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

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

Emergency Medical Services for Children
State Partnership Regionalization of Care

Announcement Type: New, Competing Continuation
Funding Opportunity Number: HRSA-16-050

Catalog of Federal Domestic Assistance (CFDA) No. 93.127

FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2016

Application Due Date: January 20, 2016

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

Release Date: November 6, 2015

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Authority: Public Health Service Act, Title XIX, § 1910, as amended by the Patient Protection and Affordable Care Act, § 5603 (P.L 111-148) (42 U.S.C. 300w-9).

EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB) is accepting applications for the Emergency Medical Services for Children State Partnership Regionalization of Care (EMSC SPROC) program for fiscal year (FY) 2016. This program will provide funding for up to four eligible entities to develop systems of care that increase access to emergency medical services for children[1] in ***United States (U.S.) rural, territorial, insular and/or tribal communities.*** The systems of care will identify the pediatric readiness[i] of facilities to stabilize and treat pediatric patients, improve the transfer process of pediatric patients to higher levels of care, and establish networks and systems to increase access to pediatric specialists. The overall purpose of this program is to reduce pediatric morbidity and mortality through increased access to pediatric specialists through an established network that includes children in rural, territorial, insular and/or tribal communities.

Funding Opportunity Title:	Emergency Medical Services for Children State Partnership Regionalization of Care
Funding Opportunity Number:	HRSA-16-050
Due Date for Applications:	January 20, 2016
Anticipated Total Annual Available Funding:	$800,000
Estimated Number and Type of Award(s):	Up to four (4) grants
Estimated Award Amount:	Up to $200,000 per year
Cost Sharing/Match Required:	No
Project Period:	June 1, 2016 through May 31, 2020 (four (4) years)
Eligible Applicants:	State governments and accredited schools of medicine. [See Section III-1 of this funding opportunity announcement (FOA) for complete eligibility information.]

Application Guide

All applicants are responsible for reading and complying with the instructions included in HRSA's *SF-424 Application Guide*, available online at http://www.hrsa.gov/grants/apply/applicationguide/sf424guide.pdf, except where instructed in this FOA to do otherwise. A short video for applicants explaining the *Application Guide* is available at http://www.hrsa.gov/grants/apply/applicationguide/.

[1] Children/Pediatric: Any person 0 to 18 years of age.

Technical Assistance

The Maternal and Child Health Bureau, Division of Child, Adolescent and Family Health, Emergency Medical Services for Children Program invites all potential applicants to a Technical Assistance webinar on **Tuesday, December 1, 2015, at 4:00 pm eastern time (ET).**
The webinar will be hosted at https://hrsa.connectsolutions.com/hrsa-16-050/.
You'll also need to dial 866-692-3158 and enter passcode 85316847# for audio.

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I. Program Funding Opportunity Description

1. Purpose

This announcement solicits applications for the Emergency Medical Services for Children State Partnership Regionalization of Care (EMSC SPROC) program. The goal of the EMSC Program is to reduce child and youth mortality and morbidity caused by severe illness or trauma. The EMSC Program does not intend to promote the development of separate EMS systems for children, but rather to enhance the pediatric capabilities of EMS systems originally designed primarily for adults. "EMS for Children" broadly means a continuum of care that includes the following components: prevention, pre-hospital care, hospital-based emergency care, and rehabilitation and reentry of the child from the emergency care environment into the community.

The overall purpose of this grant program is to reduce pediatric morbidity and mortality by developing regionalized systems of care[2] thus increasing access to pediatric specialists for children in rural, territorial, insular and/or tribal communities.

The 2006 Institute of Medicine (IOM) report on the future of emergency care described three key principles in its vision for the future of care: *regionalization, coordination, and accountability.*[ii] In January 2012, the National Quality Forum (NQF)[3] published the Endorsement Summary: Regionalized Emergency Care Framework. The NQF organized a steering committee to develop a measurement framework that could serve as a roadmap for future measurement and development within regionalized systems. The steering committee established six key domains or areas considered critical to evaluating regionalized emergency medical care systems. The domains include:

- Domain 1: Capability, Capacity, and Access
- Domain 2: Recognition and Diagnosis
- Domain 3: Resource Matching and Use
- Domain 4: Medical Care
- Domain 5: Coordination of Care
- Domain 6: Outcomes

In this next phase, the SPROC grant program will focus on the first of the NQF domains; Capability, Capacity, and Access. This domain focuses on five specific areas:

1) system public health initiatives;
2) pre-hospital capabilities;
3) real-time capacity information and the categorization of participating agencies, organizations, and facilities;
4) preparedness, monitoring, and data sharing; and
5) legal and regulatory frameworks.[3]

[2] Regionalization refers to an established network of resources that delivers specific care – such as protocols, definitive procedures, higher-care levels, or care pathways – to a defined population of patients or within a defined geography. Source: National Quality Forum, Endorsement Summary: Regionalized Emergency Care Framework. January 2012.
[3] Endorsement Summary: Regionalized Emergency Care Framework. National Quality Forum. Washington, DC. January 2012.

The EMSC SPROC program aims to develop systems of care to increase access to pediatric specialists for all children through the:

1) Development of facility recognition programs;
2) Expansion of facility recognition programs to ensure the inclusion of children in tribal, territorial, rural and insular communities; and
3) Development of similar coordinated systems of care that would reduce and prevent pediatric morbidity and mortality because of timely access to pediatric specialists through established networks.

Systems of care will:

- increase pediatric readiness of facilities to stabilize and treat pediatric patients;
- improve the transfer process of pediatric patients to higher levels of care; and
- increase access to pediatric specialists through the use of established networks.

The goals for the EMSC SPROC program for the next four years and their corresponding targets are as follows:

1) By December 2016, identify healthcare facilities within and beyond state borders that will be included in the regionalized network.
2) By May 2017, establish baseline data of healthcare facilities that will be included in the regionalized network.
3) By May 2018, develop a pediatric facility recognition program/regionalized network. For applicants that have an established pediatric facility recognition program/regionalized network, increase the number of facilities to include tribal, rural, insular and/or territorial facilities.
4) By May 2020, improve the pediatric readiness score[4] of all hospitals in the defined service area/network and the facility recognition program; and
5) By May 2020, improve clinical quality performance metrics for pediatric emergency services in service area/network hospitals as determined by the applicant.

Applicants must develop specific, measurable, achievable, relevant, and time measurable (SMART) objectives that align with the five goals mentioned above. Applicants must provide further elaboration of the activities in detailed action steps, enumeration of the products and specific health outcomes, as described in the EMSC SPROC Program logic model. A Logic Model for this program is included in Appendix A.

[4] A subpanel of experts from the national steering committee was assembled to develop weighting criteria for the national pediatric readiness assessment. Based on the results of the expert panel and the results of the California Pediatric Readiness Project, 24 of the questions were weighted in the national assessment to generate an overall weighted pediatric readiness score (WPRS) for each hospital. The WPRS was normalized to a 100-point scale. The final weighting for each section for the national assessment included 19 points for coordination of care, 10 points for physician/nurse staffing, 7 points for quality improvement, 14 points for patient safety, 17 points for policies/procedures, and 33 points for equipment and supplies.

2. Background

Emergency Medical Services for Children Program[5]

The Emergency Medical Services for Children Program is authorized by the Public Health Service Act, Title XIX, § 1910, as amended by the Patient Protection and Affordable Care Act, § 5603 (P.L. 111-148) (42 U.S.C. 300w-9). The federal EMSC Program, which is comprised of four federal award opportunities, is funded at approximately $21 million per year and is administered by the U.S. Department of Health and Human Services, Health Resources and Services Administration's Maternal and Child Health Bureau, within the Division of Child, Adolescent, and Family Health (DCAFH).

The EMSC program, which began in 1984, focuses on ensuring that every child has access to optimal pediatric emergency care no matter where he/she lives or travels. This federal initiative evolved out of recognition that children have unique needs in emergency situations -- needs that often vary from those of adults due to physiological, developmental and psychological differences.

The EMSC Program allocates funds through competitive grants or cooperative agreements to state governments and accredited schools of medicine. HRSA funds three EMSC programs in addition to that funded under this announcement, which include: 1) State Partnership grants that ensure pediatric emergency care is integrated into the larger emergency medical services system (58 grants)[6]; 2) Targeted Issues grants that support innovative cross-cutting pediatric emergency care projects of national significance (six grants); and 3) the Pediatric Emergency Care Applied Research Network (PECARN) which supports the infrastructure to conduct meaningful and rigorous multi-institutional studies in the management of acute illness and injury in children across the continuum of emergency medicine (six cooperative agreements). The newly funded cooperative agreements for PECARN also include an EMS affiliate to implement pediatric pre-hospital emergency care research in addition to the existing 18 Emergency Departments.

All EMSC State Partnership recipients are required to collect and report data on these ten performance measures. These performance measures are available at: http://www.emscnrc.org/Grantee_Portal/Performance_Measures.aspx.

The EMSC Program also supports a National Data Center and National Resource Center. The EMSC Data Center consists of the Data Coordinating Center (DCC) that supports the PECARN recipients in study, data management, and analysis; and the National EMSC Data Analysis Resource Center (NEDARC) supports state recipients on the collection, management and dissemination of data for EMSC performance measures. The EMSC Program has funded a National Resource Center since 1990 to provide technical support and resources to EMSC recipients. In 2016, the EMSC program will fund an EMSC Innovations and Improvement Center (EIIC). The proposed EIIC, through its Subject Matter Experts (SMEs), will be expected

[5] Schenk E, Edgerton EA. A Tale of Two Populations: Addressing Pediatric Needs in the Continuum of Emergency Care. Ann Emerg Med. 2015 Jun;65(6):673-678.

[6] The EMSC State Partnership (SP) grant program furthers opportunities to improve the pediatric readiness of emergency departments and prehospital provider systems. At present, SP grants provide infrastructure support to 58 states, U.S. territories and the Freely Associated States. By having a universal presence across the United States, the program aims to reach its goal of ensuring that all children receive optimal emergency care no matter where they are.

to guide states to integrate pediatric considerations into policy and make system changes where needed, and implement best practices to improve both the delivery and access children have to healthcare systems. The EIIC will utilize QI and innovative strategies to help advance both prehospital and hospital-based pediatric emergency care systems and promote the attainment of the EMSC program performance measures.

EMSC Expanding Further to Reach Children in Tribal, Territorial, Insular and Rural Communities

Children in U.S. tribal, territorial, insular and rural communities lack access to advanced technology and coordinated specialty care services. Healthcare systems in these areas have reported a lack of specialists, medical resources, and advanced technology. The EMSC program has supported and encouraged efforts across all states and territories to develop systems of care and share resources to support healthcare systems. Working with the Indian Health Service (IHS), the EMSC program sponsored an assessment of the 45 Indian Health Service and Tribal emergency departments EDs, expanding the reach of the Program to further identify gaps in emergency care in IHS and Tribal EDs. Data submitted by the facilities revealed that 69% of the EDs did not report having a pediatric patient care review process; 47% did not report having executed inter-facility transfer agreements with other hospitals for the transfer of patients of all ages, including children, in need of care not available; 33% did not report having inter-facility transfer guidelines; and 63% did not report having the recommended pediatric equipment per national guidelines.

Children are often transported outside their community in which the choice to transport is made on an event-by-event basis. The EMSC SPROC program recipients will work with tribal, territorial, insular and rural communities to expand their access to pediatric specialists and emergency personnel through the establishment of policies and procedures. Establish policies and procedures that support efforts to institutionalize an organized process that is prepared to locally manage or immediately transport severely injured or critically children and adolescents to more advanced medical facilities without delay. A coordinated regional network assures preplanned triage and shared patient management between facilities, identifies the capabilities of facilities within the network, and assures the prompt transfer of pediatric patients when medically necessary to facilities adequately equipped and staffed with pediatric specialists and resources.

"Each year, an estimated 8.7 million children and teens from birth to age 19 are treated in EDs for unintentional injuries and more than 9,000 die as a result of their injuries—one every hour, and more than 225,000 require hospitalization at a cost of around $87 billion in medical and societal costs related to childhood injuries."[iii] Additionally, "children account for 22% of annual United States emergency department (ED) visits,[iv] and require specialized attention within the ED due to physiologic, anatomical, communication, emotional, and therapeutic differences compared to adults.[v] Only 7% of hospitals are fully equipped for pediatric emergencies, and less than 9% consistently have a pediatrician on-call.[vi] These deficiencies result in demonstrable gaps in quality. For example, in one study, over 60% of children in shock in community EDs did not receive early guideline-compliant resuscitation, with worse outcomes identified for those that did not receive appropriate treatment.[vii] These issues are of particular concern in rural areas, where greater distance to referral centers and decreased pediatric volume pose additional challenges."[viii]

Key elements of regionalized healthcare systems include a network of hospitals that coordinate activities to assure the timely transfer of children to the appropriate facility. These systems also include the sharing of resources to expand access to pediatric specialists to guide facilities to locally treat and manage pediatric patients to avoid transfer if not medically necessary. Similarly, the elements of a Facility Recognition Program (FRP) program (a coordinated system of facility recognition), identifies the capabilities of hospitals within a region to care for a child.

Regionalized perinatal services and the evolution of neonatal critical care units are one of the earliest successful models of pediatric regionalization. Efforts for regionalization of pediatric critical care services have also been ongoing since the early 1990's. Evidence is widely available illustrating outcomes for critically ill and injured children are better when cared for in recognized centers, meeting predetermined criteria for trauma, burns and critical care. Developing a model regionalized healthcare system for pediatric patients involves multiple linkages and understanding the complexities of each component of the system in order to overcome the barriers. Components that may facilitate the process of regionalization include:

- identifying a centralized authority or lead agency to coordinate activities at the regional and state level and to ensure standards and processes are followed;
- defining regional system boundaries;
- developing a process for centralized medical direction;
- using standardized, evidence based triage criteria and treatment protocols that include guidelines for inter-facility transfer;
- establishing operational, formalized inter facility transfer agreements/memorandums of understanding between hospitals;
- joint-training of hospital and EMS personnel;
- linking essential data systems for the monitoring of system operations while identifying opportunities for improvement;
- coordinating regional and state continuous quality improvement activities; and
- maintaining and building upon community, regional, state and federal partnerships.

EMSC Regionalization Efforts Thus Far

In response to the 2006 IOM report on the future of emergency care, the EMSC program launched the EMSC State Partnership Regionalization of Care (EMSC SPROC) program in 2012. In total, six sites serving tribal and rural communities were awarded grant funds.[ix] Each site conducted healthcare assessments of hospitals and EMS agencies, and in a variety of ways, each has expanded, established and/or created:

- the use of telemedicine systems in rural and tribal communities for the specific pediatric emergency events, as well as distance learning for emergency personnel;
- state-wide hospital Pediatric Emergency Preparedness networks;
- criteria of a hospital's level of preparedness to medically manage pediatric acute illnesses and severe injuries;
- processes and agreements to share resources and ensure the transfer of children to hospitals that are able to provide pediatric specialty medical services needed by the child;
- partnerships with EMS and hospitals in tribal and rural communities; and
- guidelines to streamline patient movement between healthcare facilities.

The abovementioned projects anticipate completion by May 2016. Applicants are encouraged to review the additional details and anticipated deliverables of currently funded EMSC SPROC projects by visiting http://www.emscnrc.org/Grantee_Portal/SPROC.aspx.

In 2013, more than 4,100 emergency departments responded to the National Pediatric Readiness Assessment.[7] The Assessment helped the EMSC program to identify areas in need of improvement. Data results indicated that:

- only 66% of hospitals have an interfacility transfer agreement for the transfer of children to a higher level of care;
- 69% of hospitals have transfer guidelines, with only 50% of these having all the essential elements;
- only 45% of Emergency Department (ED) respondents reported having a Quality Improvement plan that addresses the needs of children;
- less than half of EDs (48%) had a physician pediatric emergency care coordinator (PECC). There were significant differences based on the hospital's pediatric patient volume.

Overall, the median Pediatric Readiness score for high-volume EDs was 89.8 while it was 61.4 for low-volume EDs.[8]

Furthermore, in 2013, 10 out of 58 state partnership recipients reported having a facility recognition program (FRP), with at least one facility being formally recognized as being capable of stabilizing and managing pediatric medical emergencies. The 10 states include Arizona, California, Delaware, Illinois, Maryland, New Jersey, Ohio, Tennessee, Utah and Wyoming. Additional EMSC state partnership and EMSC SPROC recipients (Alaska, Alabama and Montana) have developed an implementation plan for a FRP program and six recipients are in the process of developing the criteria that medical facilities must meet in order to be recognized as a facility capable of stabilizing and managing pediatric medical emergencies.

In recent years, the national pediatric readiness assessment referenced above has guided the EMSC program, as well as joint efforts with the IHS to improve systems; one such mechanism is through the State partnerships forged as a result of the implementation of the 2012 to 2016 EMSC SPROC program. EMSC SPROC requires the establishment of collaborations and partnerships beyond state borders to efficiently and effectively improve the quality and access to specialized pediatric medical services available to families and children in U.S. territorial, rural and American Indian/Alaska native communities. To ensure collaboration and coordination of efforts, recipients will be required to work in partnership with local EMSC grant programs, as well as EMSC grant recipients within the defined network area. A list of current grant recipients and the points of contact may be found at http://www.emscnrc.org/files/PDF/Grantee_Portal/State_Grantee_List.pdf.

[7] National Pediatric Readiness Project. Retrieved September 22, 2015 http://www.pediatricreadiness.org/

[8] Gausche-Hill M. Ely M, Schmuhl P, Telford R, Remick K, Edgerton E, Olson L. A National Assessment of Pediatric Readiness of Emergency Departments. JAMA Pediatr. 2015 June;169(6):527-34.

II. Award Information

1. Type of Application and Award

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

Funding will be provided in the form of a grant.

2. Summary of Funding

This program will provide funding during federal fiscal years 2016 – 2019. Approximately $800,000 is expected to be available annually to fund four recipients. Applicants may apply for a ceiling amount of up to $200,000 per year. The actual amount available will not be determined until enactment of the final FY 2016 federal budget. This program announcement is subject to the appropriation of funds, and is a contingency action taken to ensure that, should funds become available for this purpose, applications can be processed, and funds can be awarded in a timely manner. The project period is four (4) years. Funding beyond the first year is dependent on the availability of appropriated funds for "Emergency Medical Services for Children" program in subsequent fiscal years, satisfactory recipient performance, and a decision that continued funding is in the best interest of the Federal Government.

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

Limitations on indirect cost rates: This FOA does NOT support research activities, therefore, applicants may not use research indirect cost rates. The "Other Sponsored Program/Activities" rate should be applied. Those applicants without an established indirect cost rate for "other sponsored programs" may only request 10% of salaries and wages, and must request an "other sponsored programs" rate from DCA. Visit DCA's website at: https://rates.psc.gov/ to learn more about rate agreements, the process for applying for them, and the regional offices which negotiate them.

III. Eligibility Information

1. Eligible Applicants

The authorizing legislation for the EMSC Program, Public Health Act, Title XIX, § 1910, as amended by the Patient Protection and Affordable Care Act, § 5603 (P.L. 111-148) (42 U.S.C. 300w-9), defines eligible applicants for this funding opportunity as state governments and accredited schools of medicine.

Under Section 2(f) of the Public Health Service Act, 42 U.S.C. 201(f), the term "State," except as otherwise noted, includes, in addition to the several States, only the District of Columbia,

Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the Virgin Islands, American Samoa, and the Trust Territory of the Pacific Islands. The Trust Territory of the Pacific Islands now refers to the Federated States of Micronesia, the Republic of the Marshall Islands, the Republic of Palau, and the Commonwealth of the Northern Mariana Islands.

2. Cost Sharing/Matching

Cost sharing/matching is not required for this program.

3. Other

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

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

Letters of Support must be included (Attachment 4) from the organization representing the focused population. Include letters of support from partnering organizations and the EMSC state partnership program manager in your state. Letters of support must be dated and specifically indicate a commitment to the project/program (in-kind services, dollars, staff, space, equipment, etc.) In light of the focus of this FOA, coordination with key partners is critical. Therefore, attach additional letters of support that demonstrate coordination and collaboration from agencies such as the State Office of Minority Health, State Office of Rural Health, State Title V MCHB, the State EMSC State Partnership program manager, and the State Office of Minority Health are requested.

Per § 1910(a) of the Public Health Service Act, only three awards under this subsection may be made in a state (to a state or to a school of medicine in such state) in any fiscal year.

NOTE: Multiple applications from an organization are not allowable.

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

IV. Application and Submission Information

1. Address to Request Application Package

HRSA ***requires*** applicants for this FOA to apply electronically through Grants.gov. Applicants must download the SF-424 application package associated with this FOA following the directions provided at Grants.gov.

2. Content and Form of Application Submission

Section 4 of HRSA's *SF-424 Application Guide* provides instructions for the budget, budget justification, staffing plan and personnel requirements, assurances, certifications, and abstract. You must submit the information outlined in the Application Guide in addition to the program-specific information below. All applicants are responsible for reading and complying with the instructions included in HRSA's *SF-424 Application Guide* except where instructed in the FOA to do otherwise.

See Section 8.5 of the *Application Guide* for the Application Completeness Checklist.

Application Page Limit
The total size of all uploaded files may not exceed the equivalent of **80 pages** when printed by HRSA. The page limit includes the abstract, project and budget narratives, attachments, and letters of commitment and support required in the *Application Guide* and this FOA. Standard OMB-approved forms that are included in the application package are NOT included in the page limit. Indirect Cost Rate Agreement and proof of non-profit status (if applicable) will not be counted in the page limit. **We strongly urge applicants to take appropriate measures to ensure the application does not exceed the specified page limit.**

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

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

i. Project Abstract

See Section 4.1.ix of HRSA's *SF-424 Application Guide* for specific information that must be included in the abstract. Also include the following:

Abstract content:

PROBLEM: Briefly (in one or two paragraphs) state the principal challenges in delivering pediatric emergency care in the populations of focus community and associated barriers which are addressed by the project.

GOAL(S) AND OBJECTIVES: Identify the major goal(s) and objectives for the project period. Typically, the goal is stated in a sentence or paragraph, and the objectives are presented in a numbered list.

METHODOLOGY: Describe the programs and activities used to attain the objectives and comment on innovation, cost, and other characteristics of the methodology. This section is usually several paragraphs long and describes the activities which have been proposed or are being implemented to achieve the stated objectives. Lists with numbered items are sometimes used in this section as well.

COORDINATION: Describe the coordination and community engagement planned with the populations of focus community, relevant stakeholders and other appropriate national, regional, state and/or local health agencies, in the populations of focus area(s) served by the project.

EVALUATION: Briefly describe the evaluation methods used to assess program outcomes and the effectiveness and efficiency of the project in attaining goals and objectives. This section is usually one or two paragraphs in length.

ANNOTATION: Provide a three- to five-sentence description of your project that identifies the project's purpose, the needs and problems, which are addressed, the goals and objectives of the project, the activities, which will be used to attain the goals and the materials which will be developed.

The project abstract must be single-spaced and limited to one page in length.

ii. Project Narrative

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

Use the following section headers for the Narrative: Introduction, Needs Assessment, Methodology, Work Plan, Resolution of Challenges, Evaluation, and Technical Support Capacity and Organizational Information. Specific details to include related to each section are as follows:

- **INTRODUCTION** -- *Corresponds to Section V's* ***Review Criterion 1(Need)***
  This section should briefly describe the purpose of the proposed project. Details should include the focused population the applicant intends to improve access to pediatric emergency care services to; and past and present partnership activities with the focused population.

- **NEEDS ASSESSMENT** -- *Corresponds to Section V's* ***Review Criterion 1 (Need)***
  This section of the Project Narrative discusses issues of importance to the program. It should help reviewers understand the barriers faced by the focused population (communities and residents in tribal, territorial, insular, or rural geographical areas) that impact access and medical treatment for the severely ill or injured child. Demographic data should be used and cited whenever possible to support the information provided. Please discuss any relevant barriers in the service area that the project hopes to overcome.

In addition to the information requested above, details in this section should clearly describe the following:

1) How the needs of the focused population were elicited based on current relationships.
2) Prevalence and incidence of health conditions commonly encountered by EMS and hospital emergency departments.
3) Unmet healthcare needs of the population to be served, especially in rural, territorial, and tribal communities.
4) Systems, infrastructure, and community barriers and gaps that the project aims to resolve
5) Overall median pediatric readiness score[x] of hospitals (if available) in the defined network to be improved.
6) Socio-cultural determinants of health and health disparities impacting the focused population.

- **METHODOLOGY** -- *Corresponds to Section V's* ***Review Criteria 1, 2, 3 and 4 (Need, Response, Evaluative Measures, Impact)***

Propose methods that will be used to address the stated needs and meet each of the previously described program requirements and expectations in this FOA.

Details in this section should include:

1) The defined service area/network and identified need for pediatric-ready hospitals.
2) Assessment of current pediatric readiness of hospitals in service area/network; include plans to gather baseline data.
3) Plans to provide education, training and technical assistance to hospitals to improve pediatric readiness scores, therefore, improving hospital readiness to care for children. Include other strategies to improve pediatric readiness scores of facilities in the network.
4) How pediatric readiness scores will be monitored.
5) A process to define, collect, monitor, and improve clinical quality measures (at least three) for pediatric emergency services.
6) Plans to develop a coordinated system of care that would reduce pediatric morbidity and mortality as a result of timely access to pediatric specialists through established networks. An example of this would include plans to develop a pediatric facility recognition program. For applicants with an established pediatric medical recognition program/regionalized healthcare network, include the plan and process to expand the pediatric facility recognition program to include tribal, rural or territorial facilities.
7) Specific training, and/or learning experiences to foster knowledge and appreciation of how culture and language influence health literacy, patient safety, and access to high quality, effective, and predictably safe healthcare services.
8) Methods that ensure a shared and equal collaborative process that engages the focused population. Key components should include community engagement, cultural competence, community investment, and a cultural liaison.

Community Engagement: The community must be involved from the initial planning of the project. Throughout the entire project period, to include planning discussions and project start-up, the lead applicant must engage the populations of focus in all phases and incorporate a process that assures a comprehensive cultural competence and understanding of the focused population. Community engagement assures that the communities: determine their own needs; are full partners in decision making; benefit economically from collaboration; and will be involved in a reciprocal transfer of knowledge and skills among all collaborators and partners.

Cultural Competence: Cultural competence requires that organizations have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally; have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge and (5) adapt to diversity and the cultural contexts of the communities they serve; incorporate the above in all aspects of policy making, administration, practice, service delivery, and involve systematically consumers, key stakeholders and communities. Cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum (adapted from Cross et al., 1989) (National Center for Cultural Competence http://nccc.georgetown.edu/). Cultural competence extends the concept of self-determination to the community. It involves working in conjunction with natural, informal support and helping networks within culturally diverse communities (e.g. neighborhood, civic and advocacy associations; local/neighborhood merchants and alliance groups; ethnic, social, and religious organizations; and spiritual leaders and healers).

Community Investment: Investment in this vision will require health care organizations to: establish and maintain trust among community partners/members when there may be a history of adversarial relationships; effectively and equitably share limited resources among competing needs; share power and ensure that the contributions of community partners/members are valued and respected; and use varied communication modalities and technologies to provide community partners/members with full and timely access to information.

Cultural Liaison: A cultural liaison acts as a catalyst for change. In many ways, cultural liaisons are change agents because they can initiate the transformation of a health care setting by creating an inclusive and collaborative environment for providers and patients/consumers alike. They model and mentor behavioral change, which can break down bias, prejudice, and other institutional barriers that exist in health care settings. Liaisons work toward changing intergroup and interpersonal relationships, so that the organization can build capacity from within to adapt to the changing needs (Heifetz & Laurie, 1997) of the communities they serve. Whatever their

position or roles, cultural liaisons must have the capacity to: assess and understand their own cultural identities and value systems; recognize the values that guide and mold attitudes and behaviors; understand a community's traditional health beliefs, values, and practices and changes that occur through acculturation; understand and practice the tenets of effective cross-cultural communication, including the cultural nuances of both verbal and non-verbal communication; and advocate for the patient, to ensure the delivery of effective health services.

Applicants must also propose a plan for project sustainability after the period of federal funding ends. *Recipients are expected to sustain key elements of their projects, e.g., strategies or services and interventions, which have been effective in improving practices and those that have led to improved outcomes for the focused population.*

- **WORK PLAN** -- *Corresponds to Section V's Review* ***Criteria 2, 3, and 4 (Response, Evaluative Measures and Impact)***
  Describe the activities or steps that will be used to achieve each of the activities proposed in the Methodology section during the entire project period. Use a timeline that includes each activity and identifies responsible staff. As appropriate, identify meaningful support and collaboration with key stakeholders in planning, designing and implementing all activities, including development of the application and, further, the extent to which these contributors reflect the cultural, racial, linguistic and geographic diversity of the populations and communities served.

  Applicants must submit a logic model for designing and managing the project (Attachment 6). A logic model is a one-page diagram that presents the conceptual framework for a proposed project and explains the links among program elements. While there are many versions of logic models, for the purposes of this announcement the logic model should summarize the connections between the:
  - Goals of the project (e.g., objectives, reasons for proposing the intervention, if applicable);
  - Assumptions (e.g., beliefs about how the program will work and is supporting resources. Assumptions should be based on research, best practices, and experience.)
  - Inputs (e.g., organizational profile, collaborative partners, key staff, budget, other resources);
  - Target population (e.g., the individuals to be served);
  - Activities (e.g., approach, listing key intervention, if applicable);
  - Outputs (i.e., the direct products or deliverables of program activities); and
  - Outcomes (i.e., the results of a program, typically describing a change in people or systems).

  Details in this section should also include:

  1) Specific, Measurable, Achievable, Relevant and Time-framed objectives (SMART Objectives) related to the performance and outcomes of this project.
  2) How data will be collected, analyzed and tracked to measure progress and impact/outcomes related to measures below:
     - Pediatric readiness score of hospitals in service area/network

- Clinical quality performance metrics relevant to emergency medical services at hospitals in service area/network
- Process that will be followed to consistently monitor the progress of the project as it moves towards completion

3) A clear description of the national, state, and local significance of the project that include the following:
   - Focused population and stakeholder reach
   - Potential achievements in systems and process improvements
   - Potential improvements in quality of care

Note: the timeline (referenced above) must include all four (4) years and must be uploaded with the application as part of Attachment 1.

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

  Discuss challenges that are likely to be encountered in designing and implementing the activities described in the Work Plan, and approaches that will be used to resolve such challenges. If you anticipate barriers with information-sharing, include plans on how to communicate with the focused population. Please take into consideration areas without access to internet and how you intend to reach focused populations.

- **EVALUATION AND TECHNICAL SUPPORT CAPACITY** -- *Corresponds to Section V's **Review Criteria 3, 4 and 5 (Evaluative Measures, Impact and Resources/Capabilities)***

  Applicants must describe the plan for the program performance evaluation that will contribute to continuous quality improvement. The program performance evaluation should monitor ongoing processes and the progress towards the goals and objectives of the project. Include descriptions of the inputs (e.g., organizational profile, collaborative partners, key staff, budget, and other resources), key processes, and expected outcomes of the funded activities.

  In addition to the information requested, applicants must describe:

  1) the systems and processes that will support the organization's performance management requirements through effective tracking of performance outcomes, including a description of how the organization will collect and manage data (e.g., assigned skilled staff, data management software) in a way that allows for accurate and timely reporting of performance outcomes.
  2) current experience, skills, and knowledge, including individuals on staff, materials published, and previous work of a similar nature. Include project personnel qualifications by training and/or experience to:
     a. manage multi-stakeholder collaborations regionally with hospitals and other stakeholders;
     b. provide technical support;
     c. plan, implement and evaluate quality improvement strategies; and
     d. disseminate information to audiences using technology and virtual platforms accessible to reach the focused population

3) the data collection strategy to collect, analyze and track data to measure process and impact/outcomes, with different cultural groups (e.g., race, ethnicity, language) and explain how the data will be used to inform program development and service delivery.
4) potential obstacles for implementing the program performance evaluation and how those obstacles will be addressed.

- **ORGANIZATIONAL INFORMATION** -- *Corresponds to Section V's **Review Criterion 5 (Resources/Capabilities)***
  Provide information on the applicant organization's current mission and structure, scope of current activities, and an organizational chart, and describe how these all contribute to the ability of the organization to conduct the program requirements and meet program expectations. Provide information on the program's resources and capabilities to support the provision of culturally and linguistically competent and health literate services. Describe how the unique needs of the focused population are routinely assessed and improved.

NARRATIVE GUIDANCE

In order to ensure that the Review Criteria are fully addressed, this table provides a crosswalk between the narrative language and where each section falls within the review criteria.

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

iii. Budget

See Section 4.1.iv of HRSA's *SF-424 Application Guide*. Please note: the directions offered in the SF-424 Application Guide differ from those offered by Grants.gov. Please follow the instructions included in the Application Guide and, *if applicable*, the additional budget instructions provided below.

Reminder: The total project or program costs are the total allowable costs (inclusive of direct **and** indirect costs) incurred by the recipient to carry out a HRSA-supported project or

activity. Total project or program costs include costs charged to the award and costs borne by the recipient to satisfy a matching or cost-sharing requirement, as applicable.

The Consolidated and Further Continuing Appropriations Act, 2015, Division G, § 203, (P.L. 113-235) states, "None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II." Please see Section 4.1.iv Budget – Salary Limitation of HRSA's *SF-424 Application Guide* for additional information. Note that these or other salary limitations will apply in FY 2016, as required by law.

iv. Budget Justification Narrative

Review Section 4.1.v. of HRSA's *SF-424 Application Guide* carefully to ensure the inclusion of all required details and applicable budget categories. In addition, the Emergency Medical Services for Children program requires the following:

A narrative that clearly explains and itemizes costs for each line item in the budget. The budget justification should specifically describe how each item will support the achievement of proposed objectives. The budget period is for ONE year. However, the applicant **must** submit one-year budgets for each of the subsequent budget periods within the requested project period (four years). Line item information must be provided to explain the costs entered in the SF-424A. Be very careful about showing how each item in the "other" category is justified. For subsequent budget years, the justification narrative should highlight the changes from year one or clearly indicate that there are no substantive budget changes during the project period. The budget justification MUST be concise. Do NOT use the justification to expand the project narrative.

Budget for Multi-Year Award
This announcement is inviting applications for project periods up to four (4) years. Awards, on a competitive basis, will be for a one-year budget period; although the project period may be for up to four (4) years. Submission and HRSA approval of your Progress Report(s) and any other required submission or reports is the basis for the budget period renewal and release of subsequent year funds. Funding beyond the one year budget period but within the four-year project period is subject to availability of funds, satisfactory progress of the recipient, and a determination that continued funding would be in the best interest of the Federal Government. Use the budget periods and corresponding fiscal years when preparing your budgets for each fiscal year.

June 1, 2016 to May 31, 2017	Fiscal Year 2016
June 1, 2017 to May 31, 2018	Fiscal Year 2017
June 1, 2018 to May 31, 2019	Fiscal Year 2018
June 1, 2019 to May 31, 2020	Fiscal Year 2019

Include a Budget Spreadsheet and Narrative organized by the following budget Categories, if applicable:

Personnel Costs: Personnel costs should be explained by listing each staff member who will be paid from federal funds, name (if possible), position title, percentage of full-time equivalency, and annual salary. Others not paid by federal funds but will be supporting the project through in-kind or an alternate source of funding should be included as well.

To assure oversight of the program and dedicated staff, a program manager/director must be designated to oversee the project. In addition, to ensure representation, active engagement and involvement of the focused population in the development and implementation of the project, a cultural liaison is strongly recommended. A cultural liaison fosters partnerships with the communities to be served.

Other examples of personnel may include, but are not limited to:

- A project consultant(s) to provide expertise in cultural awareness, community engagement activities, pediatric education, telemedicine, legal or budgetary expertise, etc.
- A medical director;
- Community consultants to facilitate communications and coordinate meetings in the focused population community;
- A data manager to support efforts to collect and analyze data; and/or
- An experienced individual in quality improvement.

These costs may be included in this budget category or contractual services. The salary of the current EMSC state partnership program manager may **not** be included as part of this grant application, if currently funded under the state partnership program.

Fringe Benefits: Reference section 4.1.v. of HRSA's *SF-424 Application Guide.*

Travel: Reference section 4.1.v. of HRSA's *SF-424 Application Guide.*

In addition to the requirements, per section 4.1.v. of the SF-424 Application Guide, the program has mandatory attendance requirements for EMSC SPROC program grant recipients. The applicant must budget costs for attendance to the following meetings as part of the grant requirement:

- **Biennial Program Manager Meeting -** Include budgeted costs associated for attendance at the EMSC program manager meeting specifically for program managers/directors, cultural liaisons and family representatives. This meeting is held biennially in years 1 and 3. Applicants must budget for *at least two people* (the lead applicant for the Regional program and at least one representative from each of the focused populations that the main applicant has partnered with) to attend the meeting for technical assistance. The budget should include travel costs to the Washington, D.C. area for at least 4 nights/5 days. The program meeting is anticipated to be 2 ½ days and a Regional meeting will occur prior to or after the 2 ½ day program manager meeting. Approximate hotel rates for the Washington, D.C. area are $250 per night.

- **Biennial Program Meeting -** Include budgeted costs associated for attendance at the biennial all-grantee **EMSC program meeting.** The purpose of the biennial all-grantee meeting is to ensure collaborative work across all grant programs; share knowledge on best practices and lessons learned to improve the quality and delivery of pediatric

emergency care, and to assure access to in-person technical assistance from federal project officers. This meeting will be held in year 2 and 4. Applicants must budget for *at least three people,* specifically the program manager/director, cultural liaison and a representative from one of the partner facilities. The budget should include travel costs to the Washington, D.C. area for at least 4 nights/5 days. The program meeting is anticipated to be 2 ½ days and a Regional meeting will occur prior to or after the 2 ½ day program meeting. Approximate hotel rates for the Washington, D.C. area are $250 per night.

- **Regional Partner Site-Visits and Council Meetings.** Funding must be included for travel costs to visit focused population healthcare sites. To support the integration of healthcare systems to improve the quality of care for all pediatric patients, partnering facilities should understand the complexities and current capabilities of each of their respective healthcare systems. Therefore, the program requires site-visits to be conducted each year. At a minimum, travel funds are needed for two face-to-face meetings per year that should include stakeholders and eventually a Pediatric Regional Council expected to convene quarterly.

Equipment: Reference section 4.1.v. of HRSA's *SF-424 Application Guide*

Equipment items must be described in clear detail and include the purpose and how the item will contribute to the overall goal of the project. These items may not exceed $25,000 per unit cost and are subject to HRSA's review and approval. Examples of equipment to support the activities of this grant may include items necessary to pediatric medical services systems. Some equipment items may include electronics to support consulting, mobile communication devices for online medical direction, equipment to support webinars or internet live communication systems similar to Skype or office communicator for educational seminars or to create communication systems to reach the focused population(s), pediatric equipment and supply bags or supplies for clinics or transport vehicles, and other items directly related to improving communication with the focused population and access to pediatric specialists. Unit costs must be itemized.

Supplies: List the items that the project will use. In this category, separate office supplies from medical and educational purchases. Office supplies could include computers (if the unit cost is below $5,000), paper, pencils, and the like; medical supplies, and educational supplies. The applicant should address costs associated with the development of a needs assessments and regionalization plans. The dissemination of these reports may be in paper or electronic form, but must be planned for in the budget. Remember: medical, office, and educational supplies must be listed separately and cost must be itemized.

Contractual: Reference section 4.1.v. of HRSA's *SF-424 Application Guide*.
Examples of contractual costs could include contractual services for community consultants that serve as a cultural liaison, provide direct services to resource-limited areas or foster partnership and engagement at the community level. It could also be for professional services provided such as educational training, case reviews, quality improvement activities or technical assistance. Applicants must provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. Some examples of budgeted costs may also include services for a cultural liaison. Please allow additional time for contracts with sovereign entities as these negotiations may take longer.

Other examples of contractual services may include, but is not limited to:

- A project consultant(s) to provide expertise in cultural awareness, community engagement, pediatric education, telemedicine, legal or budgetary, etc.;
- A medical director;
- Community consultants to facilitate communications and coordinate meetings; and/or
- Other positions listed as examples in the personnel budget section of this FOA.

Other: Reference section 4.1.v. of HRSA's *SF-424 Application Guide*.
Other example of costs may include: Stipend funds to reimburse volunteers for their attendance and local travel expenses to attend meetings; cell phone usage for community volunteers; etc. Applicants may include the cost of access accommodations as part of their project's budget, including sign language interpreters, plain language and health literate print materials in alternate formats (including Braille, large print, etc.); and cultural/linguistic competence modifications such as use of cultural liaisons, translation or interpretation services at meetings, services for review of materials for dissemination, clinical encounters, and conferences, etc.

Indirect Costs: Reference section 4.1.v. of HRSA's *SF-424 Application Guide*

Indirect costs are those costs incurred for common or joint objectives which cannot be readily identified but are necessary to the operations of the organization, e.g., the cost of operating and maintaining facilities, depreciation, and administrative salaries. For institutions subject to OMB Circular A-21, which has been superseded by the Uniform Guidance at 45 CFR 75, as implemented by HHS, the term "facilities and administration" is used to denote indirect costs. If an organization applying for an assistance award does not have an indirect cost rate, the applicant may wish to obtain one through HHS's Division of Cost Allocation (DCA). Visit DCA's website at: http://rates.psc.gov/ to learn more about rate agreements, the process for applying for them, and the regional offices which negotiate them.

If federal funds were not budgeted in the budget category "Personnel" or "Contractual Services," please include a listing of each staff member who will be dedicated to the project through other sources. Include the individual's name (if possible), position title, percent of time (FTE) dedicated to the project, source of funding and annual salary. These individuals and their responsibilities as it relates to this project must also be reflected in the Staffing Plan and Personnel Requirements section of the application.

When requesting indirect costs, the applicant must submit a copy of the latest negotiated rate agreement. This project supports an infrastructure from which to conduct research, but is not a research project in and of itself, therefore, it is not eligible for research indirect rates. The indirect costs rate refers to the "Other Sponsored Program/Activities" rate and to neither the research rate, nor the education/training program rate. Those applicants without an established indirect cost rate for "other sponsored programs" may only request 10% of salaries and wages, and must request an "other sponsored programs" rate from DCA.

Note: HRSA/MCHB allows awardees to utilize contractors but not to issue subgrants.

v. Program-Specific Forms

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

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

2) Performance Measures for the Emergency Medical Services for Children State Partnership Regionalization of Care program

To inform successful applicants of their reporting requirements, the listing of MCHB administrative forms and performance measures for this program can be found at: https://perf-data.hrsa.gov/mchb/DgisApp/FormAssignmentList/H3A_1.html.

The MCHB's Discretionary Grant Information System (DGIS) collects program and performance measure data for more than 900 grants annually. These data help MCHB assess the effectiveness of its programs and help monitor the progress made under these grants. MCHB discretionary grants help to ensure that quality health care is available to the MCH population, which includes all of the nation's women, infants, children, adolescents, and their families, including fathers and children with special health care needs. Recipients of the EMSC SPROC grant are required to report annually on Discretionary Grant Information System (DGIS) performance measures assigned to the EMSC SPROC program. In fiscal year 2016, upon approval from the Office of Management and Budget (OMB), the Maternal and Child Health Bureau (MCHB) will release new performance measures. Once the specific performance measures have been assigned to each MCHB discretionary grant, performance measures and administrative forms for this discretionary grant program will be assigned to the EMSC SPROC program.

NOTE: The performance measures and data collection information is for your PLANNING USE ONLY. These forms are not to be included as part of this application. However, this information will be due to HRSA within 120 days after the Notice of Award.

vi. Attachments

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

Attachment 1: ***Work Plan***

Attach the Work Plan for the project that includes all information detailed in Section IV. ii. Project Narrative. Note: the timeline must include all four (4) years.

Attachment 2: ***Staffing Plan and Job Descriptions for Key Personnel***

(see Section 4.1. of HRSA's *SF-424 Application Guide)*

Keep each job description to one page in length as much as is possible. Include the role, responsibilities, and qualifications of proposed project staff.

Attachment 3: ***Biographical Sketches of Key Personnel***

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

Attachment 4: ***Letters of Support or Agreement***

Letters of Support must be included from the organization representing the focused population. Include letters of support from partnering organizations and the EMSC state partnership program manager in your state. Letters of support must be dated and specifically indicate a commitment to the project/program (in-kind services, dollars, staff, space, equipment, etc.) In light of the focus of this FOA, coordination with key partners is critical. Therefore, attach additional letters of support that demonstrate coordination and collaboration from agencies such as the State Office of Minority Health, State Office of Rural Health, State Title V MCHB, the State EMSC State Partnership program manager, and the State Office of Minority Health are requested.

Attachment 5: ***Project Organizational Chart***

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

Attachment 6: ***Logic Model***

Provide a logic model that includes the details requested in the Project Narrative's Work Plan.

Attachment 7: ***Summary Progress Report***

ACCOMPLISHMENT SUMMARY

(FOR COMPETING CONTINUATIONS ONLY)

A well-planned accomplishment summary can be of great value by providing a record of accomplishments. It is an important source of material for HRSA in preparing annual reports, planning programs, and communicating program-specific accomplishments. The accomplishments of competing continuation applicants are carefully considered during the review process; therefore, applicants are advised to include previously stated goals

and objectives in their application and emphasize the progress made in attaining these goals and objectives. Because the Accomplishment Summary is considered when applications are reviewed and scored, **competing continuation applicants who do not include an Accomplishment Summary may not receive as high a score as applicants who do.** The Accomplishment Summary will be evaluated as part of **Review Criterion 5: Resources/Capabilities**

The accomplishment summary should be a brief presentation of the accomplishments, in relation to the objectives of the program during the current project period. The report should include:

(1) The period covered (dates).

(2) Specific Objectives - Briefly summarize the specific objectives of the project as actually funded.

(3) Results- Describe the program activities conducted for each objective. Include both positive and negative results or technical problems that may be important.

Attachments 8 – 15: ***Other Relevant Documents***

Include here any other documents that are relevant to the application.

3. Dun and Bradstreet Universal Numbering System Number and System for Award Management

Applicant organizations must obtain a valid DUNS number and provide that number in their application. Each applicant must also register with the System for Award Management (SAM) and continue to maintain active SAM registration with current information at all times during which it has an active federal award or an application or plan under consideration by an agency (unless the applicant is an individual or federal agency that is exempted from those requirements under 2 CFR 25.110(b) or (c), or has an exception approved by the agency under 2 CFR 25.110(d))**.**

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

If an applicant/recipient organization has already completed Grants.gov registration for HRSA or another federal agency, confirm that the registration is still active and that the Authorized Organization Representative (AOR) has been approved.

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

- Dun and Bradstreet (http://fedgov.dnb.com/webform/pages/CCRSearch.jsp)
- System for Award Management (SAM) (https://www.sam.gov)
- Grants.gov (http://www.grants.gov/)

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

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

4. Submission Dates and Times

Application Due Date
The due date for applications under this FOA is *January 20, 2016 at 11:59 P.M. Eastern Time*.

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

5. Intergovernmental Review

The EMSC program is not a program subject to the provisions of Executive Order 12372, as implemented by 45 CFR Part 100.

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

6. Funding Restrictions

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

The General Provisions in Division G of the Consolidated and Further Continuing Appropriations Act, 2015 (P.L. 113-235) apply to this program. Please see Section 4.1 of HRSA's *SF-424 Application Guide* for additional information. Note that these or other restrictions will apply in FY 2016, as required by law.

All program income generated as a result of awarded funds must be used for approved project-related activities.

V. Application Review Information

1. Review Criteria

Procedures for assessing the technical merit of applications have been instituted to provide for an objective review of applications and to assist the applicant in understanding the standards against which each application will be judged. Critical indicators have been developed for each review criterion to assist the applicant in presenting pertinent information related to that criterion and to provide the reviewer with a standard for evaluation. Review criteria are outlined below with specific detail and scoring points.

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

Review Criteria are used to review and rank applications. The EMSC SPROC program has six (6) review criteria:

Criterion 1: *NEED (5 points) – Corresponds to Project Narrative sections - Introduction, Needs Assessment and Methodology*

The extent to which the application demonstrates the problem and associated contributing factors to the problem, to include:

1) Identifying the focused population concentrated efforts will be made to improve access to emergency care to include:

    a. barriers faced by the focused population ;
    b. demographic data to support the information provided; and
    c. relevant barriers in the service area that the project hopes to overcome;

2) prevalence and incidence of health conditions commonly encountered by EMS and hospital emergency departments, to include:
    a. unmet healthcare needs of the population to be served, especially in rural, territorial, and tribal communities. Include systems, infrastructure, and community barriers and gaps that the project aims to resolve;
    b. overall median pediatric readiness score[xi] of hospitals (if available) in the defined network to be improved; and
    c. socio-cultural determinants of health and health disparities impacting the focused population.

Criterion 2: *RESPONSE (40 points) – Corresponds to Project Narrative sections - Methodology, Work Plan and Resolution of Challenges*

The extent to which the proposed project:

1) responds to the "Purpose" included in the program description;
2) has aligned the goals and objectives and their relationship to the identified project;
3) describes activities capable of addressing the problem and attaining the project objectives;
4) clearly defines the service area/network and explains the need for pediatric-ready hospitals;

5) includes a plan to assess the current pediatric readiness of hospitals in the service area/network and included plans to gather baseline data;
6) includes a plan to provide education, training and technical assistance to hospitals to improve pediatric readiness scores, therefore, improving hospital readiness to care for children;
7) describes how pediatric readiness scores will be monitored;
8) describes the process to define, collect, monitor, and improve clinical quality measures (at least three) for pediatric emergency services;
9) describes how a coordinated system of care would be developed that would reduce pediatric morbidity and mortality as a result of timely access to pediatric specialists through established networks;
10) describes specific training, and/or learning experiences that demonstrate the applicants ability to foster knowledge and the applicants understanding of how culture and language influence health literacy, patient safety, and access to high quality, effective, and predictably safe healthcare services;
11) provides methods that ensure a shared and equal collaborative process that engages the focused population that include community engagement, cultural competence, and community investment;
12) includes a plan to include a cultural liaison to assure representation of the focused population throughout the entire project.
13) provides a plan for project sustainability after the period of federal funding has ended.
14) describes potential challenges and plans to resolve such challenges.

Criterion 3: *EVALUATIVE MEASURES (10 points) – Corresponds to Project Narrative sections - Methodology and Evaluation and Technical Support Capacity*

The extent to which the applicant:

1) provides methods to monitor and evaluate the project results;
2) provides clear plans for program performance evaluation that will contribute to continuous quality improvement;
3) describes the systems and processes that will support the organization's performance management requirements through effective tracking of performance outcomes, including a description of how the organization will collect and manage data (e.g., assigned skilled staff, data management software) in a way that allows for accurate and timely reporting of performance outcomes;
4) describes current experience, skills, and knowledge, including individuals on staff, materials published, and previous work of a similar nature;
5) describes the data collection strategy to collect, analyze and track data to measure process and impact/outcomes, with different cultural groups (e.g., race, ethnicity, language) and explain how the data will be used to inform program development and service delivery;
6) describes any potential obstacles for implementing the program performance evaluation and how those obstacles will be addressed; and
7) Describes how data will be collected, analyzed and tracked to measure progress and impact/outcomes related to measures below:
    - Pediatric readiness score of hospitals in service area/network
    - Clinical quality performance metrics relevant to emergency medical services at hospitals in service area/network

- Process that will be followed to consistently monitor the progress of the project as it moves towards completion

Criterion 4: *IMPACT (25 points) – Corresponds to Project Narrative section – Methodology, Work Plan, and Evaluation and Technical Support Capacity*

The extent to which the applicant:

1) includes activities or steps that will be used to achieve each of the activities proposed during the entire project period as proposed in the Methodology section;
2) includes a time line for all four years that includes each activity, identifies responsible staff, and included all key items requested in this FOA;
3) provides a logic model with all key elements requested;
4) includes Specific, Measurable, Achievable, Relevant and Time-framed objectives (SMART Objectives) related to the performance and outcomes of this project;
5) describes how data will be collected, analyzed and tracked to measure progress and impact/outcomes related to the pediatric readiness score of hospitals in the service area/network; clinical quality performance metrics relevant to emergency medical services in hospitals in the service area/network; and process that will be followed to consistently monitor progress.; and
6) provides a clear description of the national, state, and local significance of the project and includes the specific details requested.

Criterion 5: *RESOURCES/CAPABILITIES (10 points) – Corresponds to Section IV's Organizational Information*

The extent to which:

1) project personnel are qualified by training and/or experience to implement and carry out the project. The capabilities of the applicant organization and the quality and availability of facilities and personnel to fulfill the needs and requirements of the proposed project;
2) the applicant provides clear details about the organization's current mission and structure, and scope of current activities;
3) the applicant includes an organizational chart, and describes how these all contribute to the ability of the organization to conduct the program requirements and meet program expectations;
4) the applicant provides information on the program's resources and capabilities to support the provision of culturally and linguistically competent and health literate services;
5) the applicant describes how the unique needs of the focused population are routinely assessed and improved;
6) the applicant provides details on 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; and
7) the applicant provides details on current experience, skills, and knowledge, including individuals on staff, materials published, and previous work of a similar nature.

Criterion 6: *SUPPORT REQUESTED (10 points) – Corresponds to the Budget and Budget Justification Narrative sections*
The reasonableness of the proposed budget for each year of the project period in relation to the objectives, the complexity of the research activities, and the anticipated results.

The extent to which:

1) costs, as outlined in the budget and required resources sections, are reasonable given the scope of work; and
2) key personnel have adequate time devoted to the project to achieve project objectives.

2. Review and Selection Process

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

This program does not have any funding priorities, preferences or special considerations.

Please Note: The Health Resources and Services Administration may elect not to fund applicants with management or financial instability that directly relates to the organization's ability to implement statutory, regulatory or other requirements (45 CFR § 75.205). The decision not to make an award or to make an award at a particular funding level, is discretionary and is not subject to appeal to any OPDIV or HHS official or board.

3. Anticipated Announcement and Award Dates

It is anticipated that awards will be announced prior to the start date of June 1, 2016.

VI. Award Administration Information

1. Award Notices

The Notice of Award will be sent prior to the start date of June 1, 2016. See Section 5.4 of HRSA's *SF-424 Application Guide* for additional information.

2. Administrative and National Policy Requirements

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

Human Subjects Protection:
Federal regulations (45 CFR Part 46) require that applications and proposals involving human subjects must be evaluated with reference to the risks to the subjects, the adequacy of protection against these risks, the potential benefits of the research to the subjects and others, and the importance of the knowledge gained or to be gained. If research involving human subjects is anticipated, recipients must meet the requirements of the HHS regulations to protect human subjects from research risks as specified in the Code of Federal Regulations, Title 45 – Public Welfare, Part 46 – Protection of Human Subjects (45 CFR Part 46), available online at http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.html.

3. Reporting

The successful applicant under this FOA must comply with Section 6 of HRSA's *SF-424 Application Guide* **and** the following reporting and review activities:

1) **Progress Report**(s). The recipient must submit a progress report to HRSA on an **annual** basis. Further information will be provided in the award notice.

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

a) Performance Measures and Program Data

To prepare successful applicants for their reporting requirements, the listing of MCHB administrative forms and performance measures for this program can be found at: https://perf-data.hrsa.gov/mchb/DgisApp/FormAssignmentList/H3A_1.html.

b) Performance Reporting

Successful applicants receiving HRSA funds will be required, within 120 days of the Notice of Award (NoA), to register in HRSA's Electronic Handbooks (EHBs) and electronically complete the program-specific data forms that appear for this program at: https://perf-data.hrsa.gov/mchb/DgisApp/FormAssignmentList/H3A_1.html. This requirement entails the provision of budget breakdowns in the financial forms based on the award amount, the project abstract and other grant/cooperative agreement summary data as well as providing objectives for the performance measures.

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

c) Project Period End Performance Reporting

Successful applicants receiving HRSA funding will be required, within 90 days from the end of the project period, to electronically complete the program-specific data forms that appear for this program at: https://perf-data.hrsa.gov/mchb/DgisApp/FormAssignmentList/H3A_1.html. The requirement includes providing expenditure data for the final year of the project period, the project abstract and grant/cooperative agreement summary data as well as final indicators/scores for the performance measures.

VII. Agency Contacts

Applicants may obtain additional information regarding business, administrative, or fiscal issues related to this FOA by contacting:

Sarah E. Morgan Grants Management Specialist
HRSA Division of Grants Management Operations, OFAM
Parklawn Building, Room 10W
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 443-4584
Fax: (301) 443-5461
E-mail: SMorgan1@hrsa.gov

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

Theresa Morrison-Quinata
Program Director, Emergency Medical Services for Children
Division of Child, Adolescent and Family Health
HRSA Maternal and Child Health Bureau
Parklawn Building, Room 18W-12
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 443-1527
E-mail: TMorrison-Quinata@hrsa.gov

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

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

Successful applicants/recipients may need assistance when working online to submit information and reports electronically through HRSA's Electronic Handbooks (EHBs). For assistance with submitting information in HRSA's EHBs, contact the HRSA Contact Center, Monday-Friday, 8:00 a.m. to 8:00 p.m. ET:

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

VIII. Other Information

Logic Models:

Additional information on developing logic models can be found at the following website: http://www.cdc.gov/nccdphp/dnpao/hwi/programdesign/logic_model.htm.

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. Information on how to distinguish between a logic model and work plan can be found at the following website: http://www.cdc.gov/healthyyouth/evaluation/pdf/brief5.pdf.

Technical Assistance:

The Maternal and Child Health Bureau, Division of Child, Adolescent and Family Health, Emergency Medical Services for Children Program invites all potential applicants to a Technical Assistance webinar on **Tuesday, December 1, 2015, at 4:00 pm ET**.
The webinar will be hosted at https://hrsa.connectsolutions.com/hrsa-16-050/
You'll also need to dial 866-692-3158 and enter passcode 85316847# for audio.

To ensure notice of any updates related to this FOA, please register with Grants.gov.

IX. Tips for Writing a Strong Application

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

APPENDIX A

Program Logic Model

Emergency Medical Services for Children
State Partnership Regionalization of Care

RESOURCES/INPUTS	OUTPUTS		OUTCOMES	IMPACT
	ACTIVITIES	PRODUCT/SYSTEMS		
Required Partners	Expand Capability, Capacity and Access to Coordinated Emergency Healthcare Systems	Capability, Capacity and Access to Coordinated Emergency Healthcare Systems Expanded	Patients have access to pediatric-ready providers	Improved Health Outcomes
• Schools of Medicine • State Governments • State EMSC program managers • EMSC cultural liaison • Indian Health Service • Tribes • EMS • Hospitals • Pediatric Providers & specialists • Rural community • Family representative • Professional Assoc. • Hospital Association • EMSC resource centers	• Develop hospital partnerships • Assist hospitals to improve pediatric readiness • Recruit Pediatric specialists • Develop EMS partnerships • Develop protocols for communication, triage, patient transfer & care between partners • Provide workforce education & Training	• 1st Responders prepared to treat pediatric patients • Increased number of pediatric ready hospitals • Inter-agency protocol developed/operational for communication, triage, patient transfer & care • Specialty provider access system developed	• 1st Responders are pediatric-ready • Patients treated in pediatric-ready hospitals • Pediatric specialists available when necessary • EMSC continuum routinely communicates and collaborates	Reduced morbidity and mortality for pediatric patients requiring emergency medical services (esp. for children in American Indian/Native Alaska, Territorial and rural communities)
Measures of success		• # of hospitals with pediatric readiness score >80 (NPRS) • Increased median pediatric readiness score	• Improved clinical quality performance • % compliance with evidence-based peds protocol • % peds patients transported to peds-ready hospitals	

APPENDIX B

References:

[i] Remick, K, et al. Pediatric Readiness and Facility Verification. Annals of Emergency Medicine 2015.

[ii] An excerpt from the Institute of Medicine (IOM) Reports.

[iii] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. National Action Plan for Child Injury Prevention. Atlanta (GA): CDC, NCIPC; 2012, page 9

[iv] Schappert SM, Bhuiya F. Availability of pediatric services and equipment in emergency departments: United States, 2006. Natl Health Stat Report 2012:1-21.

[v] National Research Council. Emergency Care for Children: Growing Pains. In. Washington, D.C.: National Academies Press; 2007.

[vi] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. National Action Plan for Child Injury Prevention. Atlanta (GA): CDC, NCIPC; 2012, page 9

[vii] Carcillo JA, Kuch BA, Han YY, et al. Mortality and functional morbidity after use of PALS/APLS by community physicians. Pediatrics 2009;124:500-8.

[viii] Ray KN, et al. Attitudes Toward Rural Pediatric Emergency Telemedicine. Pediatric Emergency Care 2015.

[ix] EMSC National Resource Center. (2012). *Emergency Medical Services for Children State Partnership Regionalization of Care grant program fact sheet.* Retrieved August 25, 2015 from http://www.emscnrc.org/files/PDF/EMSC_Resources/2012-SPROC-Grant-Recipients.pdf

[x] National Pediatric Readiness Project. 2015, September 22. Retrieved http://www.pediatricreadiness.org/State_Results/National_Results.aspx

[xi] National Pediaric Readiness Project. 2015, September 22. Retrieved http://www.pediatricreadiness.org/State_Results/National_Results.aspx