U.S. Department of Health and Human Services

Federal Office of Rural Health Policy

Community Based Division

Rural Maternity and Obstetrics Management Strategies Program

Funding Opportunity Number: HRSA-22-115

Funding Opportunity Type: New

Assistance Listings (AL/CFDA) Number: 93.912

NOTICE OF FUNDING OPPORTUNITY

Fiscal Year 2022

Application Due Date: April 5, 2022

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 may take up to 1 month to complete.

Issuance Date: January 5, 2022

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See Section VII for a complete list of agency contacts.

Authority: 42 U.S.C. § 254c(f) (§ 330A(e) of the Public Health Service Act)

508 COMPLIANCE DISCLAIMER

Note: Persons using assistive technology may not be able to fully access information in this file. For assistance, please email or call one of the HRSA staff listed in Section VII. Agency Contacts.

EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA) is accepting applications for the fiscal year (FY) 2022 Rural Maternity and Obstetrics Management Strategies (RMOMS) program. The purpose of this program is to improve access to and continuity of maternal and obstetrics care in rural communities.

Funding Opportunity Title:	Rural Maternity and Obstetrics Management Strategies Program
Funding Opportunity Number:	HRSA-22-115
Due Date for Applications:	April 5, 2022
Anticipated Total Annual Available FY 2022 Funding:	$5,000,000 subject to the availability of appropriated funds
Estimated Number and Type of Awards:	Up to 5 cooperative agreements
Estimated Annual Award Amount:	Up to $1,000,000 per award
Cost Sharing/Match Required:	No
Period of Performance:	September 1, 2022 through August 31, 2026 (4 years)
Eligible Applicants:	• All public and private entities, nonprofit and for-profit, are eligible to apply. This includes, but is not limited to: faith-based and community-based organizations, federally recognized tribes, and tribal organizations. • Shall be an entity with demonstrated experience serving, or the capacity to serve, rural underserved populations.

	• Shall represent a network composed of members – (i) that include at least three or more health care organizations (including the applicant organization). • Shall not previously have received an award under this subsection for the same or similar project, unless the entity is proposing to expand the scope of the project or the area that will be served through the project. 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, except where instructed in this NOFO to do otherwise.

Technical Assistance

HRSA has scheduled the following technical assistance:

Webinar

Day and Date: Wednesday, January 26, 2022
Time: 1 – 2 p.m. ET
Call-In Number: 1-833-568-8864
Participant Code: 06048296
Weblink: https://hrsa-gov.zoomgov.com/j/1606904058?pwd=cWVmR2RaZm1UYnB5OGc0VFFiSGlsdz09

Webinar Recording: email RMOMS@hrsa.gov 24 hours after live event

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I. Program Funding Opportunity Description

1. Purpose

This notice announces the opportunity to apply for funding under the Health Resources and Services Administration's (HRSA) Rural Maternity and Obstetrics Management Strategies (RMOMS) program. The purpose of the RMOMS program is to improve access to and continuity of maternal and obstetrics care in rural communities.

The goals of the RMOMS program are to: (i) improve maternal and neonatal outcomes within a rural region; (ii) develop a sustainable network approach to increase the delivery and access of preconception, prenatal, pregnancy, labor and delivery, and postpartum services; (iii) develop a safe delivery environment with the support and access to specialty care for perinatal patients and infants; and (iv) develop sustainable financing models for the provision of maternal and obstetrics care in rural hospitals and communities. Applicants are encouraged to propose innovative ways to achieve these goals through an established or formal regional network structure.

The RMOMS program includes a robust independent evaluation and analysis effort that will rely on validated clinical data from each RMOMS award recipient and their appropriate network member in order to quantify the impact of this program investment. All network members, regardless of ownership status, will be required to collect and share clinical data. This program intends to demonstrate the impact on access to and continuity of maternal and obstetrics care in rural communities through testing models that address the following **RMOMS Focus Areas:**

1) **Rural Hospital Obstetric Service Aggregation and Approaches to Risk Appropriate Care**
2) **Network Approach to Coordinating a Continuum of Care**
3) **Leveraging Telehealth and Specialty Care**
4) **Financial Sustainability**

For more details, see Program Requirements and Expectations..

2. Background

RMOMS is authorized by 42 U.S.C. § 254c(f) (§ 330A(e) of the Public Health Services Act) to "promote rural health care services outreach by improving and expanding the delivery of health care services to include new and enhanced services in rural areas, through community engagement and evidence-based innovative, evidence- informed models."

National trends in maternal health have worsened over time and a key indicator is the pregnancy-related mortality ratio. The ratio is an estimate of the number of pregnancy-related deaths for every 100,000 live births. The pregnancy-related mortality ratio

increased from 7.2 deaths per 100,000 live births in 1987 to 17.3 deaths per 100,000 live births in 2017.[1] Similarly, Severe Maternal Morbidity (SMM) is steadily increasing and affected more than 50,000 women in the United States in 2014.[2] SMM includes unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health.[3] Reasons for the overall increase in pregnancy-related mortality and morbidity rates are unclear; however, it is known that risk from maternal mortality is especially unevenly distributed across African Americans, American Indian/Alaskan Natives, low-income persons, and rural residents.

Recent data at the national level describing the rural and urban differences for maternal morbidity and mortality rates show rural residents have a 9 percent greater chance of experiencing severe maternal morbidity and mortality compared with urban residents.[4] At the same time, considerable racial and ethnic disparities in pregnancy-related mortality persist with mortality rates for African American and American Indian/Alaskan Native women two to three times higher than White women.[5] These differences are contextualized by declining access to obstetric services in rural areas. As of 2014, more than half of all rural U.S. counties were without hospital obstetric services.[6] Furthermore, rural obstetric unit closures are more common in smaller hospitals and communities with a limited obstetric workforce.[7] These trends in the decreasing availability of obstetric units in rural areas indicate growing challenges in gaining access to care. For example, when comparing rural U.S. counties not adjacent to urban areas that had a loss of hospital-based obstetric services to counties with continuous services, there was an increase in out-of-hospital and preterm births and births in hospitals without obstetric units in the following year.[8] Rural counties had higher infant, neonatal, and post-neonatal mortality rates than large urban counties.[9]

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[1] Centers for Disease Control and Prevention. Pregnancy Mortality Surveillance System. www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm. Accessed 9/13/21

[2] Centers for Disease Control and Prevention. Severe Maternal Morbidity in the United States. https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html Accessed on 9/13/2021.

[3] Centers for Disease Control and Prevention. Severe Maternal Morbidity in the United States. https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html Accessed on 9/13/2021.

[4] Kozhimannil K, Interrante J, Henning-Smith C, Admon K. Rural-Urban Differences in Severe Maternal Morbidity and Mortality in the US, 2007-2015. Health Affairs. 2019;38 (12): 2077-2085. doi: 10.1377/hlthaff.2019.00805

[5] Centers for Disease Control and Prevention. Infographic: Racial/Ethnic Disparities in Pregnancy–Related Deaths – United States 2007-2016. https://www.cdc.gov/reproductivehealth/maternal-mortality/disparities-pregnancy-related-deaths/infographic.html. Accessed on 9.13.2021.

[6] Hung P, Henning-Smith C, Casey M, Kozhimannil K. Access to Obstetric Services in Rural Counties Still Declining, with 9 Percent Losing Services, 2004-14. Health Affairs. *2017; 36 (9): 1663-1671. doi:* 10.1377/hlthaff.2017.0338

[7] Hung P, Kozhimannil K, Casey M, Moscovice I. Why Are Obstetric Units in Rural Hospitals Closing Their Doors? Health Services Research. 2016; 51: 1546-1560. doi: 10.1111/1475-6773.12441

[8] Kozhimannil K, Hung P, Henning-Smith C, Casey M, Association Between Loss of Hospital-Based Obstetric Services and Birth Outcomes in Rural Counties in the United States. *JAMA.* 2018 online. doi:10.1001/jama.2018.1830

[9] Ely D, Hoyert D. Differences Between Rural and Urban Areas in Mortality Rates for the Leading Causes of InfantDeath: United States, 2013-2015. NCHS Data Brief No. 300. 2018. https://www.cdc.gov/nchs/data/databriefs/db300.pdf. Accessed on 9/13/2021.

Rural communities face distinct and varied challenges in light of the current negative trends in maternal health outcomes. Many factors affect the sustainability of rural obstetric care, including obstetric workforce recruitment and skill maintenance[10], birth volume, financial viability, resources, and infrastructure of prenatal and postnatal services, among others. In 2018, Medicaid paid for slightly less than half of all births nationally and covered a greater share of births in rural areas.[11]

An important element of rural health care coordination is the distance traveled to receive needed health care services. Research findings show patients who had to travel more than 30 miles to a labor and delivery location had fewer prenatal visits and infants with a lower birth weight and gestational age.[12] Telehealth can be an important tool for improving access to quality health care, especially for underserved and economically or medically vulnerable populations. Applicants who propose a telehealth component to their work plan are encouraged to reach out to one of the 12 HRSA-supported regional Telehealth Resource Centers that provide technical assistance to organizations and individuals who are actively providing or interested in providing telehealth services to rural and/or underserved communities.

II. Award Information

1. Type of Application and Award

Type of applications sought: New

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

HRSA program involvement will include:

- Providing common measures and data elements that must be reported by all recipients (See **Appendix B**);
- Participating in the planning and development of the baseline data and data collection methods (See **Appendix B**);

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[10] Hung P, Kozhimannil K, Casey M, Henning-Smith C, Prasad S. State Variations in the Rural Obstetric Workforce.Rural Health Research Center Policy Brief. 2016. http://rhrc.umn.edu/wp-content/uploads/2016/05/State-Variations-in-the-Rural-Obstetric-Workforce.pdf. Accessed on 9/13/2021.

[11] Medicaid and CHIP Payment and Access Commission. (2020). Medicaid's Role in Financing Maternity Care [Fact Sheet].]. https://www.macpac.gov/wp-content/uploads/2020/01/Medicaid%E2%80%99s-Role-in-Financing-Maternity-Care.pdf

[12] Hamlin L. Obstetric Access and the Community Health Imperative for Rural Women. Family and CommunityHealth. 2018; 41(2): 105-110. doi: 10.1097/FCH.0000000000000192

- Reviewing and providing recommendations on the implementation period work plan;
- Reviewing award activities on an ongoing basis and providing input on strategies or approach;
- Participating, as appropriate, in the planning and implementation of any meetings, training activities or workgroups conducted during the period of performance; and
- Providing consultation with the maternal and obstetrics services rural health network, as appropriate, in outreach and dissemination activities.

The cooperative agreement recipient's responsibilities will include:

- Adhering to HRSA guidelines pertaining to acknowledgement and disclaimer on all products produced by HRSA award funds;
- Complying with program terms and reporting requirements detailed in the notice of award;
- Completing activities included in the final implementation period work plan, specifically data collection and active participation in HRSA-funded efforts to contribute to the rural maternal health evidence base;
- Timely development of a data collection strategy and infrastructure to satisfy network- and patient-level data requirements (see **Appendix B**) in the planning period (year 1) and throughout implementation (years 2-4);
- Cooperating with a HRSA-funded technical assistance provider and evaluator during the period of performance (and potentially share project updates and information with them after the period of performance ends). HRSA will provide additional guidance on the technical assistance and evaluation components of the project throughout the period of performance;
- Participating in conference calls and/or meetings with HRSA;
- Responding timely to requests for information, including requests for data submissions from HRSA; and
- Establishing relationships and collaborations to leverage other federal and state supported Maternal and Child Health programs and state Medicaid agencies.

2. Summary of Funding

HRSA estimates approximately $5,000,000 to be available annually to fund up to five recipients. The actual amount available will not be determined until enactment of the final FY 2022 federal appropriation. You may apply for a ceiling amount of up to $1,000,000 total cost (includes both direct and indirect, facilities and administrative costs) per year.

The period of performance is September 1, 2022 through August 31, 2026 (4 years). Funding beyond the first year is subject to the availability of appropriated funds for RMOMS in subsequent fiscal years, satisfactory progress, 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

Applicant Organization Specifications:

Eligible applicants shall be domestic public or private, non-profit or for-profit, entities, including faith-based and community-based organizations, tribes, and tribal organizations. The applicant organization may be located in an urban or rural area and must have demonstrated experience serving, or the capacity to serve, rural underserved populations; represent a network of members that include three or more health care providers; and shall not previously have received an award under this subsection for the same or similar project, unless the entity is proposing to expand the scope of the project or the area that will be served through the project.

Please reference the Program Requirements and Expectations section for additional guidance.

2. Cost Sharing/Matching

Cost sharing/matching is not required for this program.

3. Other

HRSA may not consider an application for funding if it contains any of the non-responsive criteria below:

- Exceeds the ceiling amount
- Fails to satisfy the deadline requirements referenced in Section IV.4
- Exceeds the page limit.
- Fails to propose a service area that is entirely rural, as defined by the Rural Health Grants Eligibility Analyzer. All activities supported by the RMOMS Program must exclusively occur in HRSA-designated rural areas. Please reference the Program Requirements and Expectations section for additional guidance.

- Applicant organization fails to demonstrate that it is part of a network comprised of at least three or more health care organizations (including the applicant organization), and includes the six required network partner types defined in the glossary. Please reference the Program Requirements and Expectations section for additional guidance.

Multiple Applications

Multiple applications from an organization with the same DUNS number or Unique Entity Identifier (UEI) are allowable if the applications propose separate and distinct projects.

Applications associated with the same DUNS number or EIN should be independently developed and written. HRSA reserves the right to deem applications that provide insufficient information in **Attachment 3** or are nearly identical in content, to be ineligible. In this instance, assuming all other eligibility criteria are met, HRSA will only accept your **last** validated electronic submission, under the correct funding opportunity number, before the Grants.gov application due date as the final and only acceptable application.

Multiple Submissions

HRSA will only accept your **last** validated electronic submission, under the correct funding opportunity number, before the Grants.gov application due date as the final and only acceptable application.

Notifying your State Office of Rural Health

You are required to notify the State Office of Rural Health (SORH) of your intent to apply to this program. A list of the SORHs can be accessed at: https://nosorh.org/nosorhmembers/nosorh-members-browse-by-state/. You must include in **Attachment 4** a copy of the letter or email sent to the SORH describing your project, and any response received to this letter.

Each state has a SORH, and HRSA recommends making every effort to contact the SORH entity early in the application process to advise them of your intent to apply. The SORH may be able to provide consultation to you regarding model programs, data resources, and technical assistance for networks, evaluation, partner organizations, or support of information dissemination activities. If you do not receive a response, please include the original letter of intent requesting the support.

If you are located in Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, American Samoa, the U.S. Virgin Islands, the Federated States of Micronesia, the Republic of the Marshall Islands, or the Republic of Palau, you do not have a

designated SORH. By statute, all applicants are required to consult with their respective SORHs or other appropriate state entities in **Attachment 4**. However, if an applicant from these territories does not have a SORH equivalent or other appropriate governmental entity, this requirement does not apply and the applicant is still eligible to apply.

SORHs responding to this announcement as the applicant organization must provide an attestation in **Attachment 4** that their application was independently developed and written and that they have not knowingly duplicated efforts or project ideas of non-SORH applicants within their state.

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 notice of funding opportunity (NOFO) following the directions provided at Grants.gov: HOW TO APPLY FOR GRANTS.

The NOFO is also known as “Instructions” on Grants.gov. You must select “Subscribe” and provide your email address for HRSA-22-115 in order to receive notifications including modifications, clarifications, and/or republications of the NOFO on Grants.gov. You will also receive notifications of documents placed in the RELATED DOCUMENTS tab on Grants.gov that may affect the NOFO and your application. *You are ultimately responsible for reviewing the For Applicants page for all information relevant to this NOFO.*

2. Content and Form of Application Submission

Application Format Requirements

Section 4 of HRSA’s *SF-424 Application Guide* provides general instructions for the budget, budget narrative, staffing plan and personnel requirements, assurances, certifications, etc. You must submit the information outlined in the HRSA *SF-424 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 HRSA *SF-424 Application Guide* for the Application Completeness Checklist.

Application Page Limitation

The total size of all uploaded files included in the page limit shall be no more than the equivalent of **80 pages** when printed by HRSA. The page limit includes the project and budget narratives, and attachments required in the *Application Guide* and this NOFO.

Please note: Effective April 22, 2021, the abstract is no longer an attachment that counts in the page limit. The abstract is the standard form (SF) "Project_Abstract Summary." Standard OMB-approved forms included in the workspace application package do not count in the page limit. If you use an OMB-approved form that is not included in the workspace application package for HRSA- 22-115, it may count against the page limit. Therefore, we strongly recommend you only use Grants.gov workspace forms associated with this NOFO to avoid exceeding the page limit. Indirect Cost Rate Agreement and proof of non-profit status (if applicable) do not count in the page limit. **It is therefore important to take appropriate measures to ensure your application does not exceed the specified page limit. Any application exceeding the page limit of 80 will not be read, evaluated, or considered for funding.**

Applications must be complete, within the maximum specified page limit, and validated by Grants.gov under HRSA-22-115 before the deadline.

Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification

1) You certify on behalf of the applicant organization, by submission of your proposal, that neither you nor your principals are 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. § 3354).

3) If you are unable to attest to the statements in this certification, you must include an explanation in *Attachment 16: Other Relevant Documents*.

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

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

Section 319(e) of the Public Health Service (PHS) Act provides the Secretary of the Department of Health and Human Services (HHS) with discretion upon request by a state or tribal organization to authorize the temporary reassignment of state, tribal, and local personnel during a declared federal public health emergency. The temporary reassignment provision is applicable to state, tribal, and local public health department or agency personnel whose positions are funded, in full or part, under PHS programs and allows such personnel to immediately respond to the public health emergency in

the affected jurisdiction. Funds provided under the award may be used to support personnel who are temporarily reassigned in accordance with § 319(e). Please reference detailed information available on the HHS Office of the Assistant Secretary for Preparedness and Response (ASPR) website.

Program Requirements and Expectations

Note that failure to meet the below program requirements, in addition to the criteria outlined in the Eligibility section, may result in HRSA deeming your application nonresponsive.

Network Specifications:

For the purposes of the RMOMS program, HRSA is employing a network model to encourage a broad range of clinical and administrative partners who will work together in a collective manner and play a key role in providing maternal and obstetric services.

The applicant organization must be part of a group of entities that are either an established or a formal network, which may need to be expanded to meet this program's network definition. **A network is defined as an organizational arrangement among three or more separately owned domestic public and/or private health care organizations, including the applicant organization. For the purposes of this program, the applicant must have a network composition that includes: 1) at least two rural hospitals or Critical Access Hospitals (CAH); 2) at least one health center under section 330 of the Public Health Service Act (Federally Qualified Health Center [FQHC] or FQHC look-alike; see Appendix C); 3) at least one Medicare certified Rural Health Clinic (RHC), to the extent which these entities are in the network service area and engaged in maternal and obstetrics care (see Appendix C); 4) at least one Level III and/or Level IV facility[13]; 5) regionally and/or locally available social services in the continuum of care (i.e., state Home Visiting and Healthy Start Programs to the extent which these resources are available in the service area; see Appendix C); and 6) the state Medicaid agency.**

Partnership with the state Medicaid agency is beneficial as rural populations have a large share of Medicaid recipients and networks are to plan for financial sustainability. Accordingly, applicants are required to obtain at least a letter of commitment from the state Medicaid agency at the time of application. Special consideration will be given to applicants that have a signed Memorandum of Agreement or Understanding (MOA/U)

[13] Level III (Subspecialty Care) and Level IV (Regional Perinatal Health Care Centers) facilities are defined by Levelsof Maternal Care. Obstetric Care Consensus No. 9. American College of Obstetricians and Gynecologists. American Journal of Obstetrics and Gynecology 2019;134:e41e55. doi: 10.1016/j.ajog.2019.05.046.

with the state Medicaid agency at the time of application; additional information can be found in Section V.2. Review. To obtain an award under this funding opportunity, networks are required to obtain a MOA/U with the state Medicaid agency. Given the specialized nature of maternal health, network members should be equipped to manage and coordinate care throughout preconception, pregnancy, labor, delivery, and postpartum periods. Medicaid covers nearly 50 percent of all births nationally and the engagement, expertise, and support of state Medicaid agencies will be critical to the long-term success of the program and may also provide opportunities to achieve long-term savings.[14] Networks should include upstream tertiary partners (i.e., Level III and/or Level IV facilities as documented in **Attachment 11**) to provide enhanced case management of high-risk deliveries while also providing access to specialist, including leveraging telehealth to support care delivery and clinician support in rural communities.

An example network composition:

- Rural Hospital 1: the obstetrics delivery site with telehealth and prenatal care
- Rural Hospital 2: maternal and obstetric case management with telehealth, prenatal, and postnatal care
- CAH 3: maternal and obstetric case management with telehealth, prenatal, and postnatal care
- FQHC 1: maternal and obstetric case management with telehealth, prenatal, and postnatal care
- FQHC 2: maternal and obstetric case management with telehealth, prenatal, and postnatal care
- Rural Health Clinic (RHC)
- Public Health: well-baby care, screenings, etc.
- Healthy Start Award Recipient: connecting patients to services; providing clinical support
- Home Visiting Award Recipient: supporting at-risk new mothers and babies
- Level IV Regional Perinatal Health Care Centers linked by telehealth
- Other local providers (nurse midwives, private practice clinicians, social workers, case managers)
- State Medicaid Agency: committed to work with the providers for reimbursement

Other potential partners include, but are not limited to:

- Accredited birth centers
- Health Center Controlled Networks
- Primary care providers/offices
- Primary care associations

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[14] Rossier Markus A, et al. Medicaid Covered Births, 2008 Through 2010, in the Context of the Implementation of Health Reform. Women's Health Issues. 2013; 23 (5): e273-e280. DOI: 10.1016/j.whi.2013.06.006

- State Offices of Rural Health
- Emergency medical services entities
- Community organizations

Include the signed MOA/U that defines the roles and responsibilities for network partners 1-5: (1) at least two rural hospitals or Critical Access Hospitals (CAH); 2) at least one health center under section 330 of the Public Health Service Act (Federally Qualified Health Center (FQHC) or FQHC look-alike, see Appendix C); 3) at least one Medicare certified Rural Health Clinic (RHC, to the extent which these entities are in the network service area and engaged in maternal and obstetrics care; see Appendix C) 4) at least one Level III and/or Level IV facility[15]; 5) regionally and/or locally available social services in the continuum of care (i.e., state Home Visiting and Healthy Start Programs to the extent which these resources are available in the service area); and include at least a letter of commitment from partner 6) the state Medicaid agency as **Attachment 1**. If you are an established network, please include a summary, no longer than one page, detailing your network's history of working together and highlighting your network's products, services, and sources of sustainability as **Attachment 2**. If you are an existing RMOMS network, please also detail how you are proposing to expand the scope of the project or the area that will be served through the project in **Attachment 2**.

Note: Each network member must demonstrate involvement in the project and contribute to the project goals, including integrating data sharing and reporting capabilities (See **Appendix B**). The roles and responsibilities of each network member must be clearly defined in the MOA/U. The MOA/U must be signed by all network members at the time of application with the exception of the state Medicaid agency. A letter of commitment from the state Medicaid agency must be submitted at the time of application and included in **Attachment 1.** Upon receipt of award, networks are required to obtain a MOA/U with the state Medicaid agency.

Geographic Requirements:

The applicant organization, along with each network member who will receive any of the awarded funds, must have separate and different Employer Identification Numbers (EINs).

At least one network member must be located in a HRSA-designated rural county or rural census tract in an urban county; however, the applicant organization may be located in an urban area. All individuals served and all activities supported by this

[15] Level III (Subspecialty Care) and Level IV (Regional Perinatal Health Care Centers) facilities are defined by Levels of Maternal Care. Obstetric Care Consensus No. 9. American College of Obstetricians and Gynecologists. American Journal of Obstetrics and Gynecology 2019;134:e41e55. doi: 10.1016/j.ajog.2019.05.046.

program must exclusively target populations residing in HRSA-designated rural counties or rural census tracts in urban counties.
RMOMS Focus Areas:

Applicants are required to incorporate all four of the RMOMS Focus Areas in their proposals. Additionally, applicants are required to address the focus-specific prompts listed below as they prepare a response. Responses do not have to be limited to these items and may include additional information related to the RMOMS Focus Areas.

Rural Hospital Obstetric Service Aggregation and Approaches to Risk Appropriate Care

- Demonstrate how a regional network with several rural hospitals that are facing challenges in providing obstetric services could aggregate obstetric services to a targeted rural hospital or Critical Access Hospital (CAH) within the rural region to revive or sustain rural obstetric and maternal services. For example, volume may be too low at an individual rural hospital or CAH in the network; however, if deliveries were aggregated at one of the rural hospitals the financial viability of rural obstetric services in the rural region could be increased.
- Show how the network will ensure pregnant patients in the rural region receive care in a facility that best meets their needs and those of their neonates through appropriate risk stratification with lower-risk and routine pregnancies delivered in rural settings and higher-risk deliveries handled at a referral hospital in the network. Address how regions can approach care practices to prioritize referral to an appropriate facility during pregnancy rather than emergent transfer during labor.
- Address how rural regional risk appropriate care will improve health equity for rural residents including but not limited to Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; and persons otherwise adversely affected by persistent poverty or inequality.

Network Approach to Coordinating a Continuum of Care

- Demonstrate how the participating rural hospitals, community health centers, and other network partners focus on improving access along the continuum of care for preconception, pregnancy, labor and delivery, and postpartum health services.
- Identify and implement strategies to improve maternal and neonatal outcomes by developing more formal case management that includes rural hospitals and clinics working closely with existing HRSA award recipients, such as

Community Health Centers, Maternal, Infant and Early Childhood Home Visiting (MIECHV) and Healthy Start programs (to the extent which these resources are available in the service area; see **Appendix C**).

Leveraging Telehealth and Specialty Care

- Show how rural networks collaborate with upstream tertiary providers (Level III and Level IV facilities[16] as documented in **Attachment 11**) to enhance case management of higher-risk expectant patients living in geographically isolated areas.
- Illustrate how telehealth platforms can support rural clinicians and the obstetric patients they serve.

Financial Sustainability

- Show how rural networks, in partnership with Medicaid and other payers, can demonstrate improved outcomes and potential savings with the goal of providing the resources to ensure the ongoing support of the network once federal funding ceases.

The RMOMS program is funded via a cooperative agreement with HRSA, and may be built into an existing statewide or regional health network that supports obstetric and primary care services such that health care needs are addressed throughout preconception, pregnancy, labor and delivery, and postpartum periods. Applicants are required to develop their own strategies in response to all of the above listed RMOMS Focus Areas.

Award recipients will work with a HRSA-funded program evaluator to collect data from network members, and report network-level and patient-level data at baseline and throughout the course of the program. The purpose is for the network and the HRSA-funded evaluator to perform continuous quality improvement; identify gaps in the continuity of obstetric care and/or workforce and access to care within the targeted rural service area; leverage existing federal, state, and local maternal and obstetrics health resources; and to demonstrate the clinical and financial impact of the program. Data collection and reporting requirements, including anticipated measures, are detailed in **Appendix B**.

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[16] Level III (Subspecialty Care) or Level IV (Regional Perinatal Health Care Centers) facilities are defined by Levels of Maternal Care. Obstetric Care Consensus No. 9. American College of Obstetricians and Gynecologists. American Journal of Obstetrics and Gynecology 2019;134:e41e55. doi: 10.1016/j.ajog.2019.05.046.

Expected activities of award recipients include:

Year One (Planning Period)

a. Develop a model in alignment with RMOMS Focus Areas that supports the coordinated maternal care and delivery needs of a rural region and the necessary workforce training, services, equipment, and reimbursement needs to sustain the model.
b. Identify which small rural hospitals and/or CAHs will be part of the network, including which hospitals provide obstetric services and which do not. Address how the applicant will sustain existing services or offer new obstetric services in at least one rural hospital to ensure some level of obstetrics service in rural hospitals and/or CAHs in the service region while also identifying upstream tertiary providers (Level III and Level IV facilities1 as documented in **Attachment 11**) that will handle more complex deliveries as part of the network.
c. Coordinate with HRSA to establish a system to collect and store baseline network- and patient-level data across network partners during the planning period (year 1), which will serve as the baseline period. A data collection strategy must be finalized during year 1 for collecting and storing network- and patient-level data from network partners and reporting to the HRSA-funded program evaluator. This strategy will be utilized to continue data reporting throughout the implementation period (years 2-4) (see **Appendix B**).
d. Develop a work plan to implement the model in the target rural region during years 2, 3, and 4.
e. Engage in network capacity building and infrastructure development.

Years Two, Three, and Four (Implementation Period)

a. Implement and test model using the reviewed work plan.
b. Provide case management and coordinated care for pregnant patients, birth parents, and their infants across the continuum of care.
c. Ensure the ongoing and full participation of each network member in a shared governance model.
d. Collect data from network partners, report data to the HRSA-funded program evaluator, and adjust model based on evaluation findings.

Refer to the Project Narrative, Methodology section for more details on all activities in project years 1 – 4.

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***

Use the Standard OMB-approved Project Abstract Summary Form 2.0 that is included in the workspace application package. Do not upload the abstract as an attachment or it will count toward the page limitation. Please use the guidance below. It is most current and differs slightly from that in Section 4.1.ix of HRSA's *SF-424 Application Guide.*

Provide a summary of the application in the Project Abstract box of the Project Abstract Summary Form using 4,000 characters or less. Applicants should list the rural areas (counties) that will be served. Proposed counties should be fully rural, but if counties are partially rural counties, please include the rural census tract(s) in the **Project Abstract**. The applicant organization should also describe their experience and/or capacity serving rural populations in the **Project Abstract** section of the application. **It is important that applicants list the rural counties (or rural census tract(s) if the county is partially rural) that will be served through** their proposed project as this will be one of the factors that will determine the applicant organization's eligibility to apply for this funding.

Because the abstract is often distributed to provide information to the public and Congress, prepare this so that it is clear, accurate, concise, and without reference to other parts of the application. It must include a brief description of the proposed project including the needs to be addressed, the proposed services, and the population group(s) to be served. If the application is funded, your project abstract information (as submitted) will be made available to public websites and/or databases including USAspending.gov.

ABSTRACT HEADER CONTENT
Applicant Organization Information Organization Name, Address (street, city, state, ZIP code), Facility/Entity Type (e.g., CAH, State Office of Rural Health, tribal organization, FQHC, RHC, public health department, etc.) and Website Address *(if applicable)*
Designated Project Director Information Project Director Name & Title, Contact Phone Number *and* E-Mail Address
RMOMS Project: • Project Title and Goal(s) • Requested award amount for each project year (1-4)

ABSTRACT BODY CONTENT
Network Composition o Briefly describe the network, including name and goal(s). Indicate if you are a formal or established network, and if you expanded your network membership for this program, detail which network members were added. o Indicate the number of network members involved in the project who have signed a MOA/U; indicate organization facility type (e.g., CAH, State Office of Rural Health, tribal organization, health center, RHC, public health department, etc.)
Target Service Area It is recommended that applicants provide this information in a table format. o Entirely Rural Counties (list county name(s)) o Partially Rural Counties (list city, state, ZIP code, and census tract) Applicants should specify whether the area is in a HRSA-designated rural county or rural census tract in an urban county. To ascertain whether a particular county or census tract is rural, please refer to https://data.hrsa.gov/tools/rural-health?tab=Address
Target Population Briefly describe the target population the project proposes to serve and track. Note: your network members are required to report patient-level clinical data on your defined target population.
Capacity to Serve Rural Underserved Populations • **Applicants must demonstrate their experience serving or the capacity to serve, rural underserved populations. Please describe your capacity to serve rural underserved populations. Examples to show a history or ability to serve in this capacity may include, but is not limited to:** o Identifying formal partnerships/formalize MOA/Us with rural health care organizations *(if applicable).* o Identifying the target rural population and service area, including counties and rural census tract(s) the project will serve. o Identifying activities that build, strengthen, and maintain the necessary competencies and resources needed to sustain or improve maternal and obstetrics health services delivery in rural populations. o Discussing organizational expertise and capacity as it relates to the scope of work proposed. Include a brief overview of the organization's assets, skills and qualifications to carry on the project. o Describing current experience, including partnerships, activities, program implementation and previous work of a similar nature. o Discussing the effectiveness of methods and/or activities employed to improve maternal and obstetrics health care services in rural communities. • HRSA requires that urban applicants describe the geographic relationship to the proposed rural service population, as well as the plans to ensure that rural populations are served.

Project Activities/Services Briefly describe the proposed project activities and/or services.
Expected Outcomes Briefly describe the proposed project's expected outcomes.
<u>Funding Preference</u> **Please place any request for funding preference at the bottom of the abstract.** You must explicitly request a qualifying funding preference and cite the qualification that is being met (see 42 U.S.C. 254c(h)(3)); additional information can be found in Section V.2. Funding Preference. HRSA highly recommends that you include this language: **"(Your organization's name) is requesting a funding preference based on qualification X. County Y is in a (designated HPSA; or in a MUC/MUP; or is focusing on primary care, and wellness and prevention strategies)."** If applicable, you need to provide supporting documentation in **<u>Attachment 13</u>.** Refer to Section V.2 for further information. **<u>Special Consideration</u>** **Please place any request for a special consideration at the bottom of the abstract.** HRSA recommends you include this language and/or combine with above funding preference language, if applicable: **"(Your organization's name) is requesting special consideration based on the inclusion of a signed MOA/U with the state Medicaid agency included in Attachment 14."** If applicable, you need to provide supporting documentation in **<u>Attachment 14</u>.** Refer to Section V.2 for further information.

NARRATIVE GUIDANCE

To ensure that you fully address the review criteria, the table below provides a crosswalk between the narrative language and where each section falls within the review criteria. Any forms or attachments referenced in a narrative section may be considered during the objective review.

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 Narrative	(6) Support Requested

ii. *Project Narrative*

This section provides a comprehensive description of all aspects of the proposed project. It should be succinct, self-explanatory, consistent with forms and attachments, and organized in alignment with the sections and format below so that reviewers can understand the proposed project.

Use the following section headers for the narrative:

- INTRODUCTION -- Corresponds to Section V's Review Criterion #1 Need
  The introduction should provide a brief overview of the target population(s) and service area and the network members involved in the project. This section should clearly outline the purpose of the proposed project. It should summarize the project's goals, activities and expected outcomes as they relate to each of the RMOMS Focus Areas: rural hospital obstetric service aggregation and approaches to risk appropriate care, network approach to coordinating a continuum of care, leveraging telehealth and specialty care, and financial sustainability approaches.

- NEEDS ASSESSMENT -- Corresponds to Section V's Review Criterion #1 Need

  This section outlines the community's need for the proposed project, and how the rural region will be involved in the ongoing operations of the project. Describe how the target population was involved in determining the need and relevant barriers the project intends to overcome, and provide a geographical snapshot of the targeted service area(s). A list of resources is located in **Appendix C**.

Please use the following four sub-headings for this section: (1) Target Population Details and Maternal Health Indicators, (2) Stakeholder Involvement, (3) Target Service Area Details, and (4) Maternal and Obstetrics Health Care Availability in Service Area.

(1) Target Population Details and Maternal Health Indicators

a. Describe the target population. Describe how the population you propose to serve includes subpopulations who have historically suffered from poorer health outcomes, health disparities, and other inequities among the target population. These populations may include, but are not limited to: Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; and persons otherwise adversely affected by persistent poverty or inequality. Detail the number of people in the target population; number of births in the last 3 years in the service area and the projected number of births going forward for the period of performance. Also, include information regarding the social determinants of health and health disparities affecting the population or communities served.

b. Describe the associated unmet health needs of the target population of the proposed project. Describe the entire population of the service area and its demographics in relation to the population you will serve (if funded, you will monitor and track patient-level data on the population you serve). Identify and describe any national and/or local rankings data to include the number of maternal deaths and or most recent maternal mortality ratio; rate of Severe Maternal Morbidity (SMM); and other maternal health indicators (e.g., percentage of pregnant patients with health insurance, median age at time of first birth, rate of cesarean section deliveries, percentage of birth parents who received a postpartum visit, teen birth rate; low birth weight rate, etc.). When possible, disaggregate health indicators by race and ethnicity or other demographic characteristics and/or discuss and contextualize your target population with respect to racial and ethnic disparities or other demographic characteristics in maternal health.

(2) Stakeholder Involvement

a. Describe how you identified the needs of the target region. Further, describe the involvement of the various stakeholder health care providers and payers in the project development and future plans to ensure the project is responding to the target population's needs. Highlight the extent to which all stakeholders are represented among your network partners

and describe how you will use a shared governance model that ensures a voice for all network members in the project and regular consultation and collaboration between and among the applicant organization and each network member.

b. Discuss the manner and degree to which the region's stakeholders were included in planning the activities of the project, specifically the involvement of the target population in the program development. Provide details (frequency, number of participants, etc.) regarding the tools and methods (e.g., needs assessments, focus groups, questionnaires/surveys, etc.) that you utilized to identify the need of the target region.

***(3)* Target Service Area Details**

a. Identify the target service area(s) for the proposed project. Describe any relevant geographical features of the service area that affect access to health care services.

b. Describe the hospital service region for the network service area including both rural and Critical Access Hospitals as well as upstream tertiary (Level III and Level IV facilities as documented in **Attachment 11**) referral partners and why those facilities are part of the network.

c. Provide a map that shows the location of network members, the geographic area that will be served by your network, and include any other information that will help reviewers visualize and understand the scope of the proposed activities. Please include the map as **Attachment 5**. Note*:* Maps should be legible and in black and white.

(4)* Maternal *and Obstetrics Health Care Availability in Service Area

a. Describe the health care services available in or near the target service area and any gaps in services. Keep in mind that it is important for reviewers to understand the number and types of relevant health and social service providers that are located in and near the service area of the project as well as their relation to the project. Specifically detail the current obstetric services available or not available in the region and recent or pending changes to those services (i.e., lost or at risk of closing), average travel time between facilities, provision of prenatal and postnatal care, lack of a coordinated and continuum of care at various stages of pregnancy, financial sustainability issues as it relates to obstetric care, etc. Describe whether the network proposes to increase access to basic level obstetric services through re-opening or reviving rural obstetric services for uncomplicated pregnancies in the service area.

b. Identify if there are any FQHCs, RHCs, existing Healthy Start or Home Visiting programs or other federally funded resources in the service area (e.g., Alliance for Innovation on Maternal Health (AIM) maternal safety bundle implementation, or state-led Perinatal Quality Collaborative, State Maternal Mortality Review Committee participation). If so, describe how the proposed project will incorporate and leverage the current services and resources in the community to develop a seamless continuum of care.

c. Detail if there are other health care providers or health systems in the region that are not a part of your network that could be affected by the proposed project. Describe whether this project would enhance collaboration or competition with other regional health care service providers (e.g., changes in referral patterns, practice patterns, provider reimbursement impact, etc.).

- METHODOLOGY -- Corresponds to Section V's Review Criterion # 2 Response

  This section outlines, in a narrative format, the methods that you will use to address and respond to the aforementioned needs and meet each of the program activities and expectations in this NOFO. The following items must be addressed within the methodology sections. Please use the headings: (1) Methods for Fulfilling Planning Year 1 Activities, (2) Methods for Fulfilling Implementation Years 2-4 Activities, (3) Methods for Sustainability Planning, and (4) Methods for Maintaining Network and Stakeholder Commitment.

(1) Methods for Fulfilling Planning Year 1 Activities

Detail the methods you will use to complete each first-year activity, which include:

a. **Develop a** **model** addressing the RMOMS Focus Areas that support the coordinated maternal care and delivery needs of a region and the necessary workforce training, services, equipment, and reimbursement needs to sustain the model. Note, if your project is proposing to reopen obstetric services, then your model should clearly describe how these elements will be incorporated. The model should address and improve upon the following elements:

   - Access: improve access to patient-centered, comprehensive, risk-appropriate coordinated care for people before, during and after pregnancy. The use of telehealth to support specialty services and to reduce the travel burden of patients is encouraged.

   - Workforce: enhance skills by utilizing a multidisciplinary team and improve the distribution of maternal and obstetrics health care providers needed to facilitate a continuous team-based approach committed to improving the birth experience through the inclusion

of doctors, nurse midwives, nurses, doulas, and other health professionals.

- Reimbursement: collaborate and coordinate with state Medicaid agencies and other payers if applicable, to explore payment and reimbursement options to support the model, ensure access and improve outcomes including potential ways to reduce costs.

b. **Establish data collection strategy and collect baseline data.** Both quantitative and qualitative data will be used by the network and the HRSA-funded evaluator to perform continuous quality improvement; identify gaps in the continuity of obstetric care and/or workforce and access to care within the targeted rural service area; leverage existing federal, state, and local maternal and obstetrics health resources; and to demonstrate the clinical and financial impact of the program. Network leads must establish a process to collect and store patient-level data from clinical network partners and care coordinators, create a unique patient identification number and link the data to create a patient record. Anticipated required data elements are included in **Appendix B.** The evaluator will work with network leads to determine a secure method to transfer de-identified, patient-level data.

- Review **Appendix B**: RMOMS Data Requirements and detail how your network proposes to gather and store the network- and patient-level data, and your plan to follow patients through the continuum of care. Note: a data collection strategy must be finalized during year 1 for data collection and storage of network- and patient-level data.

- Baseline data will be reported in year 1 for the Performance Improvement Measurement System (PIMS) Questions detailed in **Appendix B** as well as at least 6 months of clinical patient-level data for a subset of data elements determined by the evaluator. Detail how your network proposes to collect and store baseline data. For the implementation period (years 2-4), network- and patient-level data will be reported every 6 months to the HRSA-funded evaluator.

c. **Develop strategic work plan** to implement the model in the target region during years 2, 3, and 4. The work plan must clearly align with the RMOMS Focus Areas, provide details on how people in the target population will be identified for inclusion in the program, and explain how the network partners will be able to track and coordinate care received by identified people throughout the network. It must also link the model's goals, strategies, activities with data collection, storage, and reporting capabilities, which will be reviewed by HRSA and the HRSA-funded program evaluator.

d. **Engage in network capacity building and infrastructure development.** This can include, but is not limited to:

- acquire appropriate staffing and equipment needs to support your model work plan;
- develop a network business model;
- identify how network members can integrate their functions and share clinical and/or administrative resources;
- identify and establish ways to obtain regional and/or local community support/buy-in around the network model;
- identify a strategy to leverage broadband connectivity to support health information technology applications in rural regions.

(2) Methods for Fulfilling Implementation Years 2-4 Activities

Detail the methods you will use to complete activities in years 2-4, which include:

a. **Implement and test models** using the reviewed strategic work plan in alignment with the RMOMS Focus Areas.

o This might include testing and refining the model in a smaller catchment area and subsequently expanding to a larger region; or implementing and refining strategies within the model by period (preconception; pregnancy, labor and delivery; and postpartum) across your region.

b. **Provide case management and care coordination** for patients and their infants across the continuum of care through appropriate risk stratification with lower-risk and routine pregnancies delivered in rural settings and higher-risk deliveries handled at a referral hospital in the network, leveraging existing services and programs. Programs to consider include, but are not limited to, the Healthy Start and the Home Visiting Programs (to the extent which these resources are available in the service area).

c. **Track data and adjust model based on evaluative measures**. As described in **Appendix B**, you will work with the HRSA-funded program evaluator to identify the data elements that will be tracked and reported throughout the course of the period of performance. The evaluator will calculate evaluative measures based on these data elements Discuss how you will use data to adjust the model where appropriate.

(3) Methods for Sustainability Planning

Describe a plan for sustaining the model funded by the RMOMS award and discuss the following:

a. How volume aggregation through appropriate risk stratification with lower-risk and routine pregnancies delivered in rural network settings and higher-risk deliveries handled at a referral hospital in the network will lead to long-term sustainable rural hospital obstetric services in the service area.

b. The strategies you will utilize to achieve the desired sustainability of the project as a result of the RMOMS funding. You must consider how to sustain your RMOMS funded programs beyond the 4-year period of performance.

c. How to leverage the partnership with the state Medicaid agency and other payers to develop innovative reimbursement strategies for sustainability. Discuss how realistic and feasible the proposed sustainability strategies are for your project. HRSA understands that the sustainability plan may evolve as you implement the project. The prospect of being financially prepared to continue the project increases if you identify strategies for sustainability during the planning stages of the project.

d. The potential sources of support for achieving sustainability with a program emphasis on testing and innovating financial models to support maternal health. Most successful sustainability strategies include a variety of sources of support and do not depend on federal funding to maintain program activities.

Note: As part of receiving the award, recipients are required to submit a final sustainability plan during the final year of their period of performance. Further information will be provided upon receipt of the award.

(4) Methods for Maintaining Network and Stakeholder Commitment

Describe how your network will maintain members' commitment throughout the period of performance to: fulfill the proposed activities, engage members in a shared governance model, promote efficient decision-making, assure accurate and timely data collection & reporting and cooperation with the evaluation, undertake sustainability planning, and ensure that local control for the award remains vested in the targeted rural communities.

Describe how the network will build and maintain stakeholder involvement and commitment to developing strategies responsive to the RMOMS focus areas, and inclusive of engaging partnerships with organizations to improve health equity throughout the period of performance.

- WORK PLAN -- Corresponds to Section V's Review Criterion #2 Response and #4 Impact

  Describe the activities or steps (including addressing the RMOMS Focus Areas) that you will use to achieve each of the activities proposed during the first year of the period of performance (Note: you will develop your work plan for years 2, 3, and 4 during year 1). Use a timeline that includes each year 1 activity and identifies the responsible staff. As appropriate, identify meaningful support and collaboration with key stakeholders in planning, designing and implementing all activities, including development of the model and, further the extent to which these contributors reflect the cultural, racial, linguistic, religious and geographic diversity of the populations and communities to be served. Please include the work plan as **Attachment 6**.

  Describe the (1) Impact, (2) Replicability, and (3) Dissemination Plan for your project model.

  (1) Impact

  Describe the expected impact on the target population and the regional health system. Although HRSA recognizes the influence of external factors when attributing the effects of an activity or program to the long-term health outcome of a community, you should still describe the expected or potential long-term changes and/or improvements in health status due to the model. This would include how lower-risk obstetric services and deliveries will be provided in rural hospitals and higher-risk deliveries will be provided in partner tertiary facilities. Similarly, describe the impacts of the model on the regional health system stakeholders. Examples of potential long-term impact could include:

  - changes in rate of maternal morbidity and mortality
  - maintenance of desired behavior
  - enhanced availability of obstetric services in at least one of the participating rural hospitals or Critical Access Hospitals.
  - policy implications
  - mitigation in access to care barriers
  - data collection disaggregated by race/ethnicity and other health equity measures

- viability of obstetric services in the region
- obstetric workforce recruitment and retention

(2) **Replicability**

Describe the expected impact from the project on the target population and the extent of the project's value to similar regions with comparable needs. You must describe the degree to which the project activities are replicable to other rural regions with similar needs.

(3) Dissemination Plan

Describe the plans and methods for widely disseminating your project results. You must include a plan that describes how you will share the information collected throughout the project with varying stakeholders. A dissemination plan must be outlined describing strategies, platforms, and activities for informing respective target audiences and stakeholders (i.e., policymakers, research community, etc.).

- RESOLUTION OF CHALLENGES -- Corresponds to Section V's Review Criterion #2 Response

  Discuss potential challenges and approaches to resolve those challenges. Include a discussion of:

  a. Designing and implementing the activities described in the work plan.
  b. Data collection capacity at each clinical site including how data will be shared, linked, and de-identified among network partners and shared with the HRSA-funded program evaluator; the treatment of patient-level data and the corresponding legal and privacy considerations; and the corresponding staffing resources necessary for each network partner and the applicant organization to support successful data collection.
  c. Keeping the network actively engaged throughout the period of performance; in particular maintaining communication and collaboration with the state Medicaid agency.
  d. External challenges such as staff turnover, geographic limitations, health workforce shortages, insurance, provider reimbursement, telehealth, and/or others.
  e. How to ensure the services provided address the cultural, linguistic, religious, and social differences of the target population.

f. If the applicant organization is located in an urban area, ensuring work and activities exclusively serve rural underserved populations.

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

  This section should demonstrate your network's capacity to collaborate (including integrating data sharing capabilities amongst network members Attachment 12) with the HRSA- funded program evaluator on individual and cross-award recipient program evaluation/analyses. Describe the process (including staffing and quality assurance safeguards) by which you will collect, store, share, manage and report quantitative and qualitative data/information across the network. Include in the budget appropriate allocation of award resources and staffing to ensure data collection at all points of service. Resources from the HRSA award may be allocated for this purpose, if necessary.

  Note that RMOMS award recipients will be expected to work with a HRSA-funded evaluator during the period of performance (and potentially share project updates and information with them after the period of performance ends). HRSA will provide additional guidance on the technical assistance and evaluation components of the project throughout the period of performance.

  Review the required measures/data elements in **Appendix B**. Detail how your network proposes to gather and store the network- and patient-level data, and link patient-level data with a unique identifier in order to follow patients through the continuum of care amongst your network sites. Include information about technological processes including but not limited to Electronic Health/Medical Record (EMR/EHR) systems, Excel, REDCap, or other systems your network will develop and use to collect, review, clean, and report the data across network sites. Resources from the HRSA award may be allocated for this purpose, if necessary. Discuss how you will address legal, privacy and staffing considerations at each network site to meet these data requirements and the anticipated roles and focus of all network providers and hospitals. For the purposes of your application, you must demonstrate the ability and capacity to report data in the following:

  a. **Demographic information:** age, race/ethnicity, health insurance coverage, etc.

  b. **Utilization of services:** prenatal visits, postpartum visits, referrals to specialty care and types of specialists, depression screening, etc. (with and without telehealth)

  c. **Maternal and infant health outcomes/behaviors:** maternal or neonatal death, pre-term birth, length of maternal hospital stay post-delivery,

gestational age at delivery, neonatal intensive care unit (NICU) stay, rates of breastfeeding, alcohol and drug use, etc.

d. **Case management/care coordination contacts:** referrals to non-medical services

e. **Cost and cost effectiveness:** billable services, cost reductions and savings, etc.

f. **Network approaches to care:** workforce[17], travel time to care, risk appropriate care and referral systems, etc.

- ORGANIZATIONAL INFORMATION -- Corresponds to Section V's Review Criterion #5 Resources/Capabilities

  This section provides insight into the organizational structure of the network and the network's ability to implement the activities outlined in the work plan. You should include staffing and network information using the following subheadings: (1) List of Network Members; (2) Organizational Chart; (3) Resources and Capabilities; and (4) Network Strength and Capacity.

  (1) ***List of Network Members*** **(Attachment 3)**: For each member of your network, include the following (**It is highly recommended to provide in a table format**; list the applicant organization first):

  (a) Member name

  (b) Member street address (include city, county, state, ZIP code)

  (c) Primary point of contact at organization (name, title, contact information)

  (d) Member Employer Identification Number (EIN)

  (e) Facility type (e.g., hospital, RHC, FQHC, etc.)

  (f) Sector (e.g., healthcare, public health, education, transportation, etc.)

  (g) List which periods in the continuum of care [(1) preconception; (2) pregnancy, labor, and delivery; (3) postpartum] that the member provides services

  (h) Specify (yes/no) whether the member is located in a HRSA-designated rural county or rural census tract of an urban county, as defined by: https://data.hrsa.gov/tools/rural-health?tab=Address

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[17] Maternal and Child Health Leadership Competencies Version 4.0 https://mchb.hrsa.gov/training/documents/MCH_Leadership_Competencies_v4.pdf

(2) ***Organizational Chart (Attachment 7):*** Provide a one-page organizational chart of the network that clearly depicts the relationship between the network members and their contribution/s to the project.

***(3) Resources* and Capabilities**

(a) Describe a clear and coherent plan detailing the staffing requirements and competencies necessary to run the project differentiating between year 1 and years 2-4. Note the applicant organization should have the staffing and infrastructure necessary to oversee program activities and serve as the fiscal agent for the award. The applicant organization must:

- Exercise administrative and programmatic direction over award-funded activities;
- Be responsible for hiring and managing the award-funded staff;
- Demonstrate the administrative and accounting capabilities to manage the award funds;
- Demonstrate they have the organizational capacity to serve rural underserved populations;
- Have at least one permanent staff at the time an award is made; and
- Have an Employer Identification Number (EIN) from the Internal Revenue Service.

HRSA requires at least 0.5 FTE be allocated for staff at the network level to coordinate data collection and reporting across all network partner clinical sites. This staff must have the capacity to travel to all network clinical sites. Applicants should strongly consider network size when determining additional FTE allocation for data collection and reporting. Resources from the HRSA award may be allocated for this purpose, if necessary.

HRSA encourages that each network partner clinical site should have designated data point of contact who will liaise and coordinate data collection and reporting with network data staff. Resources from the HRSA award may be allocated for this purpose, if necessary.

(b) A staffing plan is required and should be included in **Attachment 8**. Specifically, the following should be addressed:

- The job descriptions for key personnel listed in the application.
- The number and types of staff, qualification levels, and FTE equivalents.

        - The staffing plan must clearly detail how the applicant organization will meet the requirement of at least 0.5 FTE to be allocated at the network level for staff to coordinate data collection and reporting across all network partner clinical sites with the ability to travel to all network clinical sites. Applicants should include a brief justification for the FTE related to the network size.
        - The staffing plan should also clearly detail how each network partner clinical site should have designated data point of contact who will liaise and coordinate data collection and reporting with network data staff.

    - The information necessary to illustrate the capabilities (current experience, skills, knowledge, and experience with previous work of a similar nature) of key staff already identified, competencies and the requirements that the applicant has established to fill other key positions, if the award is received. Resumes/biographical sketches of key personnel should be included in **Attachment 9**.

      Project Director: The Project Director is typically the point person on the award, and makes staffing, financial, or other adjustments to align project activities with the project outcomes. You should detail how the Project Director will facilitate collaborative input across network members to fulfill the proposed project activities in the work plan and HRSA-required reporting requirements. **If the Project Director serves as a Project Director for other federal awards, please list the federal awards as well as the percent FTE for each respective federal award.** Project staff cannot bill more than 1.0 FTE across federal awards. If there will not be a permanent Project Director at the time of the award, recipients should make every effort to hire a Project Director in a timely manner and applicants should discuss the process and timeline for hiring a Project Director (i.e., the number of known candidates, the projected start date or the position, etc.).

(c) Staffing needs should have a direct link to the activities proposed in the project narrative and budget portion of the application.

    - HRSA requires at least 0.5 FTE be allocated at the network level for staff to coordinate data collection and reporting across all network partner clinical sites. This staff must have the ability to travel to all network clinical sites. Applicants should strongly consider network size when determining additional FTE allocation for data collection and reporting.
    - HRSA strongly encourages award recipients to:

- devote at least 0.25 FTE to the project director position;
- have at least one permanent staff at the time an award is made;
- have a minimum total equal to 2.0 FTE allocated for implementation of project activities, met across two or more staffing positions, including the project director position; and,
- have a designated data point of contact who will liaise and coordinate data collection and reporting with network data staff at each network partner clinical site.

(4) Network Strength and Capacity

(a) Describe strength, capacity, and value of your network. Describe how your network has the capacity and collective mission and vision to collaborate effectively to achieve the goals of the RMOMS program. Detail the history of collaboration among your network members and detail the strengths of your network (e.g., regional integration, ability to address gaps in the continuum of care; degree of referrals and coordinated care, etc.).

(b) Describe how your network will ensure engagement among its network members, specifically each member's ability and commitment to reporting data to the network and the allocation of award funds across network members. Explain the Network's governance structure and how it will incorporate perspectives from all members in its decision making and resource allocation in order to meet program goals while ensuring and demonstrating high-level engagement from every member.

(c) Provide safeguards in a shared network governance to ensure a collaborative decision-making process that empowers all network members to address program goals.

(d) Describe how the network will acquire, manage and share data. Explain how funding will be allocated to network members to ensure data collection across the network.

iii. *Budget*

The directions offered in the SF-424 Application Guide may differ from those offered by Grants.gov. Follow the instructions in Section 4.1.iv of HRSA's *SF-424 Application Guide* and the additional budget instructions provided below. A budget that follows the *Application Guide* will ensure that, if HRSA selects your application for funding, you will have a well-organized plan and, by carefully following the approved plan, may 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) you incur to carry out a HRSA-supported project or activity. Total project or program costs include costs charged to the award and costs borne by you to satisfy a matching or cost-sharing requirement, as applicable.

In addition, the RMOMS program requires the following:

Travel: HRSA may require award recipients to travel to conference(s) and/or technical assistance workshop(s). Please allocate travel funds for up to two program staff to attend an annual 2.5-day technical assistance workshop in Washington, DC and include the cost in this budget line item. Further information will be provided to award recipients during the period of performance. Note that the conference may be held virtually during the ongoing COVID-19 pandemic if deemed necessary for safety and project officers will work with award recipients to make any budget adjustments if necessary.

As required by the Consolidated Appropriations Act, 2021 (P.L. 116-260), Division H, § 202 and Division A of the Further Continuing Appropriations Act, 2022 (P.L. 117-70), "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 fiscal years, as required by law.

iv. *Budget Narrative*

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

In addition, RMOMS requires the following:

This notice invites applications for periods of performance up to four years. Competitive FY 2022 awards will be for a 1-year budget period, although periods of performance may be for four years. Budget period renewal and release of subsequent year funds are based on the award recipient's submission and HRSA approval of Progress Report(s) and any other required submissions or reports.

Funding beyond the 1-year budget period but within the multi-year period of performance is subject to availability of funds, satisfactory progress of the award recipient, and a determination that continued funding would be in the best interest of the Federal Government. You must submit 1-year budgets for each of the subsequent budget periods within the requested period of performance at the time of application.

v. *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 limitation.** Your indirect cost rate agreement and proof of non-profit status (if applicable) will not count toward the page limitation. **Clearly label each attachment**. You must upload attachments into the application. Any *hyperlinked* attachments will *not* be reviewed/opened by HRSA.

Attachment 1: Network Partnership Documentation

Submit a copy of your network's signed MOA/U for network partner types 1-5, and the Letter of Commitment from the state Medicaid agency. The Medicaid letter of commitment should describe the extent of the anticipated partnership for the purposes of the RMOMS program. Note: applicants will receive a special consideration that request special consideration in Section IV.2.i Project Abstract and submit a signed MOA/U with the state Medicaid agency in lieu of the letter of commitment in **Attachment 14**. For further information on this special consideration and the required documentation, please refer to Section V.2. Review and Selection Process.

Attachment 2: Established Network History (if applicable)

In one page or less detail your network's history of working together; highlighting your network's products, services, and sources of sustainability. If you are an existing RMOMS network, please detail how you are proposing to expand the scope of the project or the area that will be served through the project.

Attachment 3: List of Network Members

For each member of the existing network, include the following (**It is highly recommended to provide in a table format; list the applicant organization first**):

i. Member name
ii. Member street address (include city, county, state, ZIP code)
iii. Primary point of contact at organization (name, title, contact information)
iv. Member Employer Identification Number (EIN)
v. Facility type (e.g., hospital, RHC, FQHC, etc.)
vi. Sector (e.g., healthcare, public health, education, transportation, etc.)
vii. List which periods in the maternal health continuum of care ((1) preconception; (2) pregnancy, labor and delivery; (3) postpartum) that the member provides services.
viii. Specify (yes/no) whether member located in a HRSA-designated rural county or rural census tract of an urban county, as defined by: https://data.hrsa.gov/tools/rural-health?tab=Address

Attachment 4: Required documentation from State Office of Rural Health

All applicants are required to notify their State Offices of Rural Health (SORHs) or other appropriate state entities early in the application process to advise them of their intent to apply. SORHs can often provide technical assistance to applicants. Please include a copy of the SORH's response to your correspondence and/or the letter or email you sent to the SORH notifying them of your intent to apply. SORH's applying as the applicant organization must provide an attestation that their application was independently developed and written and that they have not knowingly duplicated efforts or project ideas of non-SORH applicants within their state. By statute, all applicants are required to consult with their SORH or other appropriate state entities in Attachment 4. However, if applicants from the U.S. territories do not have the ability to do so, this requirement does not apply and U.S. territories are still eligible to apply.

Attachment 5: Map of Target Rural Service Area

Include a map that illustrates the geographic service area that will be served by your network. Also, detail the location of all network members within the map, and other pertinent elements such as broadband coverage/service providers, transportation considerations, etc.

Attachment 6: Work Plan

Attach the work plan for the first year of the period of performance that includes all information detailed in Section IV. ii. Project Narrative.

Attachment 7: Network Organizational Chart

Provide a one-page organizational chart of your network that clearly depicts the relationship between the network members and includes your network's governing board.

Attachment 8: 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, qualifications, and FTE allocations of proposed project staff. Note: staff cannot bill more than 1.0 FTE across federal awards.

Attachment 9: Biographical Sketches of Key Personnel

Include biographical sketches for persons occupying the key positions described in Attachment 8, 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 10: Documentation of Maternal-Fetal Medicine (MFM) Physician

Include documentation of the MFM physician at a network partner facility. Include the name, credentials, any specializations, date(s) of certification, privileges, and onsite availability. Acceptable documentation may be cited or obtained from the Society for Maternal Fetal Medicine (https://www.smfm.org/) or American Board of Obstetrics and Gynecology (https://www.abog.org/verify-physician).

Attachment 11: Documentation of Level III or Level IV Facility

Include documentation clearly demonstrating which network facility meets the Level III or Level IV requirement. At a minimum, include the facility name, address, point of contact and their email and phone number. If available, include any administrative, accreditation, or certification documents attesting to the facility's level as defined in https://www.ajog.org/article/S0002-9378(19)30753-7/fulltext.

Attachment 12: Data Usage/Sharing Agreement

Submit a signed and dated document establishing the terms and conditions under which the network partners and lead applicant can acquire and use data from each other as it relates to the compliance of data reporting requirements associated with this grant program. This agreement should include attestation that the data that will be shared are appropriate and valid.

Attachment 13: Request for a Funding Preference (if applicable)

If requesting a funding preference, the application must provide documentation that supports the funding preference qualification. Please indicate which qualification is being met also in Section IV.2.i Project Abstract. For further information on funding preferences and the required documentation, please refer to Section V.2.

Attachment 14: Request for a Special Consideration (if applicable)

If requesting a special consideration, the application must request special consideration in Section IV.2.i Project Abstract and submit a signed MOA/U with the state Medicaid agency in Attachment 11. For further information on funding preferences and the required documentation, please refer to Section V.2.

Attachment 15: Other HHS Awards (if applicable)

If the applicant organization has received any HHS funds within the last 5 years, include the name of the HHS awarding agency, award number, and award amount of the previous award. If the applicant is part of another network applying to the RMOMS program, please include the application abstract.

Attachment 16: Other Relevant Documents (Optional)

Include here any other documents that may be relevant to the application (e.g., indirect cost rate agreement; letters of commitment or support that are dated and specifically indicate a commitment to the project/program such as in-kind services, dollars, staff, space, or equipment; etc.).

3. Dun and Bradstreet Data Universal Numbering System (DUNS) Number Transition to the Unique Entity Identifier (UEI) and System for Award Management (SAM)

You must obtain a valid DUNS number, also known as the Unique Entity Identifier (UEI), and provide that number in the application. In April 2022, the *DUNS number will be replaced by the UEI, a "new, non-proprietary identifier" requested in, and assigned by, the System for Award Management (SAM.gov). For more details, visit the following webpages: Planned UEI Updates in Grant Application Forms and General Service Administration's UEI Update.

You must register with 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 you are an individual or federal agency that is exempted from those requirements under 2 CFR § 25.110(b) or (c), or you have an exception approved by the agency under 2 CFR § 25.110(d))**.** For your SAM.gov registration, you must submit a notarized letter appointing the authorized Entity Administrator.

If you are chosen as a recipient, HRSA will not make an award until you have complied with all applicable SAM requirements. If you have not fully complied with the requirements by the time HRSA is ready to make an award, you may be deemed not qualified to receive an award, and HRSA may 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.

Currently, the Grants.gov registration process requires information in three separate systems:

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

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

In accordance with the Federal Government's efforts to reduce reporting burden for recipients of federal financial assistance, the general certification and representation requirements contained in the Standard Form 424B (SF-424B) – Assurances – Non-Construction Programs, and the Standard Form 424D (SF-424D) – Assurances – Construction Programs, have been standardized. Effective January 1, 2020, the forms themselves are no longer part of HRSA's application packages instead, the updated common certification and representation requirements will be stored and maintained within SAM. Organizations or individuals applying for federal financial assistance as of January 1, 2020, must validate the federally required common certifications and representations annually through SAM.gov.

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 5, 2022 *at 11:59 p.m. ET*. HRSA suggests submitting applications to Grants.gov at least **3 calendar 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

RMOMS is 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 period of performance of up to 4 years, at no more than $1,000,000 per year (inclusive of direct **and** indirect costs). This program notice is subject to the appropriation of funds, and is a contingency action taken to ensure that, should funds become available for this purpose, HRSA can process applications and award funds appropriately. 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 H of the Consolidated Appropriations Act, 2021 (P.L. 116-260) and Division A of the Further Continuing Appropriations Act, 2022 (P.L. 117-

70) apply to this program. See Section 4.1 of HRSA's *SF-424 Application Guide* for additional information. Note that these or other restrictions will apply in following fiscal years, as required by law.

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

- To build or acquire real property or for construction or major renovation or alteration of any space (see 42 U.S.C. 254c(h)).
- Minor renovations and alterations are allowable.

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 all other applicable grants requirements, the effectiveness of these policies, procedures, and controls is subject to audit.

Be aware of the requirements for HRSA recipients and subrecipients at 2 CFR § 200.216 regarding prohibition on certain telecommunications and video surveillance services or equipment. For details, see the HRSA Grants Policy Bulletin Number: 2021-01E.

All program income generated as a result of awarded funds must be used for approved project-related activities. Any program income earned by the recipient must be used under the addition/additive alternative. You can find post-award requirements for program income at 45 CFR § 75.307.

V. Application Review Information

1. Review Criteria

HRSA has procedures for assessing the technical merit of applications to provide for an objective review 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.

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.

Six review criteria are used to review and rank RMOMS applications. Below are descriptions of the review criteria and their scoring points.

Criterion 1: NEED (15 points) – Corresponds to Section IV's Introduction and Need Assessment

a. The clarity with which the proposed project thoroughly responds to:

   i. The information requested in the project abstract.

   ii. The "Purpose" and each of the four RMOMS Focus Areas included in the funding opportunity description and outlines the project target population, service area, network members, goals, activities, and anticipated outcomes of the project.

b. The extent to which the applicant identifies and documents the unmet health care needs of the target population as evidenced by:

   i. The data provided regarding the incidence of maternal mortality, severe maternal morbidity (SMM), other maternal health indicators in the target population; including demographic information relating to subpopulations and other health status indicators (e.g., social determinants of health, health disparities, etc.) relevant to the project.

   ii. The thoroughness with which the applicant illustrates the demographics of the service area (outside of the target population). The applicant should compare local data versus state and national data to demonstrate disparity and need, including disaggregation of data by racial and ethnic groups and/or a discussion of racial and ethnic disparities in the proposed target population or other demographics as appropriate.

c. The extent to which the applicant details both the range of regional stakeholders and their level of involvement in identifying the needs of the target population and in planning the project activities; and the representation of these stakeholders in the shared governance model of the proposed network partners to foster regular consultation and collaboration between and among each network member.

d. The extent to which the target service area is clearly defined and described as evidenced by a clear depiction of the hospital service region for the network and a map detailing the location of all network members and important geographical considerations.

e. The extent to which the applicant demonstrates a thorough understanding of the relevant obstetric health services currently available or not available in the targeted service area including:

   i. How the project will effectively address a gap in the regional continuum of health care with attention to obstetric services, prenatal and postnatal care, recent or pending changes to obstetric services and financial sustainability issues.

ii. The potential impact of the project on current providers (including those that are not part of the proposed project); specifically noting existing FQHCs, RHCs, and other federally funded programs (e.g., Healthy Start, Home Visiting, AIM, PQCs and MMRCs (to the extent which these resources are available in the service area) to be leveraged in the continuum of care.

iii. Other potential adverse effects (if any), as well as estimates of how the project might augment and enhance any existing capabilities in the service area (e.g., changes in referral patterns, practice patterns, provider reimbursement impact, etc.), including ongoing activities around maternal and child health, specifically noting Healthy Start and/or Home Visiting Programs where applicable.

Criterion 2: RESPONSE (25 points) – Corresponds to Section IV's Methodology, Work Plan and Resolution of Challenges

Sub-criterion one: Methodology – Planning Year 1 Activities *5 points*

The quality and extent to which the applicant clearly details the strategies they will use to complete each of the outlined activities including:

i. Develop a model in alignment with RMOMS Focus Areas that support the coordinated care and delivery needs of a region and the necessary workforce training, services, equipment, and reimbursement needs to sustain the model.

ii. Proposals to reopen obstetric services to a targeted rural hospitals or CAHs within the rural region to revive and sustain obstetric services.

iii. Develop a data collection and storage process for network- and patient-level data that includes a unique identifier to follow patients through the continuum of care and how network sites will be coordinated to meet these data requirements. Coordinate and plan with HRSA and the HRSA-funded program evaluator to submit network- and patient-level baseline data during the planning year (year 1) and submit network- and patient-level data for the implementation period (years 2-4).

iv. Develop a strategic work plan to implement the model in the target region during years 2, 3 and 4.

v. Engage in network capacity building and infrastructure development.

Sub-criterion two: Methodology – Implementation Years 2-4 Activities *5 points*

The quality and extent to which the applicant details how they will:

i. Implement and test the model using the reviewed strategic work plan.

ii. Provide case management and coordinated care for patients and their infants across the continuum of care.

iii. Collect and report data elements and adjust the model based on evaluative measures.

Sub-criterion three: Methodology – Sustainability Planning 3 points

The strength and feasibility the applicant details:

i. How volume aggregation will lead to long-term sustainable rural maternal and obstetric hospital services in the service area.

ii. Sustainability planning and strategies for continuing the project beyond the 4-year period of performance.

iii. Leveraging state Medicaid agency partnership and other payers to explore innovative reimbursement strategies.

iv. Potential sources of support for sustainability beyond federal funding.

Sub-criterion four: Methodology – Maintaining Network Commitment 3 points

The quality and extent to which the applicant details:

i. The structure of the network's shared governance and how the network will maintain all of the network members' commitment, throughout the period of performance to fulfill the proposed activities, efficient decision-making, data collection and cooperation with the evaluation, sustainability planning.

ii. How the network will ensure that local control for the award remains vested in the targeted rural communities and maintain stakeholder involvement and commitment throughout the period of performance.

iii. How the network will build and maintain stakeholder involvement and commitment to developing strategies responsive to the RMOMS focus areas, inclusive of engaging partnerships with organizations to improve health equity throughout the period of performance.

Sub-criterion five: Work Plan *4 points*

The strength and feasibility of:

i. The work plan as a logical and effective approach for addressing regional obstetric care and for completing the first year of project activities in alignment with the RMOMS Focus Areas.

ii. The clarity with which the work plan addresses the project activities, responsible parties, the timeline of the proposed activities, anticipated outputs, and the necessary processes associated with achieving project goals.

iii. The proposed work plan clearly demonstrates that the network will use a collaborative approach and that it has the capacity to implement the proposed activities.

Sub-criterion six: Resolution of Challenges *5 points*

The extent to which the applicant clearly describe the relevant barriers they hope to overcome including:

i. The extent to which the work plan addresses and resolves identified challenges and anticipated barriers.

ii. Meeting HRSA Data Requirements outlined in **Appendix B**, specifically a plan to collect and store network- and patient-level data across all network members with consideration of differences in health record systems, legal, privacy concerns, variable staffing and resource capabilities at each site.

iii. A plan to actively engage the network members throughout the period of performance; in particular maintaining communication and collaboration with the state Medicaid agency.

iv. Any pertinent geographic, workforce, socio-economic, linguistic, cultural, and/or other barrier(s) that prohibit access to health care in the target population; particularly ensuring activities exclusively serve rural underserved populations.

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

The extent to which the applicant:

a. Demonstrates the strength, quality, and capacity of the network to collaborate with a HRSA-funded program evaluator, including the capacity to collect, link,

store and report patient-level data elements and provide network-level data as outlined in **Appendix B**:

- Patient-level data elements include but are not limited to demographic information, service utilization, health outcomes, and care coordination contacts.
- Network data include but are not limited to service delivery and access, cost and utilization, referrals and risk appropriate care.
- PIMS data elements

b. Includes, in the budget, an appropriate allocation of award resources and staffing to ensure data collection, at all points of service. The work plan includes evidence of legal and privacy considerations and a strong quality assurance process to ensure the validity of data elements/information collected by the network.

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

a. The extent to which the proposed project will positively affect the target population and the extent to which the project may be replicable in other regions with similar needs.
b. The extent to which the applicant describes the potential impacts on the viability of the obstetrics health system and workforce recruitment and retention including enhanced availability of obstetric services in at least one of the participating rural hospitals or Critical Access Hospitals.
c. The feasibility and effectiveness of the proposed approach for widely disseminating information regarding results of the project.

Criterion 5: RESOURCES/CAPABILITIES (25 points) – Corresponds to Section IV's Evaluation and Technical Support Capacity and Organizational Information

Sub-criterion one: Evaluation and Technical Capacity *10 points*

The extent to which the application:

a. Demonstrates the network's capacity to gather and store patient-level data (including demographic, service utilization, health outcomes and care coordination contacts) and link the data with a unique identifier in order to follow patients through the continuum of care amongst network members.
b. Demonstrates that each network member has submitted a signed and dated document establishing the terms and conditions under which the network partners and applicant organization can acquire and use data from each other as it relates

to the compliance of data reporting requirements associated with this grant program as noted in **Attachment 12**.

c. Describes the technological processes including but not limited to Electronic Health/Medical Record (EMR/EHR) systems, Excel, REDCap, or other systems the network will develop and use to collect, review, clean, and report the data across network sites.

d. Describes the process (including staffing and quality assurance safeguards) by which the network will collect, store, and convey quantitative and qualitative data/information to the HRSA-funded evaluator to satisfy the HRSA Data Reporting Requirements in **Appendix B**.

Sub-criterion two: Organizational Information *15 points*

The extent to which the application:

a. Details the strength of the network, inclusive of the contributions, services, and rurality of each network member.

b. Clearly describes the organizational structure of the network and depicts the relationship between network members; illustrating the network's ability to implement the activities outlined in the work plan.

c. Evidence that the applicant organization has the staffing and infrastructure necessary to oversee program activities and serve as the fiscal agent for the award.

d. Provides a clear and coherent staffing plan that includes all of the requested information for each proposed project staff and has a direct link to the activities proposed in the work plan year 1 and the anticipated staffing needs for years 2-4.

e. Documents at least 0.5 FTE allocated for staff at the network level to coordinate data collection and reporting across all network partner clinical sites. Demonstrates the capacity for travel to each network clinical site.

f. Demonstrates how each network partner clinical site has a designated data point of contact who will liaise and coordinate data collection and reporting with the network data staff.

g. Details how the Project Director will serve as the lead on the award; make staffing, financial, or other adjustments to align project activities with the project outcomes; and facilitate collaborative input across network members to fulfill the proposed project activities in the work plan and HRSA-required reporting requirements.

    - If there will not be a permanent Project Director at the time of the award, the quality and extent to which the applicant details the process for hiring

a Project Director in a timely manner (i.e., the number of known candidates, the projected start date or the position, etc.).

h. Provides the resumes and/or biographical sketches that details the qualifications and relevant experience for each proposed project staff member.

  - If there will not be staff on board at the time of the award, the extent to which the applicant details the process and timeline for hiring staff (i.e., the number of known candidates, the projected start date or the position, etc.).

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

a. The extent to which the budget narrative logically documents how and why each line item request (such as personnel, travel, equipment, supplies, information technology, and contractual services) supports the goals and activities of the proposed award- funded activities over the length of the 4-year period of performance.

b. The extent to which resources and staff are allocated to satisfy network engagement and data collection requirements at each network site.

c. The degree to which the estimated cost to the government for proposed award-funded activities is reasonable.

2. Review and Selection Process

The objective review process provides an objective evaluation of applications 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. In addition to the ranking based on merit criteria, HRSA approving officials will apply other factors described below in selecting applications for award.

Funding Preferences

This program provides a funding preference for some applicants, as authorized by 42 U.S.C. 254c(h)(3). Applicants receiving the preference will be placed in a more competitive position among applications that can be funded. Applications that do not receive a funding preference will receive full and equitable consideration during the review process. HRSA staff will determine the funding preference and will grant it to any qualified applicant that demonstrates they meet the criteria for the preference(s) as follows:

Qualification 1: Health Professional Shortage Area (HPSA)

You can request funding preference if the service area of the applicant is located in an officially designated health professional shortage area (HPSA). Applicants must include a screenshot or printout from the HRSA Shortage Designation website, which indicates if a particular address is located in a HPSA: https://data.hrsa.gov/tools/shortage-area/by-address.

Qualification 2: Medically Underserved Community/Populations (MUC/MUPs)

You can request funding preference if the applicant is located in a medically underserved community (MUC) or serves medically underserved populations (MUPs). Applicants must include a screenshot or printout from the HRSA Shortage Designation website that indicates if a particular address is located in a MUC or serves an MUP: https://data.hrsa.gov/tools/shortage-area/by-address.

Qualification 3: Focus on Primary Care, and Wellness and Prevention Strategies

You can request this funding preference if your program focuses on primary care and wellness and prevention strategies. You must include a brief justification (no more than 3 sentences) describing how your program focuses on primary care and wellness and prevention strategies in **Attachment 13**.

If requesting a funding preference, please indicate which qualification is being met in the **Project Abstract** and **Attachment 13**. HRSA highly recommends that the applicant include this language to identify their funding preference request:

"(Your organization's name) is requesting a funding preference based on qualification X. County Y is (in a designated HPSA; or in a MUC/MUP; or is focusing on primary care, and wellness and prevention strategies)."

Please provide documentation of funding preference and label documentation as "Proof of Funding Preference Designation/Eligibility." See **page 44** of the HRSA SF-424 Application Guide.

You only have to meet **one** of the qualifications stated above to receive the preference. Meeting more than one qualification **does not** increase an applicant's competitive position.

Funding Special Considerations and Other Factors

This program provides a special consideration based on the extent to which the applicant documents an official partnership with the state Medicaid agency as a fully formed network. HRSA acknowledges that each state Medicaid agency varies in available resources and capacity to partner with community health care organizations. However, official partnership with the state Medicaid agency is beneficial as rural

populations have a large share of Medicaid recipients and networks are to plan for financial sustainability. A special consideration is the favorable consideration of an application by HRSA funding officials, based on the extent to which the application addresses the specific area of special consideration. PLEASE NOTE: In order to support fully formed networks, as stated for the special consideration, HRSA may need to fund out of rank order. Applications that do not receive special consideration will be given full and equitable consideration during the review process.

HRSA staff will determine if special consideration is met, and will apply it to any qualified applicant that demonstrates they meet the criteria for the special consideration. However, HRSA acknowledges that the funding preference supersedes the special consideration and will take both into consideration at the time of funding for those that qualify. The special consideration criteria are as follows:

Criteria: Signed MOA/U with state Medicaid agency

If requesting special consideration, please include a signed MOA/U with the state Medicaid agency in **Attachment 14** and indicate this request at the bottom of the **Project Abstract**. HRSA recommends you include this language and/or combine with above funding preference language:

"*(Your organization's name) is requesting special consideration based on the inclusion of a signed MOA/U with the state Medicaid agency included in Attachment 14."*

3. Assessment of Risk

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.

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 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 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).

VI. Award Administration Information

1. Award Notices

HRSA will release the Notice of Award (NOA) on or around the start date of September 1, 2022. 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*.

If you are successful and receive a NOA, in accepting the award, you agree that the award and any activities thereunder are subject to:

- all provisions of 45 CFR part 75, currently in effect or implemented during the period of the award,
- other federal regulations and HHS policies in effect at the time of the award or implemented during the period of award, and
- applicable statutory provisions.

Accessibility Provisions and Non-Discrimination Requirements

Should you successfully compete for an award, recipients of federal financial assistance (FFA) from HHS must administer their programs in compliance with federal civil rights laws that prohibit discrimination on the basis of race, color, national origin, disability, age and, in some circumstances, religion, conscience, and sex (including gender identity, sexual orientation, and pregnancy). This includes ensuring programs are accessible to persons with limited English proficiency and persons with disabilities. The HHS Office for Civil Rights (OCR) provides guidance on complying with civil rights laws

enforced by HHS. See Providers of Health Care and Social Services and HHS Nondiscrimination Notice.

- Recipients of FFA must ensure that their programs are accessible to persons with limited English proficiency. For guidance on meeting your legal obligation to take reasonable steps to ensure meaningful access to your programs or activities by limited English proficient individuals, see Fact Sheet on the Revised HHS LEP Guidance and Limited English Proficiency.
- For information on your specific legal obligations for serving qualified individuals with disabilities, including reasonable modifications and making services accessible to them, see Discrimination on the Basis of Disability
- HHS-funded health and education programs must be administered in an environment free of sexual harassment. See Discrimination on the Basis of Sex
- For guidance on administering your program in compliance with applicable federal religious nondiscrimination laws and applicable federal conscience protection and associated anti-discrimination laws, see Conscience Protections for Health Care Providers and Religious Freedom

Please contact the HHS Office for Civil Rights for more information about obligations and prohibitions under federal civil rights laws or call 1-800-368-1019 or TDD 1-800-537-7697.

The HRSA Office of Civil Rights, Diversity, and Inclusion (OCRDI) offers technical assistance, individual consultations, trainings, and plain language materials to supplement OCR guidance and assist HRSA recipients in meeting their civil rights obligations. Visit OCRDI's website to learn more about how federal civil rights laws and accessibility requirements apply to your programs, or contact OCRDI directly at HRSACivilRights@hrsa.gov.

Executive Order on Worker Organizing and Empowerment.
Pursuant to the Executive Order on Worker Organizing and Empowerment, HRSA strongly encourages applicants to support worker organizing and collective bargaining and to promote equality of bargaining power between employers and employees. This may include the development of policies and practices that could be used to promote worker power. Applicants can describe their plans and specific activities to promote this activity in the application narrative.

Requirements of Subawards

The terms and conditions in the 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, and it is the recipient's responsibility to monitor the compliance of all funded subrecipients. See 45 CFR § 75.101 Applicability for more details.

Data Rights

All publications developed or purchased with funds awarded under this notice must be consistent with the requirements of the program. Pursuant to 45 CFR § 75.322(b), the recipient owns the copyright for materials that it develops under an award issued pursuant to this notice, 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 award 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 others. If applicable, the specific scope of HRSA rights with respect to a particular grant-supported effort will be addressed in the NOA. Data and copyright-protected works developed by a subrecipient also are subject to the Federal Government's copyright license and data rights.

3. Reporting

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

1) **Data Collection Plan.** Award recipients are required to submit a data collection plan during the planning year that details each network site-level data and patient- level data capabilities and the network's plan to meet data reporting requirements. Additional instructions will be provided upon receipt of the award.
2) **Baseline Services Map.** Award recipients are required to submit a baseline services map during the planning year that will include an asset mapping exercise of the relevant maternal health services in the service area and a gap analysis. Additional instructions will be provided upon receipt of the award.
3) **Strategic Work Plan.** Award recipients are required to submit a three-year work plan and logic model during the first-year of the period of performance that implements and tests the proposed model in an iterative process using baseline data established in the first year. Elements of strategic planning tied to internal and external analysis and alignment of the model with the network goals should be integrated into the work plan. Additional instructions will be provided upon receipt of the award.
4) **Data Reporting.** Award recipients will be required to collaborate with HRSA and with the HRSA-funded program evaluator to assess the impact of their project and of the RMOMS program as a whole. During the first year of the period of performance, HRSA will provide general program measures, in addition to the specific measures/data elements that award recipients will need to collect and report on.

Required measures/data elements will include:

a. Demographic information
b. Utilization of services
c. Maternal and infant health outcomes/behaviors
d. Case management/care coordination contacts
e. Cost and cost effectiveness
f. Network approaches

Award recipients should also use process and outcome indicators to track/measure whether the individual activities outlined in the work plan are implemented effectively.

5) **Federal Financial Status Report (FFR).** A Federal Financial Report (FFR) is required at the end of each budget period. The report is an accounting of expenditures under the project that year. Financial reports must be submitted electronically. More information will be included in the Notice of Award.

6) **Progress Report.** Award recipients must submit a progress report to HRSA on an annual basis. Submission and HRSA approval of your Non-Competing Continuation (NCC) Progress Report(s) triggers the budget period renewal and release of subsequent year funds. This report demonstrates award recipient progress on program-specific goals. Further information will be provided in the Notice of Award.

7) **Performance Measures Report.** A performance measures report (PIMS) is required after the end of each budget period. Award recipients will be notified of the specific performance measures required for reporting in the first year of the period of performance, and how these results will be reported to HRSA.

8) **Sustainability Plan.** As part of receiving the award, recipients are required to submit a final Sustainability Plan during the final year of the period of performance. Additional instructions will be provided upon receipt of the award.

9) **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.

10) **Final Closeout Report.** A final report is due within 90 days after the period of performance ends. The final report details the resulting model; core performance measurement data; impact of the overall project; the degree to which the award recipient achieved the mission, goal and strategies outlined in the program; award recipient objectives and accomplishments; barriers

encountered; and responses to summary questions regarding the award recipient's overall experiences over the entire period of performance. Further information will be provided upon receipt of the award.

Note that the OMB revisions to Guidance for Grants and Agreements termination provisions located at 2 CFR § 200.340 - Termination apply to all federal awards effective August 13, 2020. No additional termination provisions apply unless otherwise noted.

VII. Agency Contacts

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

Bria Haley
Grants Management Specialist
Division of Grants Management Operations, OFAM
Health Resources and Services Administration
5600 Fishers Lane, Mailstop 10SWH03
Rockville, MD 20857
Telephone: (301) 443-3778
Email: bhaley@hrsa.gov

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

Victoria Tsai, MPH
Public Health Analyst
Federal Office of Rural Health Policy
Health Resources and Services Administration
5600 Fishers Lane, Mailstop 17W59D
Rockville, MD 20857
Email: RMOMS@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 dial 606-545-5035)
Email: support@grants.gov
Self-Service Knowledge Base

Successful applicants/recipients may need assistance when working online to submit information and reports electronically through HRSA's Electronic Handbooks (EHBs). Always obtain a case number when calling for support. For assistance with submitting in the EHBs, contact the HRSA Contact Center, Monday–Friday, 7 a.m. to 8 p.m. ET, excluding federal holidays at:

HRSA Contact Center
Telephone: (877) 464-4772 / (877) Go4-HRSA
TTY: (877) 897-9910
Web: http://www.hrsa.gov/about/contact/ehbhelp.aspx

VIII. Other Information

Technical Assistance

HRSA has scheduled following technical assistance:

Webinar

Day and Date: Wednesday, January 26, 2022
Time: 1 – 2 p.m. ET
Call-In Number: 1-833-568-8864
Participant Code: 06048296
Weblink: https://hrsa-gov.zoomgov.com/j/1606904058?pwd=cWVmR2RaZm1UYnB5OGc0VFFiSGlsdz09

Webinar Recording: email RMOMS@hrsa.gov 24 hours after the live event.

Tips for Writing a Strong Application

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

Appendix A: RMOMS Program Glossary

Continuum of Care spans the following periods:

- **Preconception**: Spans all reproductive years, which are the years that a person can have a child. Preconception care includes interventions that aim to identify and modify biomedical, behavioral and social risks to woman's health or pregnancy outcomes through prevention and management and the steps that should be taken before conception or early in pregnancy to maximize health outcomes. Source: https://cdc.gov/preconception/index.html
- **Pregnancy, Labor and Delivery**: The period occurring from conception through birth. Including prenatal care or the medical supervision of the pregnant person by a physician or other health care provider during the pregnancy.
- **Postpartum**: Begins immediately after the birth of a child and spans the period of time up to one year after birth. Source: https://www.cdc.gov/vitalsigns/maternal-deaths/index.html

Equity: The consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.[18]

Addressing issues of equity should include an understanding of intersectionality and how multiple forms of discrimination impact individuals' lived experiences. Individuals and communities often belong to more than one group that has been historically underserved, marginalized, or adversely affected by persistent poverty and inequality. Individuals at the nexus of multiple identities often experience unique forms of discrimination or systemic disadvantages, including in their access to needed services.[19]

Health Care Provider/Organizations: Health care providers are defined as: hospitals, public health agencies, home health providers, mental health centers, substance abuse service providers, rural health clinics, primary care providers, oral health providers, social service agencies, health profession schools, local school districts, emergency services providers, community and migrant health centers, federally-qualified health

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[18] Executive Order 13985 on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government, 86 FR 7009, at § 2(a) (Jan. 20, 2021), https://www.govinfo.gov/content/pkg/FR-2021-01-25/pdf/2021-01753.pdf.

[19] Executive Order 13988 on Preventing and Combating Discrimination on the Basis of Gender Identity or Sexual Orientation, 86 FR 2023, at § 1 (Jan. 20, 2021), https://www.govinfo.gov/content/pkg/FR-2021-01-25/pdf/2021-01761.pdf.

centers, tribal health programs, churches, and civic organizations that are/will be providing health related services.

Levels of Maternal Care

- **Level I (Basic Care):** Care of low- to moderate-risk pregnancies with ability to detect, stabilize, and initiate management of unanticipated maternal-fetal or neonatal problems that occur during the antepartum, intrapartum, or postpartum period until the patient can be transferred to a facility at which specialty maternal care is available.
- **Level II (Specialty Care):** Level I facility plus care of appropriate moderate- to high-risk antepartum, intrapartum, or postpartum conditions
- **Level III (Subspecialty Care):** Level II facility plus care of more complex maternal medical conditions, obstetric complications, and fetal conditions.
- **Level IV (Regional Perinatal Health Care Centers):** Level III facility plus on-site medical and surgical care of the most complex maternal conditions and critically ill pregnant women and fetuses throughout antepartum, intrapartum, and postpartum care. Source: https://doi.org/10.1016/j.ajog.2019.05.046

Memorandum of Agreement/Understanding (MOA/U): A MOA/U is a written document that must be signed by all network members to signify their formal commitment as network members. An acceptable MOA/U should at least describe the network purpose and activities; clearly specify each organization's role and responsibilities in terms of participation, governance and voting, integrating data sharing capabilities (see **Appendix B**); and membership benefits. For the purposes of this program, a letter of commitment is not the same as a MOA/U; a letter of commitment may represent one organization's commitment to the project but does not necessarily outline the roles and responsibilities that are mutually agreed upon among the network partners.

Model: A set of strategies or approaches for addressing the RMOMS program Focus Areas: (1) rural hospital obstetric service aggregation and approaches to risk appropriate care, (2) network approach to coordinating a continuum of care, (3) leveraging telehealth and specialty care, and (4) financial sustainability approaches. Models should be tested and improved upon through the use of data and evaluative measures spanning the continuum of care from the preconception period through pregnancy, labor, delivery and the postpartum period.

Networks

RMOMS Health Network: A network is defined as an arrangement among three or more separately owned domestic public and/or private health care provider organizations, including the applicant organization. For the purposes of this program, the applicant must have a network composition that includes: (1) at least two rural

hospitals or Critical Access Hospitals (CAH); 2) at least one health center under section 330 of the Public Health Service Act (Federally Qualified Health Center (FQHC) or FQHC look-alike, see Appendix C); 3) at least one Medicare certified Rural Health Clinic (RHC, to the extent which these entities are in the network service area and engaged in maternal and obstetrics care; see Appendix C) 4) at least one Level III and/or Level IV facility[20]; 5) regionally and/or locally available social services in the continuum of care (i.e., state Home Visiting and Healthy Start Programs to the extent which these resources are available in the service area); and include at least a letter of commitment from partner 6) the state Medicaid agency.

- **Formal Network**: A network organization is considered formal if the network has a signed Memorandum of Agreement (MOA), Memorandum of Understanding (MOU), or other formal collaborative agreements, including signed and dated bylaws. The network has a governing body that includes representation from all network member organizations and ensures that the governing body, rather than an individual network member, will make financial and programmatic decisions.

  An advisory board that merely provides advice is not considered a governing body. An already existing non-profit board of individuals convened for providing oversight to a single organization is not an appropriate board structure.

  The network ensures a joint decision-making model that ensures an equal voice for all network members and includes ongoing transparency related to network decisions, information and data sharing, and budget allocation decisions.

- **Established Network**: Meets the above definition of a **formal network** in addition to having a history of working together.

Obstetrics: field of study concentrated on pregnancy, childbirth and the postpartum period.

Rural Area: Project area determined rural as defined by HRSA Rural Health Grants Eligibility Advisor: https://data.hrsa.gov/tools/rural-health?tab=Address

Telehealth: HRSA defines telehealth as the use of electronic information and telecommunications technologies to support and promote, at a distance, health care, patient and professional health-related education, health administration, and public health.

[20] Level III (Subspecialty Care) and Level IV (Regional Perinatal Health Care Centers) facilities are defined by Levels of Maternal Care. Obstetric Care Consensus No. 9. American College of Obstetricians and Gynecologists. American Journal of Obstetrics and Gynecology 2019;134:e41e55. doi: 10.1016/j.ajog.2019.05.046.

Underserved Communities: Populations sharing a particular characteristic, as well as geographic communities that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life, as exemplified by the list in the preceding definition of "equity."[21]

[21] Executive Order 13985 on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government, 86 FR 7009, at § 2(a) (Jan. 20, 2021), https://www.govinfo.gov/content/pkg/FR-2021-01-25/pdf/2021-01753.pdf.

Appendix B: RMOMS Data Requirements

The HRSA-funded program evaluator will develop an evaluation design plan that will account for the evaluation and performance results of both the RMOMS program in its entirety and the unique models developed and implemented by each award recipient.

Award recipients are required to work with the HRSA-funded program evaluator and provide qualitative data, including interviews to collect service site and regional network data (see below), and quantitative data, including submitting de-identified, patient-level service utilization data (see below). These data will be necessary to assess progress in meeting the RMOMS program goals: (i) improve maternal and neonatal outcomes within a rural region; (ii) develop a sustainable network approach to increase the delivery and access of preconception, pregnancy, labor and delivery, and postpartum services ; (iii) develop a safe delivery environment with the support and access to specialty care for perinatal patients and infants; and (iv) develop sustainable financing models for the provision of maternal and obstetrics care in rural communities. Additional information will be provided by the Federal Office of Rural Health Policy.

In order to ensure consistent, crosscutting information, award recipients are also expected to collect and report on the data elements in the **Performance Improvement Measures System (PIMS)** at the start of the period of performance (baseline) and at additional time periods throughout the period of performance as specified by HRSA (See PIMS Measures below).

PATIENT DATA

The award recipient will collect, link, and store de-identified, patient-level data from clinical partners, care coordinators/patient navigators, and others on the target population. These data will be securely shared with the HRSA-funded program evaluator at least twice a year throughout the course of the period of performance. HRSA expects the applicant organization to provide support to network partners, e.g., direct funding for a data analyst position or software training and technical support, to assist them with collecting data. HRSA also expects that the applicant organization determine a data collection strategy that will link data from multiple providers by a unique identifier in order to create a de-identified patient record across the continuum of care. HRSA and the HRSA-funded evaluator will provide technical assistance to the applicant organization and partners, if needed, to build a data management system that supports care coordination efforts in addition to evaluation efforts (e.g., REDCap, Excel, automated Electronic Medical/Health Record (EMR/EHR) extracts using the format already programmed within the EMR/EHR; or encrypted unique client identifier (eUCI) application facilitate record linkage and ensure patient privacy). Resources from the HRSA award may be allocated for this purpose, if necessary.

Required patient-level data elements to be collected may include, at a minimum:

Data Element
Linking identifier
Medicaid ID
Most recent county of residence
Year of birth
Health insurance status at delivery
Pregnant during reporting period
Prenatal visits
Date of delivery
Length of NICU stay
Postpartum visit
Race
Ethnicity
Most recent health insurance status
Due date
Number of previous deliveries
Twin/multiple birth
Pregnancy is considered high-risk
Primary prenatal care provider
Location of delivery
Gestational age/preterm birth
Severe maternal morbidity
Neonatal death
Infant birthweight
Caesarean section
Length of maternal hospital stay for labor and delivery

Transferred to higher level of care for delivery
Postpartum depression screening
Patient offered effective contraception after delivery
Primary postpartum care provider
Meeting with lactation consultant
First point of contact with RMOMS
Telehealth visits
Telehealth specialty visits
Patient/family navigator visits
Received support services
Language spoken at home
Receipt of maternal-fetal medicine consultation
Emergency department deliveries
Patient selected effective contraception after delivery
Transitioned to primary/well-woman services by six months postpartum
Breastfeeding at six months postpartum
Alcohol abuse screening
Current tobacco usage in pregnancy
Substance use disorder screening
Current medication-assisted treatment (MAT) use
Receipt of behavioral health screening and services
Receipt of behavioral health treatment
Newly enrolled in insurance
Attendance at educational sessions
Discharge disposition of newborn

Note that some of these elements may be collected at baseline, throughout the entire period of performance, or opt-out.[22] Additional information on data requirements will be provided by the Federal Office of Rural Health Policy upon receipt of the award.

HRSA requires at least 0.5 FTE be allocated at the network level to coordinate data collection and reporting across all network partner clinical sites. This staff must also be able to travel to all network clinical sites. Applicants should strongly consider network size when determining additional FTE allocation for data collection and reporting staff. HRSA also encourages that each network partner clinical site should have designated data point of contact who will liaise and coordinate data collection and reporting with network data staff. The award recipient must identify an individual(s) responsible for collecting and reporting patient-level data at the network level and strongly encourages identification at each at each network partner clinical site within the network. The individual(s) must have the skills necessary to ensure timely and accurate data collection. Resources from the HRSA award may be allocated for this purpose, if necessary.

SERVICE SITE AND REGIONAL NETWORK DATA

Given the rural regional network approach, routine data collection and validation at the service site-level and network-level is also expected. The award recipient will collect and store service site and network-level data in order to share with a HRSA-funded program evaluator to analyze program outcomes at least twice a year throughout the course of the period of performance.

Examples of service site- and network-level data to be collected include, at a minimum:

- network approach to coordinating care (i.e., components of building a network, strategies to coordinate risk appropriate care in rural areas, referrals)
- barriers and facilitators to accomplishing RMOMS program goals
- delivery and access to services (i.e., workforce proficiency, telehealth, care coordination, travel time to get care)
- cost and utilization (i.e., strategies to reduce cost and improve effectiveness, impact of the program on the cost of care, savings from reductions in high cost care like NICU stays)
- replicability and generalizability

[22] Award recipients who are not providing a service(s) identified in the performance measures are not required to report on that element.

Performance Improvement Measures System (PIMS)

Sample Data Elements

Network:

1. Identify the types and number of organizations in the network for your project
2. Total number of NEW member organizations that joined the network during this reporting period
3. How many policies or procedures were created during this reporting period
4. How many policies or procedures were amended during this reporting period
5. How many policies or procedures were implemented during this reporting period
6. As a result of being part of the network, how many network member organizations were able to integrate joint policies, procedures and/or best practices within their respective organizations during this reporting period
7. Are all network sites contributing to direct service encounter data
8. Number of network sites contributing direct service encounter data

Sustainability

9. Additional funding secured to assist in sustaining the network
10. How many of the network members have provided the following in-kind services
11. Sources of Sustainability
12. Which of the following activities have you engaged in to enhance your sustained impact

(Note questions 13-15 will only be asked and reported in Year 4)

13. What is your Ratio for Economic Impact vs. HRSA Program Funding
14. Will the network sustain after this federal funding period
15. Will any of the network's activities be sustained after this federal funding period

Demographics

16. Number of counties served in project
17. Number of people in the target population

18. Number of unique individuals from your target population who received direct services during this reporting period
19. Number of unique women from your target population who received direct services during this reporting period
20. Number of people served by ethnicity
21. Number of people served by race
22. Number of people served by age group

Project Specific Domain

23. Health insurance status of women served during the reporting period in the continuum of care
24. Number of NICU stays for deliveries that occur within the network, including stays that are transferred outside of the network
25. Number of live deliveries
26. Number of maternal deaths
27. Number of women who receive a prenatal visit
28. Number of women who receive a prenatal visit in the first trimester
29. Number of women who receive a postpartum visit
30. Number of women who receive case management contact
31. Number of network sites providing/using RMOMS relevant telehealth services
32. Number of women directly served by telehealth
33. Number of women receiving specialty care services via telehealth
34. Number of providers trained and/or supported through distance learning and/or telementoring

Appendix C: RMOMS Program Resources

Your local health department may be a valuable resource in acquiring data when responding to the Needs Assessment section.

The following entities can help applicants in identifying resources for their applications:

Alliance for Innovation on Maternal Health

Alliance for Innovation on Maternal Health (AIM) works through state teams and health systems to align national, state and hospital level quality improvement efforts to improve overall maternal health outcomes.

https://safehealthcareforeverywoman.org/aim-program/

Centers for Medicare and Medicaid Services (CMS): Rural Health Clinics

For more information on RHCs: https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center

- To determine whether a facility is an RHC, visit https://qcor.cms.gov/main.jsp, select Basic Search then under Advanced Search select Rural Health Clinics (RHCs)

HRSA Resources

- Office of Regional Operations (ORO) https://www.hrsa.gov/about/organization/bureaus/oro/index.html
- Bureau of Primary Health Care (BPHC) Health Center Program https://bphc.hrsa.gov/
  - Find a Health Center (FQHC): https://data.hrsa.gov/
- National Health Service Corps (NHSC) and Primary Care Offices (PCOs)

  https://nhsc.hrsa.gov/nhsc-sites/contacts/regional-offices-state-contacts.html
- Maternal Child Health Glossary https://mchb.tvisdata.qa.hrsa.gov/Glossary/Glossary
  - Find Healthy Start and Home Visiting Program: https://data.hrsa.gov/tools/find-grants
- National Organization for State Offices of Rural Health (NOSORH)

  https://nosorh.org/nosorh-members/nosorh-members-browse-by-state/

  Note: For information on how SORHs can be helpful in supporting rural community organizations, please visit the following resources:

- Community-Based Division Factsheet:

  https://nosorh.org/wp-content/uploads/2018/01/SORH-CBD-Factsheet-Final.pdf

- Community Organization Collaboration Video: https://www.youtube.com/watch?v=Tk3hGs6Btpc

HHS resources for Health Literacy:

HHS Health.gov: Health Literate Care Model

AHRQ: Health Literacy Universal Precautions Toolkit

The National Preconception Health and Health Care: Preconception Resource Guide

The goal of the Preconception Resource Guide is focused improving the health of young adults and any children they may choose to have. The vision is that all people of reproductive age will achieve optimal health and wellness, fostering a healthy life course for them and any children they may have.

https://beforeandbeyond.org/resources/toolkits-reports/

Preconception Health: http://www.cdc.gov/preconception/index.html

Rural Health Information Hub

The Rural Health Information Hub (RHIhub) is supported by funding from HRSA and helps rural communities and other rural stakeholders access the full range of available programs, funding, and research that can enable them to provide quality health and human services to rural residents. Please visit RHIhub's website at: https://www.ruralhealthinfo.org.

RHIhub also provides free customized assistance that can provide support in gathering data, statistics, and general rural health information. You can contact RHIhub and information specialists can provide the information you need in responding to this section. To utilize RHIhub's free customized assistance, please call 1-800-270-1898 or send an email to info@ruralhealthinfo.org.

Rural Health Research Gateway

The Rural Health Research Gateway website provides easy and timely access to all of the research and findings of the HRSA-funded Rural Health Research Centers. You can use the site to find abstracts of both current and completed research projects, publications resulting from those projects, and information about the research centers themselves as well as individual researchers.

The Rural Health Research Gateway website is hosted at the University of North Dakota Center for Rural Health with funding from HRSA. Its intent is to help move new research findings of the Rural Health Research Centers to various end users as quickly and efficiently as possible. Please visit their website at: http://www.ruralhealthresearch.org.

Regional Telehealth Resource Centers

Provide technical assistance to organizations and individuals who are actively providing or interested in providing telehealth services to rural and/or underserved communities. https://www.telehealthresourcecenter.org/