical assistance, creating technical assistance modules and materials. Describe how project personnel are qualified by training and/or experience to provide quality technical support.

Provide information on the hardware and software tools that will be used to store and analyze data and to store documents or tools created by the participants of the project. Describe a data collection plan including how data will be collected from the participating teams, and report the findings on an annual basis. Provide an evaluation plan that will measure the progress and results of the project and its potential for spread and dissemination to other sites. Describe any potential obstacles anticipated for planning and executing the implementation evaluation and how those obstacles will be addressed.

At the end of the project, in addition to a review of the innovative payment models piloted by the participating teams and an economic assessment of the payment models that can support integrated care for CMC, the awardee will be expected to prepare and present a report summarizing findings, lessons learned, best practices, recommendations, and recommend next steps. The report should summarize achievements of the CoIIN, detailing processes and elaborating on tools and strategies that can be supported by public/private insurance and sustained in the health care delivery system.

- ▪ *ORGANIZATIONAL INFORMATION -- Corresponds to Section V's Review Criterion 5 (Resources/Capabilities)*
  Provide information on your organization's current mission and structure, scope of current activities, and an organizational chart, and describe how these all contribute to the ability of the organization to conduct the program requirements and meet program expectations. Provide information on the program's resources and capabilities to support provision of culturally and linguistically competent and health literate services. Provide information regarding past participation and/or leadership as part of a consortium related to CYSHCN and QI. Discuss the expertise of staff as it relates to the scope of the work proposed, including experience in collaborating with families of CMC, pediatric care clinicians, leaders of integrated health care delivery systems and/or freestanding children's hospitals, and state Title V CYSHCN and Medicaid leaders. Discuss the experts on child health care delivery system, care and financing for CMC, and patient/family-centered care that are available within core staff and not through consultants. This can include both applicant and partners/collaborators. Describe experience in developing and disseminating informational materials and participation in QI efforts, and provision of training on the QI process. In the case of a consortium, identify the lead organization, describe the roles and responsibilities of each member of the consortium, and discuss how the consortium will operate.

NARRATIVE GUIDANCE	
In order to ensure that the Review Criteria are fully addressed, 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, (5) Resources/Capabilities
Needs Assessment	(1) Need
Methodology	(2) Response, (3) Evaluative Measures, and (4) Impact
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. Please follow the instructions included in the Application Guide and, *if applicable*, the additional budget instructions provided below.

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, 2016, Division H, § 202, (P.L. 114-113) 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." Please 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 FY 2017, as required by law.

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

In addition, the Health Care Delivery System Innovations for Children with Medical Complexity program requires the following:

At least 50 percent of the annual funding award is to be dedicated towards supporting the work of the teams, including data collection, facilitation of communication and participation of specific team members, and financial assistance for CMC family involvement/engagement. Each team can be awarded at least $135,000 annually, as determined by the teams' needs.

v. Program-Specific Forms

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

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

2) *Performance Measures for the* Health Care Delivery System Innovations for Children with Medical Complexity Program

To inform successful applicants of their reporting requirements, the listing of MCHB administrative forms and performance measures for this program can be found in Section "VI. Award Administration Information" of this FOA.

NOTE: The performance measures and data collection information is for your PLANNING USE ONLY. These forms are not to be included as part of this application.

vi. Attachments

Please 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. **Each attachment must be clearly labeled**.

Attachment 1: Work Plan
Attach the work plan for the project that includes all information detailed in Section IV. 2. ii. Project Narrative. Also include the required logic model in this attachment.

Attachment 2: Staffing Plan and Job Descriptions for Key Personnel (see Section 4.1. of HRSA's *SF-424 Application Guide)*
Keep each job description to one page in length as much as is possible. Include the role, responsibilities, and qualifications of proposed project staff.

Attachment 3: Biographical Sketches of Key Personnel
Include biographical sketches for persons occupying the key positions described in Attachment 2, not to exceed two pages in length per person. In the event that a biographical sketch is included for an identified individual who is not yet hired, please include a letter of commitment from that person with the biographical sketch.

Attachment 4: Letters of Agreement and/or Description(s) of Proposed/Existing Contracts (project-specific) including Memoranda of Understanding
Provide any documents that describe working relationships between your organization and other entities and programs cited in the proposal, including partnerships with stakeholders, consortium partners (if applicable), and identified states. Documents that confirm actual or pending contractual agreements should clearly describe the roles of the contractors and any deliverable. Letters of agreement must be dated.

Attachment 5: Project Organizational Chart
Provide a one-page figure that depicts the organizational structure of the project.

Attachment 6: Tables, Charts, etc.
To give further details about the proposal (e.g., Gantt or PERT charts, flow charts, etc.).

Attachments 7 – 15: Other Relevant Documents
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 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*.

Applicants that fail to allow ample time to complete registration with SAM or Grants.gov 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 FOA is February 27, 2017 *at 11:59 P.M. Eastern Time*.

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

5. Intergovernmental Review

The Health Care Delivery System Innovations for Children with Medical Complexity Program is not a program 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 Application Guide* for additional information.

6. Funding Restrictions

You may request funding for a project period of up to four (4) years, at no more than $3,200,000 per year. Awards to support projects beyond the first budget year will be contingent upon Congressional appropriation, satisfactory progress in meeting the project's objectives, and a determination that continued funding would be in the best interest of the Federal Government.

Funds under this announcement may not be used for the following purposes:
   1) To provide payments for clinical services
   2) To purchase service delivery equipment (i.e., telemedicine)

The General Provisions in Division H of the Consolidated Appropriations Act, 2016 (P.L. 114-113) 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 FY 2017, 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 the all federal funding requirements and prohibitions such as lobbying, gun control, abortion, etc. 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.

7. Other Submission Requirements

Notification of Intent to Apply
A Letter of Intent is strongly encouraged. You are eligible to apply even if no letter of intent is submitted. The letter should identify your organization and its intent to apply, and briefly describe the proposal to be submitted. Receipt of Letters of Intent will ***not*** be acknowledged.

This letter should be sent via e-mail by December 2, 2016*,* to:

   HRSA Digital Services Operation (DSO)
   Please use HRSA opportunity number as e-mail subject (HRSA-17-100)
   HRSADSO@hrsa.gov

V. Application Review Information

1. Review Criteria

Procedures for assessing the technical merit of applications have been instituted to provide for an objective review of applications and to assist you in understanding the standards against which your application will be judged. Critical indicators have been developed 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. Review criteria are outlined below with specific detail and scoring points.

These criteria are the basis upon which the reviewers will evaluate the application. The entire proposal will be considered during objective review.

Review criteria are used to review and rank applications. The Health Care Delivery System Innovations for Children with Medical Complexity Program has six (6) review criteria:

Criterion 1: NEED (5 points) – Corresponds to Section IV's Introduction and Needs Assessment

The extent to which the applicant (5 points):
1) Describes the purpose of the proposed project, and identifies the target population of CMC, including the structure and financing of the current child health care delivery system, and their unmet needs.
2) Discusses any relevant barriers and gaps in the health care delivery system for CMC that the project hopes to overcome.

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

The extent to which the applicant:
1) Proposes innovative approaches to respond to the program requirements and expectations and addresses challenges likely to be encountered in designing the activities. Provides a work plan, including a logic model, which describes the activities or steps used to achieve each of the activities during the project period. (5 points)
2) Describes how they will identify and convene an expert committee of national stakeholders with subject matter expertise to provide leadership and guidance, including the identification of relevant standards and indicators, development of CoIIN aims, and technical content references and materials. Describes how they will facilitate communication across teams with the expert committee of national stakeholders. (4 points)

3) Identifies at least ten and up to twelve teams reflecting diversity in population, health care system structures, and geographic representation. Provides details on strategies used for identifying and sustaining teams, including the various team members as listed in the methodology section, and including a proposed timeline for working with the teams, and the environmental scan process. (5 points)
4) Describes how they will develop and implement the methods for providing ongoing training and technical assistance on QI methodology and innovation practices with an emphasis on rapid cycle testing, including ongoing technical assistance on how to apply QI methodologies through a CoIIN framework. (5 points)
5) Describes how they will provide assistance to the teams with the development of aims, change packages and measures to track progress on proposed topic areas that teams will focus on during the project period. Proposes a plan for identifying, selecting, and managing a web-based collaborative workspace to facilitate the collaboration of participating teams. (4 points)
6) Develops a plan for conducting in-person learning sessions with participating teams, including at least one annual in-person meeting with participating teams and other relevant stakeholders, and annual on-site in-person meetings with teams. (4 points)
7) Develops a plan to evaluate CoIIN processes. Proposes a plan to facilitate the spread of successful innovation tools, processes, and models among CoIIN participants, and describes a plan for dissemination of successful innovations to non-participating states/jurisdictions. Describes a plan to assist teams with developing a plan to sustain the key elements of the project after the period of federal funding ends. (5 points)
8) Discusses challenges likely to be encountered in designing and implementing the activities, and approaches that will be used to resolve such challenges. In particular, discuss challenges with processes for maintaining engagement of CoIIN participants, and how to evaluate various team QI processes using the same measures. (3 points)

Criterion 3: EVALUATIVE MEASURES (10 points) – Corresponds to Section IV's Methodology and Evaluation and Technical Support Capacity

The extent to which the applicant:
1) Describes the plan for the program performance evaluation that will contribute to continuous QI with an emphasis on managing collaboratives, providing technical assistance, and creating technical assistance modules and materials. Describes the program performance evaluation to address the system, clinic, and family indicators listed in the Evaluation and Technical Support Capacity section. (4 points)
2) Provides an evaluation plan that will measure the progress and results of the project and its potential spread and dissemination to other sites. (3 points)
3) Describes any potential obstacles anticipated for planning and executing the implementation evaluation and how these obstacles will be addressed. (3 points)

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

The extent to which:
1) A logic model is included presenting the conceptual framework of the proposed project, in addition to a timeline that includes each activity and identifies responsible staff. (3 points)
2) The activities proposed to accomplish the project goal show measureable change and impact across the project period. (3 points)
3) The applicant describes a plan to assist teams with developing a plan to sustain the key elements of the project after the period of federal funding ends and describes a plan for dissemination of successful innovations to non-participating states/jurisdictions. (4 points)

Criterion 5: RESOURCES/CAPABILITIES (30 points) – Corresponds to Section IV's Introduction, Evaluation and Technical Support Capacity, and Organizational Information
The extent to which the applicant:
1) Describes the hardware and software tools that will be used to store and analyze data and to store documents or tools created by the project participants. (4 points)
2) Describes how project personnel, proposed partners, including maternal and child health experts and experts on child health care delivery system, care and financing for CMC, and joint-applicant organizations/agencies personnel, are qualified by training, expertise, and/or experience to implement and carry out the project and attain the benchmarks. (8 points)
3) Provides information on the organization/consortium's current mission and structure, scope of current activities, and an organizational chart, and how these all contribute to the ability of the organization/consortium to meet the program expectations. If the applicant is applying as a consortium, the applicant describes the roles and responsibilities of each member of the consortium and how the consortium will function to carry out the project. (4 points)
4) Describes experience in data collection necessary to accomplish QI activities, and in developing and disseminating information materials and providing training on the QI process. Demonstrates a solid understanding of the Collaborative Improvement and Innovative Networks approach, QI processes, different QI models, and the principles of collaborative learning. (6 points)
5) Demonstrates experience in collaborating with families of CMC, pediatric care clinicians, leaders of integrated health care delivery systems and/or freestanding children's hospitals, and state Title V CYSHCN and Medicaid leaders. (8 points)

Criterion 6: SUPPORT REQUESTED (10 points) – Corresponds to Section IV's Budget and Budget Narrative
The reasonableness of the proposed budget for each of the four years of the project period in relation to the objectives, the complexity of the research activities, and the anticipated results.
  1) The extent to which costs, as outlined in the budget and required resources sections, are reasonable given the scope of work. The extent to which key personnel have adequate time devoted to the project to achieve project objectives. (4 points)
  2) The extent to which the budget reflects adequate support to effectively implement face-to-face meetings proposed (3 points)
  3) The extent to which the budget reflects adequate support for participating teams. (3 points)

2. Review and Selection Process

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

Please see Section 5.3 of HRSA's *SF-424 Application Guide* for more details.

3. Assessment of Risk and Other Pre-Award Activities

The Health Resources and Services Administration 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).

Applications receiving a favorable objective review that HRSA is considering for funding are reviewed for other considerations. These include, as applicable, cost analysis of the project/program budget, assessment of the applicant's management systems, ensuring continued applicant eligibility, and compliance with any public policy requirements, including those requiring just-in-time submissions. You may be asked to submit additional programmatic or awards 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 an award will be made. Following review of all applicable information, the HRSA approving and business management officials will determine whether an award can be made, 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 the applicant that is in the Federal Awardee Performance and Integrity

[Information System (FAPIIS)](#). An applicant may review and comment on any information about itself that a federal awarding agency previously entered. HRSA will consider any comments by the applicant, in addition to other information in [FAPIIS](#) in making a judgment about the applicant's integrity, business ethics, and record of performance under federal awards when completing the review of risk posed by applicants as described in [45 CFR § 75.205 HHS Awarding Agency Review of Risk Posed by Applicants.](#)

A determination that an applicant is not qualified will be reported by HRSA to FAPIIS ([45 CFR § 75.212](#)).

4. Anticipated Announcement and Award Dates

HRSA anticipates issuing/announcing awards prior to the start date of August 1, 2017.

VI. Award Administration Information

1. Award Notices

HRSA will issue the Notice of Award prior to the start date of August 1, 2017. See Section 5.4 of HRSA's *SF-424 Application Guide* for additional information.

2. Administrative and National Policy Requirements

See Section 2 of HRSA's *SF-424 Application Guide*.

3. Reporting

On June 10, 2016, the Office of Management and Budget approved MCHB to collect new performance measures from recipients as part of its Discretionary Grant Information System (DGIS). The new performance measures reflect MCHB's strategic and priority areas including financial and demographic information, health domain and program-specific measures, and program-specific measures that highlight the unique characteristics of discretionary grant/cooperative agreement projects that are not already captured. Collectively, these data communicate the MCHB "story" to a broad range of stakeholders on the role of the Bureau in addressing the needs of maternal and child health populations. These performance data will also serve several purposes, including recipient monitoring, performance reporting, MCHB program planning, and the ability to demonstrate alignment between MCHB discretionary programs and the MCH Title V Block Grant program.

These new performance measures will allow a more accurate and detailed picture of the full scope of activities supported by MCHB-administered grant/cooperative agreement programs, while reducing the overall number of performance measures from what was previously used. The MCHB Project Officer will assign a subset of measures relevant to the program for which the recipients will report. In addition to reporting on the new performance measures, recipients will continue to provide financial and program data.

The new reporting package can be reviewed at:
http://mchb.hrsa.gov/sites/default/files/mchb/Data/Discretionary_Grant_Information_System_Performance_Measure_Update.pdf.

New and continuing awards issued on or after October 1, 2016, will be required to report on the new measures. For successful competing continuation awards, recipients will report on their previous year activities (defined as those completed before October 1, 2016) using the forms and measures in DGIS as assigned in the previous FOA.

The successful applicant under this FOA 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 an **annual** basis. Further information will be provided 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 SPRANS projects, CISS projects, and other grant/cooperative agreement programs administered by MCHB to include national performance measures that were developed in accordance with the requirements of the Government Performance and Results Act (GPRA) of 1993 (Public Law 103-62). This Act requires the establishment of measurable goals for federal programs that can be reported as part of the budgetary process, thus linking funding decisions with performance. Performance measures for states have also been established under the Block Grant provisions of Title V of the Social Security Act, MCHB's authorizing legislation.

a) **Performance Measures and Program Data**

To prepare successful applicants for their reporting requirements, the following listing of MCHB administrative forms and performance measures are applicable to this award program:

Administrative Forms: Form 1, 2, 4, 6 and 7

Performance Measures: Core 1, 2, and 3; CB2, 3 and 5; CSHCN 1, 2, and 3; LC1

Program Specific Measures: N/A

b) Performance Reporting Timeline

Successful applicants receiving HRSA funds will be required, within 120 days of the Notice of Award (NoA), to register in HRSA's Electronic Handbooks (EHBs) and electronically complete the program-specific data forms that 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 NoA, 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 obtain additional information regarding business, administrative, or fiscal issues related to this FOA by contacting:

Sharon R. Farris
Grants Management Specialist
Division of Grants Management Operations, OFAM
Health Resources and Services Administration
5600 Fishers Lane, Room 12N-112C
Rockville, MD 20857
Telephone: (301) 945-9883
Fax: (301) 594-6096
E-mail: sfarris@hrsa.gov

Additional information related to the overall program issues and/or technical assistance regarding this funding announcement may be obtained by contacting:

Anna Maria Padlan
Public Health Analyst
Attn: Health Care Delivery System Innovations for Children with Medical Complexity Program
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane, Room 18W-10D
Rockville, MD 20857
Telephone: (301) 443-1737
Fax: (301) 594-0878
E-mail: APadlan@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, seven days a week, excluding federal holidays at:

Grants.gov Contact Center
Telephone: 1-800-518-4726 (International Callers, please dial 606-545-5035)
E-mail: 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, 8:00 a.m. to 8:00 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:

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:

A pre-submission technical assistance call will be held for all prospective applicants. The call will be on:

Day/Date/Time: Monday, November 28, 2016 from 2:00 – 3:00pm ET
Call-in Number: 1-888-677-1801
Passcode: 5206602
Webinar link: https://hrsa.connectsolutions.com/cmcfoa2017/

IX. Tips for Writing a Strong Application

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