U.S. Department of Health and Human Services

Health Resources & Services Administration

Maternal and Child Health Bureau

Division of Healthy Start and Perinatal Services

Catalyst for Infant Health Equity

Funding Opportunity Number: HRSA-22-066

Funding Opportunity Type(s): New

Assistance Listings (AL/CFDA) Number: 93.926

NOTICE OF FUNDING OPPORTUNITY

Fiscal Year 2022

Letter of Intent Requested by: February 18, 2022

Application Due Date: April 19, 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 19, 2022

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See Section VII for a complete list of agency contacts.

Authority: 42 U.S.C. § 254c-8 (Title III, Part D, § 330H 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 Catalyst for Infant Health Equity program. The purpose of this new program is to support the *implementation* of existing action plans that apply data-driven policy and innovative systems strategies to reduce infant mortality (IM) disparities in a specific county/jurisdiction. For the purposes of this NOFO, since "county" is not a term used for all geographic areas, the term "jurisdiction" is also used and refers to tribal areas; the District of Columbia; municipalities within Puerto Rico; and similar geographical areas found within the US-affiliated Pacific Islands and Freely Associated States. The goals of the Catalyst for Infant Health Equity program are twofold: 1) to continue reducing overall IM rates in the United States, and 2) to decrease and ultimately eliminate disparities in IM across racial/ethnic groups by achieving steeper declines for groups with the highest rates. To accelerate disparity reduction, this project seeks to move beyond direct services to implementing targeted policy and systems interventions that will focus on one or more specific social determinants of health (SDOH) domains that contribute to IM disparities in a particular county/jurisdiction.

Funding Opportunity Title:	Catalyst for Infant Health Equity
Funding Opportunity Number:	HRSA-22-066
Due Date for Applications:	April 19, 2022
Anticipated Total Annual Available FY 2022 Funding:	Up to $2,500,000 subject to the availability of appropriated funds.
Estimated Number and Type of Award(s):	Up to 5 awards subject to the availability of appropriated funds.
Estimated Annual Award Amount:	Up to $500,000 per award subject to the availability of appropriated funds.
Cost Sharing/Match Required:	No
Period of Performance:	September 1, 2022 through August 31, 2027 (5 years)

Eligible Applicants:	Eligible applicants include any domestic public or private entity. Domestic faith-based and community-based organizations, tribes, and tribal organizations are also eligible to apply for these funds. Note: Eligible applicants are not required to be Healthy Start grant recipients. 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: Monday, January 31, 2022
Time: 1 p.m. ET
Join ZoomGov Meeting: https://hrsa-gov.zoomgov.com/j/1612652252?pwd=VHppWER0UEs4dHllWG43N0xYQkJnQT09

Audio Conference details

- Computer audio is recommended (make sure computer speakers are "on")
- Attendees should click the above and select '**Join with Computer Audio'**
- Attendees without computer access or computer audio can use the dial-in information below

  - Dial-in Toll-Free #: 833 568 8864
  - Meeting ID: 161 265 2252
  - Passcode: 57453797

HRSA will record the webinar and make it available at: https://mchb.hrsa.gov/fundingopportunities/default.aspx.

Table of Contents

I. Program Funding Opportunity Description

1. Purpose

This notice announces the opportunity to apply for funding under the Catalyst for Infant Health Equity program. The goals of the new Catalyst for Infant Health Equity program are twofold: 1) to continue reducing overall infant mortality (IM) rates in the United States, and 2) to decrease and ultimately eliminate disparities in IM across racial/ethnic groups by achieving steeper declines for groups with the highest rates. To accomplish these goals, award recipients are expected to address the broader social and structural determinants (or root causes) contributing to IM disparities at the county or jurisdiction[1] level. For example, recipients will support implementation of existing action plans that address public policies, systemic racism and discrimination, and/or institutional practices. To maximize impact on disparities in infant mortality rates at the national level, counties/jurisdictions with larger numbers of excess infant deaths[2] will be considered priority areas.

The **purpose** of the Catalyst awards is to support the *implementation* of existing action plans that apply data-driven policy and innovative systems strategies to reduce IM disparities and prevent excess infant deaths. Recipients are expected to implement action plans that address the social determinants of health (i.e., environmental, social, and economic conditions), and/or the structural determinants of health (e.g., institutions, systemic barriers, policies) that contribute to disparities in IM. The policy and systems change strategies in such action plans should be targeted and specific to reducing disparities among the racial or ethnic group(s) with the highest IM rates or excess infant deaths (i.e., priority population) in a target county/jurisdiction. The plan must be implemented in partnership with cross-sector state and/or local partners (including agencies that administer the State Title V Maternal and Child Health Block Grant Program), community members, and individuals with lived experience.

Healthy People 2030 has grouped social determinants of health (SDOH) into the five domains[3] below. Successful award recipients will be expected to implement policy and systems strategies in their action plan from at least one of these domains, and focus on an objective(s) within that domain that can affect birth outcomes and contribute to reducing the IM disparity in the target county/jurisdiction.

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[11] For the purposes of this NOFO, "jurisdiction" refers to tribal areas; the District of Columbia; municipalities within Puerto Rico; and similar geographical areas found within the US-affiliated Pacific Islands and Freely Associated States.

[2] **Excess infant deaths** are those that occur due to higher mortality rates relative to non-Hispanic White infants, and can be referred to as deaths attributable to disparity or deaths that need to be prevented to achieve equity in IM rates. Excess infant deaths are calculated by multiplying excess infant mortality rates by the number of births (e.g., [Black IMR – White IMR] X Black births).

[3] https://health.gov/healthypeople/objectives-and-data/social-determinants-health

Domain 1: Economic Stability

Domain 2: Education Access and Quality

Domain 3: Health Care Access and Quality

Domain 4: Neighborhood and Built Environment

Domain 5: Social and Community Context

Award recipients are expected to address the three areas of focus below during the period of performance in order to successfully achieve the goals and objectives of the Catalyst for Infant Health Equity program:

1) **Action Plan Implementation**: implement an already developed action plan containing SDOH policy and systems changes to reduce racial/ethnic disparities in IM in a selected priority population (e.g., racial/ethnic group with the highest numbers of excess infant deaths) within a target county/jurisdiction.
2) **Strategic Partnerships**: assure accountability and sustainability of the action plan by facilitating, supporting, and building the capacity of a network of local organizations, service providers, and consumers/community members who can advance systems and policy changes that will address contributors to IM and disparities.
3) **Outcome Evaluation**: continuously assess progress toward implementing the action plan and reducing both IM and disparities in IM among racial or ethnic group(s) with the highest IM rates or excess infant deaths (i.e., priority population) in the target county/jurisdiction.

For more details, see Program Requirements and Expectations.

For definitions of terms, see Appendix: Glossary.

2. Background

HRSA's Maternal & Child Health Bureau and 2021 Strategic Plan

The Maternal and Child Health Bureau (MCHB) administers programs with focus areas in maternal and women's health, adolescent and young adult health, perinatal and infant health, child health, and children with special health care needs. To achieve its mission of improving the health and well-being of America's mothers, children, and families, MCHB has established a strategic plan that includes the following four goals:

Goal 1: *Assure access to high quality and equitable health services to optimize health and well-being for all MCH populations*

Goal 2: *Achieve health equity for MCH populations*

Goal 3: *Strengthen public health capacity and workforce for MCH*

Goal 4: *Maximize impact through leadership, partnership, and stewardship*

MCHB is committed to promoting equity in its health programs for mothers, children, and families. This program primarily addresses MCHB's goal *to achieve health equity for MCH populations* by focusing on eliminating racial disparities seen in IM.

To learn more about MCHB and the bureau's strategic plan, visit https://mchb.hrsa.gov/about.

Healthy Start

The Catalyst for Infant Health Equity program is authorized by 42 U.S.C. § 254c-8 (Title III, Part D, § 330H of the Public Health Service Act). The Healthy Start (HS) program is funded under this legislation. Eligible entities are not required to be HS grant recipients to apply for this new program funding. Overarching goals of the HS program are to reduce infant mortality; improve health outcomes before, during, and after pregnancy; and reduce racial/ethnic differences in rates of infant death and adverse perinatal outcomes. Under this authority, MCHB currently funds the HS program, *Healthy Start Initiative: Eliminating Disparities in Perinatal Health*.

Overview of the Healthy Start Initiative: Eliminating Disparities in Perinatal Health

Since its start as a demonstration project in 1991, the HS program has been providing grants to communities at high risk for infant mortality, with IM rates at least 1.5 times the United States national average and high rates of other adverse perinatal outcomes (e.g., low birthweight, preterm birth, maternal morbidity and mortality). The purpose of the HS program is to reduce the rate of infant mortality and improve perinatal outcomes by using a community-based approach to service delivery and facilitating access to a comprehensive approach to women's health care. HS works to reduce the disparity in health status between the general population and individuals who are members of racial or ethnic minority groups. For more information on HS, see https://mchb.hrsa.gov/maternal-child-health-initiatives/healthy-start

A competitive supplement was recently awarded to a cohort of existing HS award recipients to support the *development* of action plans to develop innovative data-driven policy and systems level strategies to address the social and structural determinants of health impacting IM disparities in HS communities. The supplement is intended to accelerate reductions in IM disparities, consistent with the purpose of the Healthy Start program, while also adding to the current HS approaches that generally focus on individual and behavioral interventions. For a list of supplement award recipients, see: https://mchb.hrsa.gov/maternal-child-health-initiatives/healthy-start/fy21-awards.

Achieving Infant Health Equity by 2030: *Catalyst for Infant Health Equity program*

Infant mortality (IM) rates in the United States remain high compared to other well-resourced countries. While the U.S. IM rate has historically trended downward, and has

declined 17% since 2005[4], racial/ethnic disparities in IM in the United States have persisted. The highest IM rates in the country are among non-Hispanic Black, Native Hawaiian/Other Pacific Islander, and American Indian/Alaska Native (AI/AN) infants (10.62, 8.19, and 7.91 infant deaths per 1,000 live births in 2019, respectively) with rates that are approximately twice that of non-Hispanic Whites (4.49 infant deaths per 1,000 live births in 2019)—the population with the most births and longest historical advantages.[5] The stark infant mortality differences across racial and ethnic groups reflect social inequities and contribute to the high overall national IM rate.

Structural inequities in access to health-promoting resources, such as education, employment, housing, and health care, contribute to racial/ethnic disparities in perinatal health[6],[7]. Each year, approximately 3,500 excess infant deaths occur due to higher mortality rates among non-Hispanic Black, Native Hawaiian/Other Pacific Islander, and non-Hispanic AI/AN infants, relative to non-Hispanic White infants.

Healthy People (HP) 2030[8] has established a target of 5.0 infant deaths per 1,000 live births for all race/ethnic groups–a target already achieved at the national level for non-Hispanic White, non-Hispanic Asian, and Hispanic infants. Achieving equity will require maintaining declines in the IM rate of these infants, **and** accelerating the rate of decline among non-Hispanic Black, Native Hawaiian/Other Pacific Islander, and non-Hispanic AI/AN infants.

To accelerate the reduction of IM disparities and excess infant deaths, the Catalyst for Infant Health Equity program will support policy and systems changes (i.e., structural interventions) that improve conditions, such as educational and employment opportunity, to promote equity across a range of health outcomes[9].

Theoretical Framework

To accelerate the reduction in disparity, this program seeks to move beyond direct services to implement targeted policy and systems changes that are focused on one or more specific SDOH domains contributing to IM disparities in a particular county/jurisdiction. The Catalyst for Infant Health Equity program utilizes the social-

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[4] https://www.cdc.gov/nchs/data/nvsr/nvsr69/NVSR-69-7-508.pdf

[5] https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/DVS/period-cohort-linked/19PE18CO_linkedUG.pdf

[6] Lorch SA, Enlow E. The role of social determinants in explaining racial/ethnic disparities in perinatal outcomes. Pediatr Res. 2016 Jan; 79 (1-2):141-7. doi: 10.1038/pr.2015.199.

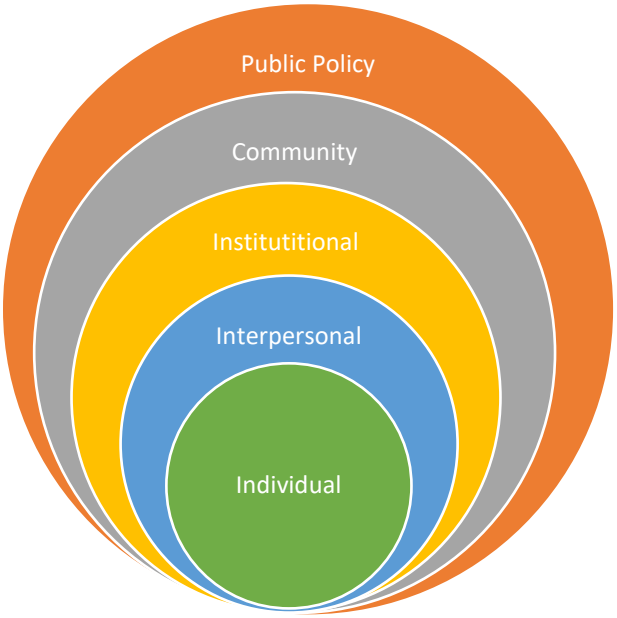
[7] Crear-Perry J, Correa-de-Araujo R, Lewis Johnson T, McLemore MR, Neilson E, Wallace M. Social and Structural Determinants of Health Inequities in Maternal Health. J Womens Health (Larchmt). 2021 Feb;30(2):230-235. doi: 10.1089/jwh.2020.8882.

[8] https://health.gov/healthypeople/objectives-and-data/browse-objectives/infants/reduce-rate-infant-deaths-mich-02

[9] Brown AF, Ma GX, Miranda J, Eng E, et al. Structural interventions to reduce and eliminate health disparities. AM J Public Health. 2019: 109: S72-S78. doi:10.2105?AJPH.2018.304844

ecological model as a framework for examining and addressing disparities in IM and excess infant deaths[10,11]. In this model, individual outcomes and health disparities across racial groups are shaped by broader interpersonal, institutional, community and policy factors such as personally-mediated and institutional racism, providers' cultural competence, access to quality health care, neighborhood quality, and economic and housing policy. The levels at which these factors operate include:

a) Individual: Characteristics of the individual
b) Interpersonal: Social network and support system
c) Institutional: Social institutions, rules and regulations for operations
d) Community Factors: Relationships among organizations, institutions, and informal networks within defined boundaries
e) Public Policy: Local, state, and national laws and policies



Using the social-ecological model as a guide for assessing factors that can influence outcomes (i.e., IM disparity), this program seeks to implement existing action plans that address institutional, community and public policy levels , which can more directly influence the social and structural determinants of health such as health care, education, housing, transportation and the justice system.

[10] Alia AP, Richman AR, Clayton HB et al. An ecological approach to understand disparities in perinatal mortality. Matern Child Health J. 2010;14:557-566. Doi 10.1007/s10995-009-0495-9
[11] Reno R, Hyder A. The Evidence Base for Social Determinants of Health as Risk Factors for Infant Mortality: A Systematic Scoping Review. J Health Care Poor Underserved. 2018;29(4):1188-1208.

II. Award Information

1. Type of Application and Award

Type(s) of applications sought: New

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

HRSA program involvement will include:

- Assuring the availability of HRSA personnel to participate in the planning and development of all phases of the project;
- Conducting ongoing reviews of the establishment and implementation of activities, procedures, measures, and tools for accomplishing the goals of the cooperative agreement;
- Participating, as appropriate, in conference calls, virtual and in-person meetings, and training/capacity-building sessions that are conducted during the period of performance;
- Ensuring integration into HRSA programmatic and data reporting efforts;
- Assisting with the establishment and facilitation of collaborative relationships with federal and state contacts, HRSA-funded awards, and other entities that may contribute to successful project outcomes;
- Reviewing and providing advisory input on written documents, including information and materials to support the activities conducted through the cooperative agreement, prior to submission for publication or public dissemination; and
- Participating with the award recipient in the dissemination of project findings, best practices, and lessons learned from the project.

The cooperative agreement recipient's responsibilities will include:

- Completing activities proposed in response to the Program-Specific Instructions section of this notice of funding opportunity (NOFO);
- Meeting with the federal project officer within 2 weeks after award to review the current strategies and to ensure the project and goals align with HRSA priorities for this activity;
- Providing ongoing, timely communication and collaboration with the federal project officer, including holding regular check-ins with the federal project officer;

- Providing the federal project officer with the opportunity to review and provide advisory input on written documents, including information and materials to support the activities conducted through the cooperative agreement, prior to submission for publication or public dissemination. Such review should start as part of concept development and include review of drafts and final products;
- Establishing contacts relevant to the project's mission such as federal and non-federal partners, and other HRSA projects that may be relevant to the project's mission;
- Collaborating with HRSA on ongoing review of activities, procedures and budget items, and interagency agreements; and
- Assuring that all recipient administrative data and performance measure reports, as designated by HRSA, will be completed and submitted on time.

2. Summary of Funding

HRSA estimates approximately $2,500,000 to be available annually to fund 5 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 $500,000 total cost (includes both direct and indirect, facilities and administrative costs) per year. 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.

The period of performance is September 1, 2022 through August 31, 2027 (5 years). Funding beyond the first year is subject to the availability of appropriated funds for the Catalyst in Infant Health Equity program 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

Eligible applicants include any domestic public or private entity. Domestic faith-based and community-based organizations, tribes, and tribal organizations are also eligible to apply for these funds.

Note: Eligible applicants are not required to be Healthy Start grant recipients.

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

NOTE: Multiple applications from an organization are not allowable.

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.

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-22-066 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 Limit

The total size of all uploaded files included in the page limit shall be no more than the equivalent of **60 pages** when printed by HRSA. The page limit includes the project and budget narratives, and attachments required in the *Application Guide* and this NOFO, *except* for Attachment 7-Copy of Proposed Action Plan.

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-22-066, 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 60 pages 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-22-066 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 *Attachments 8–15: 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

To accelerate the reduction of IM disparities and excess infant deaths the Catalyst for Infant Health Equity program seeks to go beyond individual-level direct service interventions to policy and systems changes that alter the fundamental social, physical, or economic environment shaping health behaviors and health outcomes.

Recipients are expected to meet the following program objectives by August 31, 2026:

1) **Action Plan Implementation**: Implement an action plan containing specific policy and systems changes to reduce racial/ethnic disparities in IM in a county/jurisdiction. The action plans being implemented must address the "upstream" factors or environmental, social, and economic conditions, and/or structural (institutions and policies) or systemic barriers that contribute to disparities in IM in a county/jurisdiction. The action plans should include targeted policy and systems change strategies, specific to the target county/jurisdiction, that will reduce disparities among the racial or ethnic group(s) with the highest IM rates and excess infant deaths (i.e., priority population). The plan must be implemented in partnership with cross-sector state and/or local partners (including agencies that administer the State Title V Maternal and Child Health Block Grant Program), community members, and individuals with lived experience.
2) **Strategic Partnerships:** Support, assist, and facilitate a network of cross-sector state and/or local organizations (including agencies that administer the State Title V Maternal and Child Health (MCH) Block Grant program), service providers, and consumers/community members to make policy and system changes that will address contributors to IM and disparities. Provide the network with tools, training, and capacity building to be skilled to support policy and system changes that address root causes of, and contributors to, disparities in IM. This network is intended to help the award recipients assure that action plans being implemented through this funding address the racial or ethnic group(s) with the highest IM rates and excess infant deaths in the target county/jurisdiction (i.e., priority population). In addition, award recipients must coordinate their services and activities with agencies that administer State Title V MCH Block Grant programs in order to promote cooperation, integration, and dissemination of information with statewide systems and with other community services.

3) **Outcome Evaluation:** Conduct regular and ongoing measurement of plan progress and its impact on IM disparities and on the racial or ethnic group(s) with the highest IM rates or excess infant deaths in the target county/jurisdiction (i.e., priority population). Regularly report out/disseminate this information to community members, partners, and stakeholders.

Healthy People 2030 has grouped SDOH into the five domains[12] below. Successful award recipients will be expected to implement policy and systems strategies in their action plan from at least one of these domains, and focus on an objective(s) within that SDOH domain that can affect birth outcomes and contribute to reducing the IM disparity seen in the target county/jurisdiction. Additional social or structural determinants that contribute to IM disparities but are not listed below may be addressed in the action plan's policy and systems strategies, such as: racism, discrimination, and bias; supportive economic policy (e.g., paid parental leave, living wages); housing programs and policies; culturally respectful and equitable health care[13,14,15]; among others.

Domain 1: Economic Stability

Examples of Relevant HP Objectives:

- Reduce the proportion of adolescents and young adults who are neither enrolled in school nor working (AH-09)
- Reduce the proportion of persons living in poverty (SDOH-01)
- Increase employment among the working-age population (SDOH-02)
- Increase the proportion of children living with at least one parent employed year round, full time (SDOH-03)
- Reduce the proportion of families that spend more than 30 percent of income on housing (SDOH-04)
- Reduce household food insecurity and in doing so reduce hunger (NWS-01)

Domain 2: Education Access and Quality

Examples of Relevant HP Objectives:

- Increase the proportion of high school students who graduate in 4 years — AH-08

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[12] https://health.gov/healthypeople/objectives-and-data/social-determinants-health
[13] https://www.thecommunityguide.org/content/task-force-findings-health-equity
[14] Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT. Structural racism and health inequities in the USA: evidence and interventions. Lancet. Apr 8 2017;389(10077):1453-1463.
[15] Crear-Perry J, Correa-de-Araujo R, Lewis Johnson T, McLemore MR, Neilson E, Wallace M. Social and Structural Determinants of Health Inequities in Maternal Health. J Womens Health (Larchmt). Feb 2021;30(2):230-235.

- Increase the proportion of high school completers who were enrolled in college the October immediately after completing high school (SDOH-06)

Domain 3: Health Care Access and Quality

Examples of Relevant HP Objectives:

- Increase the proportion of adults who receive appropriate evidence-based clinical preventive services (AHS-08)
- Increase the proportion of adolescents who received a preventive health care visit in the past year (AH-01)
- Increase the number of community-based organizations providing population-based primary prevention services (ECPB-D07)
- Increase the proportion of women who get needed publicly funded birth control services and support (FP-09)
- Reduce the proportion of people who can't get medical care when they need it (AHS-04)
- Increase the proportion of adults whose health care provider checked their understanding (HC/HIT-01)
- Decrease the proportion of adults who report poor communication with their health care provider (HC/HIT-02)
- Increase the proportion of adults whose health care providers involved them in decisions as much as they wanted (HC/HIT-03)
- Increase the proportion of adults with limited English proficiency who say their providers explain things clearly (HC/HIT-D11)
- Increase the use of telehealth to improve access to health services (AHS-R02)
- Increase the proportion of people with health insurance (AHS-01)
- Increase the proportion of pregnant women who receive early and adequate prenatal care (MICH-08)

Domain 4: Neighborhood and Built Environment

Examples of Relevant HP Objectives:

- Reduce the rate of minors and young adults committing violent crimes (AH-10)
- Increase the proportion of adults with broadband internet (HC/HIT-05)

- Increase the proportion of people whose water supply meets Safe Drinking Water Act[16] regulations (EH-03)
- Reduce the number of days people are exposed to unhealthy air (EH-01)
- Reduce health and environmental risks from hazardous sites (EH-05)
- Reduce the amount of toxic pollutants released into the environment (EH-06)
- Increase the proportion of schools with policies and practices that promote health and safety (EH-D01)
- Increase the proportion of adults who walk or bike to get places (PA-10)
- Increase the proportion of adolescents who walk or bike to get places (PA-11)
- Increase the proportion of smoke-free homes (TU-18)
- Reduce the proportion of people who don't smoke but are exposed to secondhand smoke (TU-19)
- Increase the number of states, territories, and DC that prohibit smoking in worksites, restaurants, and bars (TU-17)
- Increase the number of states, territories, and DC that prohibit smoking in multiunit housing (TU-R01)
- Increase the proportion of worksites with policies that ban indoor smoking (ECBP-D06)

Domain 5: Social and Community Context

Examples of Relevant HP Objectives:

- Reduce the proportion of children with a parent or guardian who has served time in jail (SDOH-05)
- Increase the proportion of adults who talk to friends or family about their health (HC/HIT-04)
- Increase the health literacy of the population (HC/HIT-R01)
- Increase the proportion of adolescents who have an adult they can talk to about serious problems (AH-03)
- Increase the proportion of children and adolescents who show resilience to challenges and stress (EMC-D07)

[16] https://www.ecfr.gov/current/title-40/chapter-I/subchapter-D/part-141.

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.

- Address
- Project Director Name
- Contact Phone Numbers (Voice, Fax)
- Email Address
- Website Address, if applicable
- List all grant program funds requested in the application, if applicable

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.

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 and (4) Impact
Work Plan	(2) Response and (4) Impact
Resolution of Challenges	(2) Response

Narrative Section	Review Criteria
Evaluation and Technical Support Capacity	(3) Evaluative Measures
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.

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

- INTRODUCTION -- Corresponds to Section V's Review Criterion (1) NEED
  Briefly describe the purpose of your proposed project. Include which SDOH domain(s) your proposed action plan addresses, the proposed policy and systems change strategies that will be implemented from the action plan, and the priority population of focus (e.g., non-Hispanic Black pregnant women and infants). Also state the county/jurisdiction that your proposed action plan focuses on.

- NEEDS ASSESSMENT -- Corresponds to Section V's Review Criterion (1) NEED
  This section will help reviewers understand the need for the project, the needs of your selected priority population, and the social and structural determinants of health that are contributing to IM disparities and excess infant deaths in your selected county/jurisdiction.

  State and describe the target county or jurisdiction. Describe the social and structural determinants of health that are contributing to disparities in IM and excess infant deaths, and driving health inequity for the selected priority population(s) in your target county/jurisdiction.

  Describe the selected priority population(s) in your target county/jurisdiction that will be impacted by the proposed policy and systems changes and strategies in your action plan. Explain why you chose to focus on this population(s). Be sure to include:

  - their IM rate (deaths per 1,000 live births based on 10 or more deaths; use multiple years if needed),
  - the absolute gap compared to non-Hispanic White infants (group IM rate – non-Hispanic White IM rate),

- their average annual number of births (total births / # of years used),
- excess annual deaths (absolute gap ÷ 1,000 x average annual births), and
- the data source for these calculations

County-level or jurisdiction level data should be used, given the focus of this funding on broader policy and systems-level solutions. An example calculation, using 2017–2019 linked birth/infant death data, shows the national number of excess non-Hispanic Black infant deaths is 3,421 as calculated by the absolute IM rate difference (10.78 for non-Hispanic Black infants minus 4.60 for non-Hispanic White infants = 6.18 / 1000 = 0.00618) multiplied by 553,606 average annual non-Hispanic Black births. Infant mortality statistics by race/ethnicity for counties with population sizes of 250,000 or more are available on CDC Wonder https://wonder.cdc.gov/lbd.html. If technical assistance is needed in calculating excess infant deaths for your target county/jurisdiction, please contact MCHB at infanthealthequity@hrsa.gov.

Discuss known barriers and challenges related to reducing the disparity in IM in your target county/jurisdiction that the project hopes to overcome.

Discuss the SDOH domain(s) addressed in your action plan and its connection to IM disparities and excess infant deaths. Describe the current policy context, including challenges, gaps, and opportunities for addressing the selected SDOH domain(s).

Describe currently available services and state/local/community resources intended to reduce infant mortality for the selected priority population(s).

Use and cite demographic data whenever possible to support the information provided above.

- METHODOLOGY -- Corresponds to Section V's Review Criteria (2) RESPONSE and (4) IMPACT
  This section will help reviewers understand your proposed methods and activities planned in order to meet each of the program requirements and expectations in this NOFO.

  Describe the action plan that will be implemented through this funding. Include which Healthy People 2030 SDOH domain(s) and objective(s) it addresses, and any additional social or structural determinants outside of Healthy People 2030 that are addressed in the action plan you will implement. A copy of the action plan must be included in Attachment 7. The action plan should include (among other things) activities and/or steps under the selected domain(s) that are feasible during the period of performance and will help to achieve the goals of the Catalyst for Infant Health Equity program.

  Describe the cross-sector network that will help you assure that your action plan and the policy and systems strategies support the racial or ethnic group(s) with the

highest IM rates or excess infant deaths in the target county/jurisdiction. Describe how you will implement the action plan in partnership with cross-sector state and/or local partners (including agencies that administer the State Title V Maternal and Child Health Block Grant Program), community members, and individuals with lived experience. Include any letters of support in Attachments 8–15: Other Relevant Documents. Include any Letters of Agreement, Memoranda of Understanding, and/or Description(s) of Proposed/Existing Contracts (project-specific) in Attachment 4.

Describe your plans for providing the network with tools, training, and capacity building in order for them to be skilled at promoting policy and system changes that address root causes of, and contributors to, disparities in IM.

Describe plans for ongoing facilitation, support, and assistance to the network of local organizations, service providers, and consumers/community members in order for them to engage decision-makers for policy and system changes that will address contributors to IM and disparities. State whether community members and/or consumers on the network will be provided financial support/payment for their time and work.

Describe your proposed process and activities for regularly reporting out/disseminating information to community members, partners, and stakeholders on the action plan's progress and impact.

Describe how you will conduct regular and ongoing measurement of your action plan's implementation.

Propose a plan for project sustainability after the period of federal funding ends. HRSA encourages recipients to sustain key elements of their projects, e.g., strategies and interventions which have been effective in improving policies/practices and those that have led to improved outcomes for the priority population. A sustainability plan will be required in the final year of the award..

- WORK PLAN -- Corresponds to Section V's Review Criteria (2) RESPONSE and (4) IMPACT

Develop a work plan for the entire period of performance that details the activities and steps that you will use to achieve each of the three required objectives in the NOFO Purpose and include it in Attachment 1. Include a timeline with dates for completing key tasks in the work plan and identify responsible personnel/staff or other parties. The work plan should demonstrate that your organization possesses a baseline capacity to implement and carry out the proposed project successfully within the period of performance.

In this section of the Project Narrative, describe the key activities and steps that you will use to achieve each of the required objectives and major milestones of your

proposed work plan. If you will make subawards or expend funds on contracts, describe how your organization will ensure proper documentation of funds.

Logic Models

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

- Goals of the project (e.g., reasons for proposing the intervention, if applicable);
- Assumptions (e.g., beliefs about how the program will work and support resources. Base assumptions on research, best practices, and experience.);
- Inputs (e.g., organizational profile, collaborative partners, key personnel, budget, other resources);
- Target population (e.g., the individuals to be served);
- Activities (e.g., approach, listing key intervention, if applicable);
- Outputs (i.e., the direct products of program activities); and
- Outcomes (i.e., the results of a program, typically describing a change in people or systems).

Although there are similarities, a logic model is not a work plan. A work plan is an "action" guide with a timeline used during program implementation; the work plan provides the "how to" steps. You can find additional information on developing logic models at the following website: https://www.acf.hhs.gov/sites/default/files/documents/prep-logic-model-ts_0.pdf.

- RESOLUTION OF CHALLENGES -- Corresponds to Section V's Review Criterion (2) RESPONSE

  Discuss challenges that you are likely to encounter in designing and implementing the activities described in the work plan, and approaches that you will use to resolve such challenges. Your discussion should also include the specific challenges you anticipate in addressing the selected SDOH domain(s) and while implementing your action plan and the policy/systems strategies within it. You should also include the efforts that you will take to address and overcome these challenges.

- EVALUATION AND TECHNICAL SUPPORT CAPACITY -- Corresponds to Section V's Review Criterion (3) EVALUATIVE MEASURES

  The program performance evaluation should monitor ongoing processes and progress towards the goals and objectives of the project, and contribute to continuous quality improvement. Describe the plan for the program performance evaluation, including: the systems and processes that will support your organization's performance management requirements; how you will effectively

track performance outcomes; and how the organization will collect and manage data (e.g., assigned skilled staff, data management software) in a way that allows for accurate and timely reporting of performance outcomes.

Submit a proposed plan for a project outcome evaluation that will assess/evaluate the impact of your action plan (i.e., the planned policy and systems strategies) on your selected priority population(s). A final evaluation plan will be required 6 months after the award is made. The project outcome evaluation plan should include the following:

- The inputs (e.g., organizational profile, collaborative partners, key personnel, budget, and other resources), key processes, and expected policy/system change outputs of the funded activities.
- Proposed measures to track and assess performance and progress towards the objectives outlined in the Purpose section of the NOFO (including short term/intermediate term) and the data sources, and how you will access the data needed.

  Award recipients will be required to document their plans/ability to collect and report data on those performance measures as part of their annual progress report. This includes plans for establishing baseline data and targets.
- Any applicable baseline measurements necessary to demonstrate improvements in the selected SDOH domain(s) when compared with end-line measurements.
- How the evaluation plan demonstrates that the measures will effectively assess the extent to which the project achieved its objectives;
- How the evaluation plan will demonstrate the project's activities contributed to a decrease in IM disparities in your target area/county and excess infant deaths in your selected priority population.
- A plan to evaluate and disseminate any data, policies, products/services that result from your project and demonstrate a positive impact on the IM disparities and excess infant deaths in your target county/jurisdiction.

Describe any potential obstacles for implementing the program performance and outcome evaluation, and your plan to address those obstacles.

- ORGANIZATIONAL INFORMATION -- Corresponds to Section V's Review Criterion (5) RESOURCES/CAPABILITIES

Succinctly describe your organization's current mission, structure, and scope of current activities. Include an organizational chart in Attachment 5. Describe current collaboration efforts or partnerships with state and local/community resources to address disparities in IM. Describe how these elements all contribute to the

organization's ability to implement the program requirements and meet program expectations.

Describe your organization's experience in convening and facilitating a network of local organizations, service providers, and consumers/community members to address IM disparities. Describe your experience with providing consumers, community members, and/or people with lived experience tools, training, and capacity building in order for them to be skilled at engaging decision-makers for policy/system changes that address root causes of/contributors to disparities in IM.

Describe your organization's capacity and experience in implementing systems and policy changes that address social and/or structural determinants of health, and your work specifically in the SDOH domain(s) selected.

Include a staffing plan in Attachment 2. Describe here the key personnel responsible for the project and the amount of time each will devote to the project, the total sum of which should equal at least one full-time equivalent. Describe current experience, relevant expertise, skills, and knowledge of staff, contractors, and partners. Include biographical sketches for each key personnel in Attachment 3 that demonstrate the following:

- At least one key personnel should have experience with implementing policy and systems change strategies in your selected SDOH domain(s), and have worked on projects addressing social and structural determinants of health.

Identify the individual or organization who is responsible for evaluation activities and describe that individual or organization's qualifications.

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.

Note: Funds awarded under this Catalyst for Infant Health Equity NOFO cannot be used to provide in-kind benefits or cash payments (e.g., rental assistance payments, housing vouchers, income supplements, etc.).

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." Effective January 2022, the Executive Level II salary increased from $199,300 to **$203,700**. 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*.

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: Work Plan and Logic Model

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

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

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

Attachment 3: Biographical Sketches of Key Personnel

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

Attachment 4: Letters of Agreement, Memoranda of Understanding, and/or Description(s) of Proposed/Existing Contracts (project-specific)

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

Attachment 5: Project Organizational Chart

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

Attachment 6: Tables, Charts, etc.

This attachment should give more details about the proposal (e.g., Gantt or PERT charts, flow charts).

Attachment 7: Copy of Proposed Action Plan **(this attachment does not count towards the page limit)**

> This attachment should be a copy of an existing action plan that will be implemented with the Catalyst funding, if awarded. The action plan should include (among other things) activities and/or steps under the selected SDOH domain(s) that are feasible during the period of performance and will help to achieve the goals of the Catalyst for Infant Health Equity program. You may submit an entire action plan, or only relevant portions of a plan that will be implemented using Catalyst funds if awarded. For example: you may have a statewide IM action plan, but only submit a portion of the plan that focuses on a particular county with high disparities in IM; you may submit a sub-section of an existing plan that focuses on an SDOH domain and not include the sections of the plan that focus on direct service delivery.

Attachments 8–15: Other Relevant Documents (15 is the maximum number of attachments allowed)

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

3. Dun and Bradstreet Data Universal Numbering System (DUNS) Number 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 19, 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

The Catalyst for Infant Health Equity program 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 5 years, at no more than $500,000 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.

Note: Funds awarded under this Catalyst for Infant Health Equity NOFO cannot be used to provide in-kind benefits or cash payments (e.g., rental assistance payments, housing vouchers, income supplements, etc.).

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. Effective January 2022, the Executive Level II salary increased from $199,300 to **$203,700**.

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.

7. Other Submission Requirements

Letter of Intent to Apply

The letter should identify your organization and its intent to apply, and briefly describe the proposal. HRSA will ***not*** acknowledge receipt of letters of intent.

Send the letter via email by February 18, 2022 to:

HRSA Digital Services Operation (DSO)
Use the HRSA opportunity number as email subject (HRSA-22-066)
HRSADSO@hrsa.gov

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

V. Application Review Information

1. Review Criteria

HRSA has procedures for assessing the technical merit of applications to provide for an objective review 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 (6) review criteria are used to review and rank the Catalyst for Infant Health Equity program applications. Below are descriptions of the review criteria and their scoring points.

Criterion 1: NEED (20 points) – Corresponds to Section IV's Introduction and Needs Assessment

The need for the project will be assessed based on this primary factor (10 points):

- The degree to which the application shows a substantial/high number of excess infant deaths in the selected priority population in the target county/jurisdiction through the data provided. (*For the selected priority population, the data provided should be at the county or jurisdiction level, and include their IM rate, the absolute gap compared to non-Hispanic White infants in the same jurisdiction[17], their average annual number of the births and their excess annual infant deaths)*.

  Note: HRSA's analysis of excess infant deaths shows that counties with the highest excess infant deaths have ≥15 Black and/or ≥4 AI/AN excess infant deaths per year - at least 1.5 times the county-level average for their respective populations.[18]

[17] The national non-Hispanic White rate may be used if there are no non-Hispanic White births in the county/jurisdiction (**Puerto Rico municipalities or tribal areas only**)
[18] Calculated using the latest 3-year linked birth/infant death data (2016-2018) for counties with reportable infant mortality rates (≥10 infant deaths).

Secondary factors for assessing the application are the degree to which it (10 points):

- Justifies the applicant's selection of Healthy People 2030 SDOH domains/objectives or other SDOH factors. (*For example, demonstrating alignment to the proposed action plan being implemented with this funding, connecting the SDOH domains or factors to infant mortality or birth outcomes)*.
- Demonstrates thorough knowledge and awareness of barriers/challenges to equity in IM as well as the state, tribal, local, and/or community resources and services intended to reduce infant mortality for the selected priority population(s), including current collaborations/partnerships and policy and systems interventions intended to address disparities in IM.

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

The application will be assessed based on the degree to which it:

Criterion 2 (a): Methodology (15 points)

- Demonstrates that the action plan to be implemented is innovative, data-driven, and focused on policy and systems change strategies that address social and/or structural determinants contributing to disparities in IM in the target county/jurisdiction and selected priority population(s). The action plan should address at least one Healthy People 2030 SDOH domain/objective.
- Provides a feasible and appropriate approach to implement the action plan in partnership and collaboration with cross-sector state and/or local partners (including the State Title V Maternal and Child Health Block Grant Program), community members, and individuals with lived experience. Demonstrates diverse and appropriate types of organizations, sectors, and stakeholders on the network that will help assure that the action plan and the policy/systems strategies being implemented through this funding address the racial or ethnic group(s) with the highest IM rates and excess infant deaths in the target county/jurisdiction (i.e., priority population).
- Provides an effective and feasible approach or process for regularly reporting out/disseminating information to community members, partners, and stakeholders on the action plan's progress and impact.

Criterion 2 (b): Feasibility and strength of the work plan (10 points)

- Demonstrates in the provided work plan that the applicant organization has adequate capacity to implement and carry out the proposed project successfully within the period of performance.

- The specificity and measurability of the objectives and activities in the work plan and the degree to which they align with the NOFO's purpose, goals, and objectives.)
- Provides a logic model that shows a clear connection between the priority population(s), inputs, activities, outputs, anticipated outcomes, and goals of the project.
- Demonstrates sufficient understanding of the possible challenges to the implementation of the action plan and in addressing the selected SDOH domains to reduce IM disparities and excess infant deaths in the priority population.

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

The application will be assessed based on the degree to which it:

- Demonstrates a feasible and appropriate approach for monitoring and tracking overall performance and progress on the project's activities and objectives, including implementation of the action plan; and for evaluating measurable outcomes.
- Demonstrates that the proposed measures align with the purpose of the NOFO and are adequate to assess performance and progress towards the objectives of the NOFO.

Criterion 4: IMPACT (15 points) – Corresponds to Section IV's Methodology and Work Plan

The application will be assessed based on the degree to which it:

- Demonstrates that the overall project will result in outcomes (policy or systems changes) and that the project's outcomes will have a positive impact on the priority population(s) in the target county/jurisdiction (i.e., reduction in IM disparities and excess infant deaths).
- Provides a feasible work plan that aligns with program objectives and expectations.

Criterion 5: RESOURCES/CAPABILITIES (15 points) – Corresponds to Section IV's Organizational Information

The application will be assessed based on the degree to which it:

- Demonstrates the applicant organization (including contractors/consultants, partners, and key personnel/project staff) has the knowledge, capacity, time/level of effort, infrastructure and resources necessary to address the selected SDOH domain(s) and implement structural or policy/systems strategies to reduce IM disparities and excess infant deaths in the priority population(s) and to conduct other project activities successfully.

- Demonstrates diversity in the types of members to be included in the multi-sector teams or networks; and provides sufficient plans for training the network on engaging decision-makers successfully in systems and policy changes.
- Demonstrates sufficient experience in convening and facilitating diverse, multi-sector teams or networks that include community members and people with lived experience/consumers.

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

The application will be assessed based on the degree to which:

- Costs, as outlined in the budget and required resources sections, are adequately described and are reasonable given the scope of work and the period of performance.
- The budget and budget narrative is aligned with the NOFO's requirements and objectives, and the applicant's proposed activities/technical approach.

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.

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) **DGIS Performance Reports.** Available through the HRSA Electronic Handbooks (EHBs), the Discretionary Grant Information System (DGIS) is where recipients will report annual performance data to HRSA. Award recipients are required to submit a DGIS Performance Report **annually**, by the specified deadline. To prepare successful applicants for their reporting requirements, the listing of administrative forms and performance measures for this program are available at. https://grants4.hrsa.gov/DGISReview/ProgramManual?NOFO=HRSA-22-066&ActivityCode=U1V.

2) The type of report required is determined by the project year of the award's period of performance.

Type of Report	Reporting Period	Available Date	Report Due Date
a) New Competing Performance Report	9/1/2022 – 8/31/2023 *(administrative data and performance measure projections, as applicable)*	Period of performance start date	120 days from the available date
b) Non-Competing Performance Report	9/1/2023 – 8/31/2024, 9/1/2024 – 8/31/2025, 9/1/2025 – 8/31/2026	Beginning of each budget period (Years 2–5, as applicable)	120 days from the available date

Type of Report	Reporting Period	Available Date	Report Due Date
c) Project Period End Performance Report	9/1/2026 – 8/31/2027	Period of performance end date	90 days from the available date

The full OMB-approved reporting package is accessible at https://mchb.hrsa.gov/data-research-epidemiology/discretionary-grant-data-collection (OMB Number: 0915-0298 | Expiration Date: 06/30/2022).

3) **Progress Report(s)**. The recipient must submit a progress report narrative to HRSA **annually** via the Non-Competing Continuation Renewal in the EHBs, which should address progress against program outcomes (e.g., accomplishments, barriers, significant changes, plans for the upcoming budget year). Submission and HRSA approval of a progress report will trigger the budget period renewal and release of each subsequent year of funding. Further information will be available in the NOA.

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

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:

Tonya Randall
Grants Management Specialist
Division of Grants Management Operations, OFAM
Health Resources and Services Administration
5600 Fishers Lane, Mailstop 10SWH03
Rockville, MD 20857
Telephone: (301) 594-4259
Email: Trandall@HRSA.gov

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

Lud Abigail Duchatelier-Jeudy, PhD, MPH
Public Health Analyst, Maternal and Women's Health Branch
Attn: HRSA-22-066
Division of Healthy Start and Perinatal Services
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane, Room 18N-96
Rockville, MD 20857
Telephone: (301) 443-0543
Email: infanthealthequity@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 the 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: Monday, January 31, 2022
Time: 1 p.m. ET
Join ZoomGov Meeting: https://hrsa-gov.zoomgov.com/j/1612652252?pwd=VHppWER0UEs4dHllWG43N0xYQkJnQT09

Audio Conference details

- Computer audio is recommended (make sure computer speakers are "on")
- Attendees should click the above and select '**Join with Computer Audio'**
- Attendees without computer access or computer audio can use the dial-in information below

    - Dial-in Toll-Free #: 833 568 8864
    - Meeting ID: 161 265 2252
    - Passcode: 57453797

HRSA will record the webinar and make it available at: https://mchb.hrsa.gov/fundingopportunities/default.aspx.

Tips for Writing a Strong Application

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

Appendix: Glossary

Downstream Interventions - Involves individual-level behavioral approaches for prevention or health management.
https://www.cdc.gov/pcd/issues/2010/jul/09_0249.htm

https://www.barhii.org/barhii-framework

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

Excess Infant Deaths – Infant deaths that occur due to higher mortality rates relative to non-Hispanic White infants, and can be referred to as deaths attributable to disparity or deaths that need to be prevented to achieve equity in infant mortality rates. Excess deaths are calculated by multiplying excess death rates by the number of births (e.g., [Black IM rate – White IM rate] X Black births).

Health Disparities – The preventable differences in the burden of disease, injury, violence, or in opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other population groups, and communities.
https://www.cdc.gov/healthyyouth/disparities/index.htm

Health Equity - The attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.
https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

Health Inequities - systematic differences in the opportunities groups have to achieve optimal health, leading to unfair and avoidable differences in health outcomes (World Health Organization, 2011).

Infant Mortality - Infant mortality is the death of an infant before their first birthday.
https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm

Jurisdiction – For the purposes of this NOFO, since “county” is not a term used for all geographic areas, “jurisdiction” refers to tribal areas; the District of Columbia;

municipalities within Puerto Rico; and similar geographical areas found within the US-affiliated Pacific Islands and Freely Associated States.

Root Causes of Health Inequities - The intrapersonal, interpersonal, institutional, and systemic mechanisms that organize the distribution of power and resources differentially across lines of race, gender, class, sexual orientation, gender expression, and other dimensions of individual and group identity. Root causes of health inequity are also tied to the unequal allocation of power and resources—including goods, services, and societal attention—which manifest in unequal social, economic, and environmental conditions, also called the social determinants of health.
National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States; Baciu A, Negussie Y, Geller A, et al., editors. Communities in Action: Pathways to Health Equity. Washington (DC): National Academies Press (US); 2017 Jan 11. 3, The Root Causes of Health Inequity. Available from: https://www.ncbi.nlm.nih.gov/books/NBK425845

Social Determinants of Health - The conditions in which people are born, grow, live, work and age as well as the complex, interrelated social structures and economic systems that shape these conditions. Social determinants of health include aspects of the social environment (e.g., discrimination, income, education level, marital status), the physical environment (e.g., place of residence, crowding conditions, built environment [i.e., buildings, spaces, transportation systems, and products that are created or modified by people]), and health services (e.g., access to and quality of care, insurance status). https://www.cdc.gov/nchhstp/socialdeterminants/index.html)
https://www.cdc.gov/socialdeterminants/index.htm
https://health.gov/healthypeople/objectives-and-data/social-determinants-health

Structural Determinants of Health - The interplay between the socioeconomic-political context, structural mechanisms generating social stratification and the resulting socioeconomic position of individuals.
https://www.who.int/publications/i/item/9789241500852

Structural Inequities - the systemic disadvantage of one social group compared to other groups with whom they coexist, and the term encompasses policy, law, governance, and culture and refers to race, ethnicity, gender or gender identity, class, sexual orientation, and other domains.
National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States; Baciu A, Negussie Y, Geller A, et al., editors. Communities in Action: Pathways to Health Equity. Washington (DC): National Academies Press (US); 2017 Jan 11. 3, The Root Causes of Health Inequity. Available from: https://www.ncbi.nlm.nih.gov/books/NBK425845/

Structural Racism - systems, social forces, institutions, ideologies, and processes that interact with one another to generate and reinforce inequities among racial and ethnic groups[19]. Structural racism affects the inequitable distribution of resources, materials, and power in racial and ethnic minority communities – resulting in health inequities. National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States; Baciu A, Negussie Y, Geller A, et al., editors. Communities in Action: Pathways to Health Equity. Washington (DC): National Academies Press (US); 2017 Jan 11. 3, The Root Causes of Health Inequity. Available from: https://www.ncbi.nlm.nih.gov/books/NBK425845/

[19] Powell JA. Structural racism: Building upon the insights of John Calmore. 86 N.C. L. Rev. 791 (2008). National Academies of Sciences, Engineering, and Medicine.