

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES



Health Resources & Services Administration

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

***National Maternal and Child Health Consortium for
Oral Health Systems Integration and Improvement***

Funding Opportunity Number: HRSA-21-037
Funding Opportunity Type(s): Competing Continuation, New
Assistance Listings (CFDA) Number: 93.110

NOTICE OF FUNDING OPPORTUNITY

Fiscal Year 2021

Application Due Date: February 17, 2021

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

Issuance Date: November 18, 2020

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

EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA) is accepting applications for the fiscal year (FY) 2021 National Maternal and Child Health Consortium for Oral Health Systems Integration and Improvement, hereafter referred to as the Consortium. HRSA will award one cooperative agreement recipient to lead a group of nationally recognized organizations in oral health care.

The purpose of the Consortium is to develop and expand accessible, high-quality integrated preventive oral health care for maternal and child health (MCH) populations, with an emphasis on supporting MCH safety net services. The Consortium members should have expertise and demonstrable knowledge in providing technical assistance to improve the delivery of integrated preventive oral health care, strategies to maximize reimbursement, and state practice guidance and public policy innovations. The Consortium's three core functions are: **1) identify gaps and barriers** within systems of care that prevent an optimal delivery of preventive oral health care to MCH populations; **2) improve MCH systems of care**, overcoming identified gaps and barriers, to optimize delivery of preventive oral health care and reduce oral health disparities among MCH populations by better integrating oral health and primary care; and **3) translate evidence into practice**, raising awareness and knowledge through the dissemination of new and reliable resources and guidance that serve to overcome gaps and barriers and reduce oral health disparities among MCH populations.

This notice also includes an announcement for additional funding to implement the *Oral Health Core Clinical Competencies (OH3C) Project*. You may apply for this additional funding to increase oral health competency among non-dental providers to improve oral health integration within primary care settings.

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.

| | |
|--|---|
| Funding Opportunity Title: | National Maternal and Child Health Consortium for Oral Health Systems Integration and Improvement |
| Funding Opportunity Number: | HRSA-21-037 |
| Due Date for Applications: | February 17, 2021 |
| Anticipated Total Annual Available FY 2021 Funding: | <i>Total Annual Funding:</i> \$1,325,000 Consortium: \$1,075,000 Additional Funding: \$250,000 |
| Estimated Number and Type of Award(s): | Up to one cooperative agreement |
| Estimated Award Amount: | Consortium with Additional Funding: Up to \$1,325,000 per year, subject to the availability of appropriated funds. |
| Cost Sharing/Match Required: | No |

| | |
|------------------------|---|
| Period of Performance: | July 1, 2021, through June 30, 2024 (3 years) |
| Eligible Applicants: | Any domestic public or private entity, including Indian tribes or tribal organizations (as those terms are defined at 25 U.S.C. § 450b) is eligible to apply. Domestic faith-based and community-based organizations are also eligible to apply. See Section III.1 of this notice of funding opportunity for complete eligibility information. |

Application Guide

You (the applicant organization/agency) are responsible for reading and complying with the instructions included in HRSA's *SF-424 Application Guide*, available online at <http://www.hrsa.gov/grants/apply/applicationguide/sf424guide.pdf>, except where instructed in this NOFO to do otherwise.

Technical Assistance

HRSA has scheduled the following technical assistance:

Webinar

Day and Date: Wednesday, December 16, 2020

Time: 3–4 p.m. ET

Call-In Number: 1-888-390-5922

Participant Code: 8656697

Weblink: https://hrsa.connectsolutions.com/hrsa-21-037_technical_assistance_webinar/

Instant Replay (Generally available 1 hour after a call ends.)

Call-In Number: 1-800-841-8614

Passcode: 21921

HRSA will record the webinar and make it available at:

<https://mchb.hrsa.gov/fundingopportunities/default.aspx>.

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I. Program Funding Opportunity Description

1. Purpose

This notice announces the opportunity to apply for funding under the National Maternal and Child Health Consortium for Oral Health Systems Integration and Improvement, hereafter referred to as the Consortium. The Maternal and Child Health Bureau (MCHB) will award one cooperative agreement recipient to lead a group of nationally recognized expert organizations in oral health care.

The purpose of the Consortium is to develop and expand accessible, high-quality integrated preventive oral health care for maternal and child health (MCH) populations by providing targeted technical assistance (TA)¹ to MCHB oral health Special Projects of Regional and National Significance (SPRANS) and Title V MCH Services Block Grant Program (Title V) award recipients, utilizing a learning collaborative (LC) approach. The Consortium's lead, in collaboration with Consortium partners and key national stakeholders, will advance excellence in oral health care TA in support of preventive oral health care delivery, with an emphasis on MCH safety net services.² To achieve its purpose, the Consortium will perform three core functions:

- 1) Identify Gaps and Barriers** – Encompass key elements of the MCH Pyramid of Services³ to identify and address gaps and barriers within systems of care that prevent optimal delivery of preventive oral health care that serve MCH populations.
- 2) Improve MCH Systems of Care**⁴ – Foster improvements within MCH systems of care that overcome identified gaps and barriers to optimize delivery of preventive oral health care and reduce oral health disparities among MCH populations by better integrating oral health and primary care.
- 3) Translate Evidence into Practice** – Raise awareness and knowledge through the dissemination of new and reliable resources and guidance that serve to reduce the oral health disparities among MCH populations.

In response to this notice, you will be expected to address Program Expectations (see [Section IV.2](#)).

Program Goal

The goal of the Consortium is to advance evidence-driven transformations within MCH systems of care that reduce the oral health disparities among MCH populations.

¹ For the purpose of this cooperative agreement, targeted TA includes the evaluation and synthesis of a recipient's TA priorities and, given their implementation capacity, the TA provider identifies the most relevant, feasible TA solutions.

² MCH safety net services are comprised of health care provider services, payment program services, and care received at facilities that provide MCH clinical, nonclinical, and support services.

³ Health Resources and Services Administration. Maternal and Child Health Bureau. (December, 2020). Title V Maternal and Child Health Services Block Grant To States Program Application/Annual Report Guidance, 8th Edition. (OMB NO: 0915-0172). Retrieved from: <https://mchb.tvisdata.hrsa.gov/uploadedfiles/TvisWebReports/Documents/blockgrantguidance.pdf>

⁴ For the purpose of this cooperative agreement, MCH systems of care coordinate and synchronize MCH safety net services to address the physical, social, emotional, mental, and cultural needs of women, children, youth, and their families.

Program Objectives

The recipient will develop a program that achieves the following objectives, indicative of program implementation and outcome:

- Program Implementation
 - By June 2022, 90 percent of the Title V programs participating in the Consortium-led LC selected to test the [MCH Oral Health Integration Capacity Inventory](#) will complete this tool to identify priority TA needs.
 - By June 2022, 90 percent of all Title V programs participating in Consortium-led LCs will select common metrics, develop a common plan for evaluating progress, and create timelines for implementing system improvements.
- Program Outcome
 - By June 2024, 75 percent of MCHB oral health SPRANS⁵ and Title V programs participating in Consortium-led LCs will report annually to the Consortium on all common metrics.
 - By June 2024, 75 percent of MCHB oral health SPRANS⁵ and Title V programs participating in Consortium-led LCs will report system improvements (among those who report annually on all common metrics).
 - By June 2024, average an annual 10 percent increase in website traffic, including (but not limited to): direct access and referral traffic linked to built-in links within social media and/or email outreach, and top referring sites that represent key-stakeholders in the field of oral health.

Additional Funding

This notice includes the opportunity to apply for additional funding to implement the *Oral Health Core Clinical Competencies (OH3C) Project*. This additional funding can be used to increase oral health competency among non-dental providers to improve oral health integration within primary care. The actual amount available will not be determined until enactment of the final FY 2021 federal appropriation. The purpose of the OH3C Project is to support implementation of oral health core clinical competencies within primary care settings as described in HRSA's 2014 report, [Integration of Oral Health and Primary Care Practice](#). The objective of this project is to utilize targeted TA to increase the adoption of oral health core clinical competencies among non-dental providers and likelihood of sustained implementation within these primary service sites.

2. Background

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

Maternal and Child Oral Health

Research has shown that pregnant women, children, and adolescents commonly experience oral health problems (i.e., tooth decay, also called dental caries and cavities, and gingivitis) that are preventable with routine oral health care, early detection, and

⁵ MCHB oral health Special Projects of Regional and National Significance (SPRANS) period of performance September 1, 2019 – August 30, 2024, the Networks for Oral Health Integration (NOHI) within the Maternal and Child Health Safety Net. <https://www.hrsa.gov/grants/find-funding/hrsa-19-053>.

age- and risk-appropriate management.⁶ Data shows 48%⁷ of children (age 3–19 years) have had persistent tooth decay in their primary or permanent teeth, with 13%⁸ experiencing active and untreated tooth decay. Parents and/or caregivers report that 12%⁹ of children (age 0–17 years) had problems with decayed teeth in the past year. Though early detection could minimize the impact of tooth decay, young children (age 2–5 years), children with no health insurance, and those from lower-income and lower-educated households have decreased likelihood of a preventive dental visit as well as specific preventive services.⁹ In addition, nearly 48% of children who had untreated caries faced non-financial barriers (i.e., dental office too far away or not open at a convenient time, another dentist did not recommend the dental care, fear of or do not like dentists, unable to take time off from work or too busy, or expect dental problems to go away).⁶

A child's oral health is closely linked with their mother's oral health and overall health. Tooth decay is an infectious disease that can be transmitted from mothers to their infants.¹⁰ Yet, fewer than half of pregnant women receive recommended preventive oral health services, such as teeth cleaning.¹¹ In addition, children whose parents report poor overall health are more likely to experience dental caries and teeth that are in poor-to-fair condition.⁹ Chronic dental caries, when left untreated, can negatively affect a child's quality of life, impair academic performance, and is associated with parental work absenteeism.^{12,13} In response, the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG) encourage their respective members to integrate preventive oral health care into their practices.^{14,15} Despite these evidence-driven recommendations, commonly reported barriers prevent access to preventive oral health services in the primary care setting (e.g., lack of clinical knowledge and skills, lack of time, inadequate reimbursement, and staff buy-in),¹⁶ which disproportionately impacts the women and children who could benefit the most.

⁶ Gupta N, Vujicic M, Yarbrough C, Harrison B. Disparities in untreated caries among children and adults in the U.S., 2011–2014. BMC Oral Health. 2018;18(1):30. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5840689/>.

⁷ Healthy People 2030 [Internet]. Oral Health Objective OH-1: Reduce the proportion of children and adolescents with lifetime tooth decay experience in their primary or permanent teeth. Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion [cited September 9, 2020]. <https://health.gov/healthypeople/objectives-and-data/browse-objectives/oral-conditions>

⁸ Healthy People 2030 [Internet]. Oral Health Objective OH-2: Reduce the proportion of children and adolescents with active and currently untreated tooth decay in their primary or permanent teeth. Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion [cited September 9, 2020]. <https://health.gov/healthypeople/objectives-and-data/browse-objectives/oral-conditions>

⁹ Lebrun-Harris LA, Canto MT, Vodicka P. Preventive oral health care use and oral health status among US children. JADA. 2019;150:246–258. DOI: doi.org/10.1016/j.adaj.2018.11.023

¹⁰ Finlayson TL, Gupta A, Ramos-Gomez FJ. Prenatal Maternal Factors, Intergenerational Transmission of Disease, and Child Oral Health Outcomes. Dent Clin North Am. 2017 Jul;61(3):483–518. DOI: doi.org/10.1016/j.cden.2017.02.001

¹¹ Centers for Disease Control and Prevention. Pregnancy Risk Assessment Monitoring System (PRAMS), 2012–2015. <https://www.cdc.gov/prams/prams-data/mch-indicators/states/pdf/2015/PRAMS-All-Sites-2012-2015-508.pdf>

¹² Fleming E, Afful J. Prevalence of total and untreated dental caries among youth: United States, 2015–2016. NCHS Data Brief, no 307. Hyattsville, MD: National Center for Health Statistics. 2018. <https://www.cdc.gov/nchs/data/databriefs/db307.pdf>

¹³ Jackson SL, Vann WF Jr, Kotch JB, Pahel BT, Lee JY. Impact of poor oral health on children's school attendance and performance. Am J Public Health. 2011;101(10):1900–1906. <https://doi.org/10.2105/AJPH.2010.200915>

¹⁴ Hagan JF, Shaw JS, Duncan PM, eds. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017 <https://brightfutures.aap.org/>

¹⁵ Oral health care during pregnancy and through the lifespan. Committee Opinion No. 569. American College of Obstetricians and Gynecologists. Obstet Gynecol 2013; 122:417–22. (Reaffirmed 2017)

¹⁶ Atchison, KA, Rozier RG, Weintraub JA. 2018. Integration of oral health and primary care: Communication, coordination, and referral. NAM Perspectives. Discussion Paper. National Academy of Medicine, Washington, DC. <https://doi.org/10.31478/201810e>

The Oral Health Safety Net

The [2000 Surgeon General's Report on Oral Health in America](#)¹⁷ stressed to the nation that oral health is essential to general health and well-being, and it must be included in the provision of health care and the design of community programs. In 2010, a sense of urgency concerning the capacity of the U.S. oral health care system to eliminate oral health disparities and ensure access to basic services led to a list of attributes that describe an ideal oral health care system, including integration with focus on prevention; cost-effective; and equitable to name a few.¹⁸ In 2016 at least 74 million Americans were found to have no form of dental coverage, thereby limiting their access to dental care.¹⁹ Research has found that earning a low-income, lacking health insurance, living in a rural area, and identifying as a racial or ethnic minority are more likely to be associated with having poor oral health.²⁰ Among our nation's children, for example, the prevalence of a preventive dental visit in the past year for children (age 2–17 years) has been found to decline with income, with only 76% of children from households <100% FPL having a preventive dental visit compared to 89% of their peers from households >400% FPL.⁹ In addition, children of non-Hispanic Black race/ethnicity are less likely to have a preventive dental visit in the past year (78%) than their non-Hispanic White peers (85%).⁹

Investment in Oral Health

[HRSA's FY 2019–2022 Strategic Plan](#) seeks to improve access to quality health services, foster a workforce able to address current and emerging needs, and achieve health equity. To achieve oral health equity, we need to: support oral health integration within the rest of the health care system; emphasize evidence-based disease prevention that demonstrates cultural humility and is cost effective; implement continuous quality assessment and assurance; and empower communities and individuals to create conditions conducive to improving overall health and oral health.^{18,20}

MCHB invests in two primary mechanisms to improve oral health equity: (1) testing innovations and building evidence around specific strategies for enhancing integration of oral health care into MCH safety net services, and (2) providing individualized TA to state and local stakeholders whose goal is to increase access to and utilization of preventive oral health care. Regarding the latter, in 2017 MCHB established the National Maternal and Child Center for Oral Health Systems Integration and Improvement (2017 COHSII), represented by three national organizations who convened to work collectively with key stakeholders to improve access to preventive oral health services within existing MCH systems of care. As the 2017 COHSII project enters into its final year, it has: (1) established a set of national MCH oral health quality indicators for assessing and monitoring oral health care delivery; (2) utilized enhanced TA to support MCHB oral health SPRANS and Title V award recipients in identifying

¹⁷ U.S. Department of Health and Human Services. Oral Health in America: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000. <https://www.nidcr.nih.gov/sites/default/files/2017-10/hck1ocv.%40www.surgeon.fullrpt.pdf>

¹⁸ Tomar SL, Cohen LK. Attributes of an ideal oral health care system. Journal of Public Health Dent 70(2010):S6–S14. <https://doi.org/10.1111/j.1752-7325.2010.00172.x>

¹⁹ Contreras OA, Stewart D, Valachovic RW. Examining America's dental safety net. Washington, DC: American Dental Education Association, 2018. <https://www.adea.org/policy/white-papers/Dental-Safety-Net.aspx>

²⁰ Northridge ME, Kumar A, Kaur R. Disparities in Access to Oral Health Care. Annual Review of Public Health. 2020;41:513–535. <https://doi.org/10.1146/annurev-publhealth-040119-094318>

best practices and other improvement processes to better integrate oral health within primary care;²¹ and (3) translated evidence into practice through the development and dissemination of reliable resources in support of preventive oral health services within MCH systems of care.

Identifying and Addressing Oral Health Gaps and Barriers – The MCH Pyramid

The 2017 COHSII identified a set of standardized indicators, through expert consensus, that are both feasible and meaningful for measuring and improving the quality of oral health care in MCH programs, with the potential to align improvement efforts within Department of Health and Human Services (HHS) agencies that serve MCH populations. The identification of this core set of indicators began with the development of a framework to support quality measurement and improvement spanning from the site of care (i.e., individual practices and clinics) to broader systems of care (e.g., a Medicaid program).²² The Framework for Oral Health Quality Performance Measurement and Improvement (The Framework, see Figure 1) takes into account the significant impact of non-clinical factors on health outcomes, including social determinants of health such as social, economic, and environmental factors, as well as health behaviors.^{23,24} The Framework encompasses key elements of the multi-tiered MCH Pyramid of Services.³ The pyramid's three categories of services that influence the MCH system of care (i.e., direct services, enabling services, public health services and systems), equate to the *Care*, *Community-Based Systems and Supports*, and *System* categories within the oral health framework, respectively. To date, the 2017 COHSII has validated a core set of 16 quality indicators (see [Appendix](#)) and recently released a user guide²⁵ to assist in the surveillance of oral health services delivered in public health programs and systems of care at the national, state, and local levels. Included in this user guide is a readiness (feasibility) assessment tool to identify a state's current data analytic capacity and what capacity building is needed to improve data collection and reporting.

The 2021 Consortium award recipient will be responsible for utilizing the Framework, adapting if needed, to develop a [MCH Oral Health Integration Capacity Inventory](#) tool that can identify gaps within a state's MCH system of care and barriers to the full integration of high-quality preventive oral health care. With this tool, a state can align capacity building needs with a plan for targeted TA, and create benchmarks for capacity improvements as they work towards a fully integrated MCH system of care.

²¹ Lorenzo S, Goodman H, Stemmler P, Holt K, Barzel R, eds. 2019. The Maternal and Child Health Bureau–Funded Perinatal and Infant Oral Health Quality Improvement (PIOHQI) Initiative 2013–2019: Final Report. Washington, DC: National Maternal and Child Oral Health Resource Center. <https://www.mchoralhealth.org/PDFs/piohqi-final-report-2019.pdf>

²² Center for Oral Health Systems Integration and Improvement Quality Indicator Advisory Team, National Maternal and Child Oral Health Resource Center, Dental Quality Alliance. 2018. Oral Health Quality Improvement for the Maternal and Child Health Population: Identifying a Set of Quality Indicators. Washington, DC https://www.mchoralhealth.org/PDFs/COHSII_QualityIndicatorsReport.pdf

²³ Artiga S, Hinton E. Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. The Kaiser Family Foundation Issue Brief. San Francisco, CA: Henry J. Kaiser Family Foundation, May 2018. <https://collections.nlm.nih.gov/catalog/.nlm.nlmuid-101740257-pdf>

²⁴ McGovern L, Miller G, Hughes-Cromwick P. 2014. The Relative Contribution of Multiple Determinants to Health Outcomes. Princeton, NJ: Robert Wood Johnson Foundation. <https://www.rwjf.org/en/library/research/2014/08/the-relative-contribution-of-multiple-determinants-to-health-out.html>

²⁵ Center for Oral Health Systems Integration and Improvement Quality Indicator Advisory Team, Dental Quality Alliance, and National Maternal and Child Oral Health Resource Center. 2020. Oral Health Quality Indicators for the Maternal and Child Health Population: User Guide and Technical Specifications. Washington, DC: National Maternal and Child Oral Health Resource Center, and Chicago, IL: Dental Quality Alliance. <https://www.mchoralhealth.org/PDFs/COHSII-user-guide.pdf>

Figure 1: Framework for Oral Health Quality Performance Measurement and Improvement

| Domain | System | Community-Based Systems and Supports | Care |
|-------------|---|--|---|
| Access | Eligibility Provider availability | Transportation | Appointment availability Provider availability |
| Utilization | Appropriate site of care Use of services | Appropriate site of care Use of services | Scope of services Appropriate site of care Use of services |
| Structure | Facilities and equipment Health information technology Leadership coordination Level of funding Policy linked with evidence Provider training Scope of benefits Transitions to adulthood | Facilitating service-delivery programs in community sites Health information technology Supportive environment in a medical-dental neighborhood based on needs | Coding Service-delivery partnerships in community sites Health information technology Leadership coordination Provider training |
| Process | Care coordination Enrollment Person- or family-centered care Population education | Care coordination Community needs assessment Enrollment (outreach) Person- or family-centered care | Care coordination Culturally competent care Enrollment (assistance) Evidence-based care Person- or family-centered care Referral |
| Outcome | Health care system experience Health literacy Health status (population) Patient-reported outcomes | Health care system experience Health literacy Health status (community) Patient-reported outcomes | Health care system experience Health literacy Health status (individual) Patient-reported outcomes |

Systems Improvement – Technical Assistance Fostering Quality Improvement

MCHB prioritizes delivering TA more effectively and efficiently. A TA service can be viewed as an ‘interpretive bridge’ or continuum to catalyze improvement,²⁶ to assist in adapting and applying new knowledge, technology, and innovative practices to improve outcomes and increase impact. In 2019, MCHB completed an internal evaluation to better understand the collective impact of its oral health investments, including identification of best practices as well as challenges faced. Regarding the latter, an evaluation of TA needs among MCHB oral health SPRANS and Title V award recipients found a need for systems-related assistance with: 1) implementing an evidence-based system of care model to better integrate oral health and primary care, 2) achieving quality improvement and performance measure data collection and analysis, and 3) informing statewide policy.

Applied to systems transformation, TA can be a dynamic, capacity-building process for designing or improving the quality, effectiveness, and efficiency of systems of care, specific programs, or individual services. Moreover, a TA service should continually

²⁶ Logan JA, Beatty M, Woliver R, Rubinstein EP, Averbach AR. Creating a bridge between data collection and program planning: a technical assistance model to maximize the use of HIV/AIDS surveillance and service utilization data for planning purposes. *AIDS Educ Prev.* 2005;17(6 Suppl B):68–78. <https://pubmed.ncbi.nlm.nih.gov/16401184/>

assess TA needs and monitor the relevance and utility of an evolving base of experience, knowledge, and technology.²⁷ Assessing readiness to integrate new knowledge or technology into practice can help prioritize the TA need as well as identify the most relevant, feasible TA solutions. Accordingly, the 2021 Consortium award recipient will be adaptive and flexible in its advancement of a targeted TA approach. Utilizing the [MCH Oral Health Integration Capacity Inventory](#) tool to guide and benchmark TA needs, the Consortium will be instrumental in identifying a collective of evidence-driven best practices (e.g., changes packages) to inform system improvements (i.e., policy change). This approach will not only target TA needs that can ensure change but will lead to a better understanding of the TA's influence on system transformations, such as:

- Health system-level improvements (e.g., performance measurement, evaluation, and quality improvement practices) that lead to more effective oral health integration.
- Policy solutions (e.g., teledentistry guidelines) through key stakeholder partnerships that increase access to preventive oral health services.
- Enhanced awareness and knowledge among MCH providers, policy makers, and other key stakeholders to advance oral health integration within primary care.

Translate Evidence to Practice – Raising Awareness, Knowledge, and Skill

A multifaceted, systems-integrated approach is needed to address oral health disparities.²⁰ In 2014, in response to the 2011 Institute of Medicine reports, *Advancing Oral Health in America*²⁸ and *Improving Access for Oral Health for the Vulnerable and Underserved*,²⁹ HRSA developed the [Integration of Oral Health and Primary Care Practice](#) initiative, which calls for increased collaboration between primary care and dental providers and increased integration of oral health care into primary care safety net settings. In response to impacts from the COVID-19 pandemic, the [National Association of Community Health Centers](#)³⁰ has called for a significant acceleration of HRSA's 2014 efforts to support inter-professional collaborations and oral health integration in primary care.

A successful execution of an integrated approach will require the translation of evidence into easily accessible resources and guidelines responsive to the existing needs at the state and local levels, which will further provide a foundation for evidence-based practice. Furthermore, engaging federal partners and key stakeholders in the field will be necessary to achieve synergy, minimize duplication, and maximize investments and resource development that can foster sustainable improvements aimed at accelerating oral health equity for MCH populations. As a national leader in oral health for MCH populations, the 2021 Consortium award recipient will serve as a central convener and promoter of new knowledge and skill, providing expert-led training and TA along with readily accessible evidence-based/informed resources for stakeholders nationwide.

²⁷ West GR, Clapp SP, Averill EM, Cates Jr W. Defining and assessing evidence for the effectiveness of technical assistance in furthering global health. *Global Public Health*. 2012;7(9), 915–930. <https://doi.org/10.1080/17441692.2012.682075>

²⁸ IOM (Institute of Medicine) and NRC (National Research Council). 2011. *Advancing Oral Health in America*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/13086>.

²⁹ IOM (Institute of Medicine) and NRC (National Research Council). 2011. *Improving access to oral health care for vulnerable and underserved populations*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/13116>

³⁰ Crandal, J. (2020, May 27). Health Center Advocacy Network Blog. *Reimagining Oral Health Care in Health Centers Beyond the COVID-19 Pandemic*. <https://blog.nachc.org/reimagining-oral-health-care-in-health-centers-beyond-the-covid-19-pandemic/>

II. Award Information

1. Type of Application and Award

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

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

HRSA program involvement will include:

- Providing the assistance of experienced HRSA personnel available as participants in the planning and development of the project.
- Providing ongoing oversight to ensure compliance with the application requirements and expectations outlined in the Purpose, Program Expectations, Project Narrative (see Sections [I.1](#), [IV.2](#), and [IV.2.ii](#)), and Reporting (see [Section VI.3](#)).
- Conducting ongoing reviews and final recommendation on all activities, procedures, measures, and tools established and implemented for accomplishing the program goals and objectives, including key personnel recruitment.
- Participating, as determined appropriate by the project officer, in conference calls, meetings, and TA sessions that are conducted during the period of the cooperative agreement.
- Assisting in the establishment and facilitation of effective collaborative relationships with federal agencies, especially bureau/division/office leads within MCHB and across HRSA, and lead organizations (i.e., award recipients) of HRSA-funded projects that may be relevant for the successful completion of tasks and activities identified in the approved scope of work.
- Providing ongoing review of the recipient's due diligence to not duplicate similar work funded by MCHB, HRSA, and other federal and non-federal agencies.
- Participating with the recipient in the dissemination of products developed, project findings, best practices, and lessons learned in response to this cooperative agreement.

The cooperative agreement recipient's responsibilities will include:

- Collaborating with the project officer for ongoing review of the recipient's management of activities, procedures, and budget items. The recipient will submit a monthly update within the first full week of each month, to include a phone/video conference call per project officer's request, summarizing accomplishments and forecasting the upcoming month's activities.
- Retaining personnel in key positions (e.g., epidemiological/biostatistical expert), with a sufficient time commitment to successfully perform the full functions of their position.
- Building and maintaining strategic collaborations with relevant programs within MCHB (i.e., MCHB oral health SPRANS and Title V award recipients), across HRSA, and with other federal, state, and national organizations, as appropriate, to address gaps in access to preventive oral health care for MCH populations.

- Responding to the project officer's comments, questions, and requests in a timely manner in order to collaborate on short-term, long-term, and ongoing activities within the approved work plan. A response to rapid-response requests may require a shorter turnaround, to be determined by the project officer on a case-by-case basis.
- Consulting with the project officer when scheduling any meetings that pertain to the scope of work and at which the project officer's attendance would be appropriate (as determined by the project officer).
- Providing the project officer with the opportunity to review and discuss any product (i.e., publications, audiovisuals, other materials, etc.) produced under the auspices of this cooperative agreement, including consultation with the project officer at the time of concept development of materials and including review of drafts and final products.
- Ensuring all products and materials developed or produced, in response to this cooperative agreement partially or in full, are fully accessible and available free to the public. The project officer will receive an electronic copy of, or electronic access to, each product/material developed before dissemination.
- Adhering to HRSA guidelines pertaining to acknowledgement and disclaimer on all products produced, in part or in full, by HRSA award funds in accordance with the [FY 2018 Consolidated Appropriations Act \(Public Law 115-141\)](#), including the website that serves as a central repository for said products.
- Manuscripts with or without MCHB personnel listed as co-author will also include the acknowledgement and disclaimer information required on all products supported by HRSA award funds.
- Collecting and reporting data annually in response to the Program Goal and Objectives (see Purpose, [Section I.1](#)). Baseline data will be reported at the conclusion of the first year of the period of performance.

2. Summary of Funding

HRSA estimates approximately \$1,075,000 to be available annually to fund one National Maternal and Child Health Consortium for Oral Health Systems Integration and Improvement award recipient. In addition, up to \$250,000 is expected to be available annually to fund the *Oral Health Care Clinical Competencies (OH3C) Project*. The actual amount available will not be determined until enactment of the final FY 2021 federal appropriation. You may apply for a ceiling amount of up to \$1,325,000 total cost (including both direct and indirect, facilities and administrative costs) per year for the Consortium and OH3C Project.

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 July 1, 2021 through June 30, 2024 (3 years). Funding beyond the first year is subject to the availability of appropriated funds for the Consortium and the OH3C Project in subsequent fiscal years, satisfactory recipient performance, and a decision that continued funding is in the best interest of the Federal Government.

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

III. Eligibility Information

1. Eligible Applicants

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

2. Cost Sharing/Matching

Cost sharing/matching is not required for this program.

3. Other

HRSA will consider any application that exceeds the ceiling amount **non-responsive** and will not consider it for funding under this notice.

HRSA will consider any application that fails to satisfy the deadline requirements referenced in [Section IV.4](#) **non-responsive** and will not consider it for funding under this notice.

NOTE: Multiple applications from an organization are **not allowable**.

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

IV. Application and Submission Information

1. Address to Request Application Package

HRSA **requires** you to apply electronically. HRSA encourages you to apply through [Grants.gov](#) using the SF-424 workspace application package associated with this notice of funding opportunity (NOFO) following the directions provided at <http://www.grants.gov/applicants/apply-for-grants.html>.

The NOFO is also known as “Instructions” on Grants.gov. You must select “Subscribe” and provide your email address for each NOFO you are reviewing or preparing in the workspace application package 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

Section 4 of HRSA's [SF-424 Application Guide](#) provides instructions for the budget, budget narrative, staffing plan and personnel requirements, assurances, certifications, and abstract. You must submit the information outlined in the Application Guide in addition to the program-specific information below. You are responsible for reading and complying with the instructions included in HRSA's [SF-424 Application Guide](#) except where instructed in the NOFO to do otherwise. You must submit the application in the English language and in the terms of U.S. dollars (45 CFR § 75.111(a)).

See Section 8.5 of the [Application Guide](#) for the Application Completeness Checklist.

Application Page Limit

The total size of all uploaded files included in the page limit may not exceed the equivalent of **75 pages** when printed by HRSA. The page limit includes the abstract, project and budget narratives, attachments, and letters of commitment and support required in the *Application Guide* and this NOFO.

Standard Office of Management and Budget (OMB)-approved forms that are included in the workspace application package do not count in the page limit. Please note: If you use an OMB-approved form that is not included in the workspace application package for HRSA-21-037, 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.**

Applications must be complete, within the specified page limit, and validated by Grants.gov under the correct funding opportunity number prior to 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. § 3321).
- 3) Where you are unable to attest to the statements in this certification, an explanation shall be included as [Attachments 9–15: Other Relevant Documents](#).

See Section 4.1 viii of HRSA's [SF-424 Application Guide](#) for additional information on all certifications.

Program Expectations

The Consortium's key personnel is encouraged to demonstrate expertise in, but not limited to, health systems integration, payment and data systems, data analysis and interpretation, state practice acts, MCH public policy, and provider/consumer education.

Consortium Management Team

A Consortium Management Team is encouraged to oversee the full implementation of this project. It is recommended the recipient select a team, representing consortium partners with different areas of expertise, who will:

1. Develop a unified approach to provide program oversight, management, strategic planning, and evaluation.
2. Consult with, or identify within the management team, key stakeholders who represent diverse, underserved, and/or underrepresented populations.

The Consortium Management Team is encouraged to have a program structure composed of separate bodies that come together as need, to provide oversight of the three core functions and counsel from a national perspective. To do this work, oversight committees to guide implementation of the three core functions can be considered, such as: Systems Improvement Oversight Committee (to oversee core functions 1 and 2), MCH Oral Health Data Analytics Oversight Committee (core function 2), and Knowledge Management Oversight Committee (core function 3).

To provide counsel from a national perspective, the Consortium Management Team is encouraged to convene and lead a national advisory collective made up of key federal and non-federal partners (approved by the project officer). To do this work, the following is offered for consideration:

- 1) Select members who are key to a collective impact approach to improve access to and delivery of preventive oral health care to MCH populations, such as:
 - a. Federal partners: Centers for Medicare and Medicaid Services, Centers for Disease Control and Prevention, Indian Health Service, Office of Head Start, Office of Minority Health, National Institute of Dental and Craniofacial Research
 - b. National and professional organizations: AAP, ACOG, AMCHP, American Academy of Pediatric Dentistry, American Dental Association, American Network of Oral Health Coalitions, Association of State and Territorial Dental Directors, Association of State and Territorial Health Officials, Medicaid-CHIP State Dental Association, National Association of Medicaid Directors, National Conference of State Legislatures, National Governors Association, and National Network for Oral Health Access
 - c. Policy Centers: National Academy for State Health Policy, Northwest Center to Reduce Oral Health Disparities, Oral Health Workforce Research Center, University of California San Francisco Center to Address Disparities in Oral Health, University of Colorado at Denver Center for Native Oral Health Research
 - d. Foundations: DentaQuest Partnership for Oral Health Advancement, Grantmakers in Health, National Interprofessional Initiative on Oral Health,
- 2) Annually gather council members whose collective aim is to magnify a coordinated effort in addressing systematic barriers that perpetuate oral health

disparities, restricting access to and utilization of high-quality preventive oral health care for MCH populations.

Three Core Functions

Successful applications will develop a plan for executing strategies to achieve the three core functions as categorized here:

- 1) Identify Gaps and Barriers – Encompass key elements of the MCH Pyramid of Services to identify gaps and barriers within systems of care that prevent optimal delivery of preventive oral health care that serve MCH populations.
- 2) Improve MCH Systems of Care – Foster improvements within MCH systems of care that overcome identified gaps and barriers to optimize delivery of preventive oral health care and reduce oral health disparities among MCH populations by better integrating oral health and primary care.
- 3) Translate Evidence into Practice – Raise awareness and knowledge through the dissemination of new and reliable resources and guidance that serve to reduce oral health disparities among the MCH populations.

Core Function 1 – Identify Gaps and Barriers

Effective oversight of core function 1 will be instrumental in identifying a MCH Oral Health Integration Capacity Inventory tool to assist MCH Safety Net service sites and state Title V programs in their efforts to make high-quality, integrated preventive oral health care more accessible. You are strongly encouraged to apply the existing Framework (see Background, [Section I.2.](#)) to the development of this instrument and consider the following activities to accomplish core function 1:

- 1) Conduct a literature search that highlights gaps in systems of care processes that deter preventive oral health care integration within MCH systems of care.
- 2) Modify the Framework, as needed, to specify elements that can and should be measured and monitored to ensure a systematic process for oral health integration. The Consortium should also consider other conceptual models for closing gaps in health care disparities.²⁰
- 3) Utilize a LC approach, see NPM13 LC as described in core function 2, to validate the MCH Oral Health Integration Capacity Inventory tool. Validation is expected to be completed by the end of Year 1 of the period of performance (see Program Objectives, [Section I.1](#)).

Core Function 2 – Improve MCH Systems of Care

Effective oversight of core function 2 will be instrumental in delivering a two-tiered TA approach: (1) targeted TA utilizing LCs, during which group and peer-to-peer learning is facilitated; and (2) general assistance and education opportunities that can serve LC participants as well as a broader audience. The Consortium lead will advance excellence in TA in support of preventive oral health care delivery, with an emphasis on MCH safety net services. To do this work, the Consortium members should have expertise and demonstrable knowledge in providing TA to improve the delivery of integrated preventive oral health care, strategies to maximize reimbursement, and state practice guidance and public policy innovations.

Targeted Technical Assistance

You will implement targeted TA, using a LC approach to increase knowledge and skill among MCHB oral health SPRANS and participating Title V award recipients (the LC

participants). The targeted TA will be intentional in its efforts to foster improvements within MCH systems of care, providing ongoing assistance designed to reach the outcomes desired throughout the LC participants' planned stages of change that relate (but not limited) to systems integration, data analysis and interpretation, policy change, and/or community outreach. At times, you may find the LC participants will experience a singular, unique TA need (e.g., electronic health record improvement) that is outside the scope of the Consortium's content expertise. In such cases, you should seek assistance from experts in the field and you are strongly encouraged to first consider other HRSA-funded TA efforts, if suitable, such as HRSA's Bureau of Primary Health Care funded [National Training and Technical Assistance Partners](#), including the [Health Information and Technology, Evaluation and Quality Center](#) and the [National Network for Oral Health Access](#).

Your work plan for delivering targeted TA is strongly encouraged to include implementation of up to three LCs:

- 1) NOHI LC - One LC will continue, with minimal disruption, the collaboration among the three MCHB-funded Networks for Oral Health Integration within the Maternal and Child Health Safety Net (NOHI) projects.³¹
- 2) NPM13 LC - One LC, targeting Title V programs who selected the Title V oral health national performance measure (NPM13)³² or a state oral health performance measure, will validate and implement the MCH Oral Health Integration Capacity Inventory tool to best determine TA needs and the course for targeted technical assistance in support of system improvements. A timeline for implementation and plan for evaluating progress will be completed by end of Year 1 (see Program Objectives, [Section I.1](#)).
 - a. It is recommended that a minimum of five participating Title V programs participate in the NPM13 LC to identify common strategy in their approach to addressing the oral health national performance measure.
 - b. Utilization of the Oral Health Quality Indicators for the Maternal and Child Health Population (see [Appendix](#)) is encouraged to be included in the capacity assessment for systems change. Oversight should include epidemiological/biostatistical expertise with a sufficient time commitment to successfully perform this responsibility.
- 3) OH3C LC – One LC, targeting Title V programs who selected the Title V NPM13 or a state oral health performance measure will model oral health core clinical competencies (OH3C) within primary care practices as described in HRSA's 2014 report, [Integration of Oral Health and Primary Care Practice](#).
 - a. It is recommended that a minimum of five Title V programs participate in the OH3C LC to identify common strategy in their approach to implement oral health core clinical competencies within primary care practices.
 - b. You will submit a separate Work Plan, Budget, and Budget Justification for the implementation of the OH3C LC ([Attachment 8](#)).
 - c. As instructed in the Summary of Funding ([Section II.2.](#)), this activity is subject to the appropriation of funds. The inclusion of the OH3C LC is a contingency action taken to ensure that, should funds become available for this purpose,

³¹ Center for Oral Health Systems Integration and Improvement. Networks for Oral Health Integration within the Maternal and Child Health (MCH) Safety Net Collaboration. Period of performance 2017–2021. <https://www.mchoralhealth.org/projects/nohi.php>

³² Utilization of preventive oral health care is the focus of Title V National Performance Measure (NPM) 13; NPM 13.1 (Percent of women who had a preventive dental visit during pregnancy) and NPM 13.2 (Percent of children, age 1 - 17, who had a preventive dental visit in the past year). <https://mchb.wisdata.hrsa.gov/PrioritiesAndMeasures/NationalPerformanceMeasures>

HRSA can process your submission and award funds appropriately. Detailed instructions are provided in the description for [Attachment 8](#).

Your work plan for delivering targeted TA is strongly encouraged to include a LC approach that:

- 1) Continues the NOHI LC. Stipulations made for the NOHI projects to participate in the LC can be found in the NOHI NOFO.⁵
- 2) Recruits and on boards Title V programs to participate in the two Title V participating LCs as described above (NPM13 LC and OH3C LC, respectively). A fourth LC is optional given interest in the field and approval by the project officer.
- 3) Utilizes expert-led problem solving in the implementation of LC activities, such as:
 - a. A mechanism to request individual TA and track the type of individual assistance provided.
 - b. Monthly web-based LC learning sessions.
 - c. One annual multi-day LC forum (either virtual or in-person). A plan to transition the multi-day forum from in-person to virtual if unable to have an in-person gathering.
 - d. Online, password-protected portal for collection of data and sharing of project activities in a trusted space.
 - e. LC-designated email list for peer-to-peer sharing and updates from Consortium partners and/or MCHB updates that may influence the project.
- 4) Guides LC participants in the identification of common metrics, data source(s), and a collaborative implementation plan to evaluate individual project progress.
- 5) Provides expert-led guidance in data collection, analysis, and interpretation (i.e., telling compelling stories of LC participants' successes and lessons learned to effectively connect with and influence stakeholders).
- 6) Self-assesses targeted TA and LC approach to identify and implement ongoing improvements. Self-assessment and analysis will demonstrate the impact of the targeted TA approach.
- 7) Ensures efforts to address pregnant women and children's preventive oral health care align with current guidance in the field, including the AAP's Bright Futures Guidelines, 4th Edition;¹⁴ the Bright Futures Periodicity Schedule;³³ and the ACOG's committee opinion, Oral Health Care During Pregnancy and Through the Lifespan;¹⁵ Oral Health Care During Pregnancy: A National Consensus Statement.³⁴
- 8) Utilizes and/or develops reliable training and education materials to facilitate LC participation and to support others who seek to replicate and/or learn from the LC achievements.

³³ American Academy of Pediatrics. Recommendations for Preventive Pediatric Health Care: Periodicity Schedule for Preventive Care. https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

³⁴ Oral Health Care During Pregnancy Expert Workgroup. 2012. Oral Health Care During Pregnancy: A National Consensus Statement. Washington, DC: National Maternal and Child Oral Health Resource Center. <https://www.mchoralhealth.org/PDFs/OralHealthPregnancyConsensus.pdf>

General Assistance and Education

To accomplish core function 2, you are strongly encouraged to also provide general assistance and education services that permit LC participants and a broader audience (i.e., Title V program staff, state dental directors, dental and non-dental health care providers, policy makers) access to up-to-date, emerging, and seminal information to gain new knowledge for professional and/or organizational development. The recipient will be positioned to implement general assistance and education to the broader audience upon receipt of the Consortium award. Your plan for general assistance and education activities is strongly encouraged to include:

1. Knowledge sharing through a variety of outreach events.
2. Outreach and information sharing to expand knowledge of the Oral Health Quality Indicators for the Maternal and Child Health Population (see [Appendix](#)). Oversight should include epidemiological/biostatistical expertise with a sufficient time commitment to successfully perform this responsibility, including outreach events and/or more guided discussions using town halls or focus groups.
3. Self-assessment of the general assistance and education activities to identify and implement ongoing improvements in efforts to expand knowledge of the broader audience.

Core Function 3 – Translate Evidence into Practice

Oversight of core function 3 will be instrumental in development, compilation, and dissemination of new and reliable tools and education materials to inform professional and organizational development in their efforts to increase access to high-quality preventive oral health care for MCH populations. The Consortium recipient should be positioned to implement core function 3 upon receipt of the award. To do this work, you are strongly encouraged to:

- 1) Recruit and onboard workgroups consisting of a broad range of content experts to update and reaffirm materials, as well as review and synthesize new evidence, including emerging topics, for new resource development. For the development of consumer materials, the workgroup is encouraged to include parent/caregiver representation.
- 2) Increase and/or broaden the use of reliable resources and dissemination pathways with input and consensus among partner organizations and input from the field. The recipient is encouraged to collaborate with MCHB-funded organizations and projects, such as the AAP's Bright Futures Guidelines, AMCHP, Strengthen the Evidence Base for Maternal and Child Health Programs, and the National MCH Workforce Development Center.

Easy access to these materials is necessary to succeed in raising awareness and knowledge. The successful Consortium recipient should have a publicly-accessible website at the onset of the period of performance that at a minimum:

- 1) Makes accessible educational resources and other technical assistance materials that are reliable and meet the educational needs in the field.
- 2) Houses consumer education materials to aid in community outreach, highlighting credible materials produced by the Consortium, or other federal agencies or non-federal professional organizations, to fill a void for reliable information, accommodating multiple languages and low literacy levels.
- 3) Provides LC participants an online, password-protected portal for peer sharing and discussion in a trusted space.

- 4) Features access to topic-specific updates (e.g., email lists), implementing proper management to ensure effective communication with and among recipients.
- 5) Displays social media sites used for information dissemination, to include HRSA messaging as appropriate.
- 6) Measures how well it targets its audience, including where the visitor originated from (e.g., direct access or built-in referral link, Program Objectives, [Section I.1](#)).

Program-Specific Instructions

Important Note:

Internal planning for the implementation of an oral health competency-improvement project to improve oral health integration within primary care settings must remain consistent with a budget of \$250,000 and you should not include the costs of the OH3C Project in the overall budget request for the Consortium. Your proposed Consortium budget must not exceed \$1,075,000 per year. The additional funding for the OH3C Project will not be finalized until post-award, pending availability of funds. Please see further instruction under Budget ([Section IV.2.iii](#)). Detailed instructions for the submission of an OH3C Project Work Plan, Budget, and Budget Justification can be found in the description for [Attachment 8](#).

In addition to application requirements and instructions in Section 4 of HRSA's [SF-424 Application Guide](#) (including the budget, budget narrative, staffing plan and personnel requirements, assurances, certifications, and abstract), include the following:

i. Project Abstract

See Section 4.1.ix of HRSA's [SF-424 Application Guide](#).

ii. Project Narrative

This section provides a comprehensive framework and description of all aspects of the proposed project. It should be succinct, self-explanatory, consistent with forms and attachments, and well-organized so that reviewers can understand the proposed project. Supporting documents not described below can be included as [Attachments 9–15: Other Relevant Documents](#). All attachments are included in the page count (see [Application Page Limit](#)).

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

- **INTRODUCTION** -- Corresponds to Section V's Review Criteria (1) [Need](#) and (5) [Resources and Capabilities](#)

Briefly describe the purpose of the proposed project, demonstrating a clear understanding of the aims, expectations, and timeline of the project. This section must:

- Describe the challenges within state and local systems of care that staff and/or programs face to effect change that improves access to and utilization of preventive oral health care among MCH populations.
- Briefly describe how you will provide leadership and resources to improve MCHB oral health SPRANS and Title V award recipients' capacity to accomplish the goals of their program.

- Demonstrate an understanding and use of promising practices in targeted TA and general assistance to increase knowledge and effect change among health professionals, program administrators, educators, and others working in or with MCH programs.
- **NEEDS ASSESSMENT** -- *Corresponds to Section V's Review Criterion (1) [Need](#).*
This section will help reviewers understand the need for targeted TA for MCHB award recipients and general assistance and education for a broader audience, including the purpose/need for readiness/capacity assessment tools and publicly accessible assistance and educational materials geared towards the oral health of MCH populations. This section must clearly:
 - Describe the state of oral health among the MCH populations and demonstrate an understanding of the gaps within the current MCH systems of care, to include oral health care access issues such as payment, policies, and quality standards.
 - When possible, use and cite demographic data to support the information provided.
 - Demonstrate an understanding of the needs of the MCHB oral health SPRANS and Title V award recipients to achieve project goals and objectives and the broader challenges to effect change within the MCH systems of care at the local and state level.
 - Describe the dynamics of common messaging from a national perspective.

The needs assessment findings must inform the project activities; therefore, describe how you will apply these findings in the development and implementation of your proposed plan.

- **METHODOLOGY** -- *Corresponds to Section V's Review Criteria (2) [Response](#), (3) [Evaluative Measures](#), and (4) [Impact](#).*
In this section, propose methodology that is organized and reasonable in its approach to accomplish the three core functions introduced in the Purpose (see [Section I.1](#)) and all activities anticipated in Program Expectations (see [Section IV.2](#)). The proposed methodology must clearly identify:
 - Project goals and objectives that respond to the stated need of the project and include or clearly reflect the program goals and objectives as stated in the NOFO Purpose (see [Section I.1](#)).
 - Objectives that are specific, measurable, achievable, relevant, and time-oriented (SMART).
 - A plan for oversight that outlines a unified approach that demonstrates capacity to strategically plan and manage the project to achieve the goals and objectives, clearly linking to its evaluation for informing program development and TA delivery.
 - A sound, thoughtful overall approach to the project, including problems anticipated and the steps taken to counter them.
 - A plan to disseminate reports, products, and/or project outputs so key target audiences receive the project information in a timely manner.

In addition, the plan must demonstrate that you have the knowledge and skill to complete the project:

- Identifying effective tools and strategies for ongoing staff outreach, collaborations, clear communication, and information sharing and dissemination with efforts to involve professionals and, as appropriate, consumers from diverse and underserved/underrepresented populations.
- Include a description of any innovative methods that you will use to address the stated needs.

Applications should not duplicate existing activities. Funds for this project are not to be used to supplant current organizational activities.

▪ **WORK PLAN -- Corresponds to Section V's Review Criteria (2) [Response](#) and (4) [Impact](#)**

In this section, describe all activities or steps that you will use to achieve goals and objectives throughout the proposed project's entire period of performance and as addressed in the Methodology section.

- As appropriate, identify meaningful support and collaboration with key stakeholders in planning, designing, and implementing all activities, including developing the application.
- Submit, as [Attachment 1](#), a work plan that includes all Consortium activities detailed in this narrative section, identifying the timeline and responsible staff in table format. You are encouraged to include a separate bar-style chart (e.g., Gantt chart) that more easily visualizes the milestones of the planned performance.
- Submit, as [Attachment 8](#), a work plan, budget, and budget justification for the OH3C Project.

Logic Model

Submit, as [Attachment 2](#), a logic model for designing and managing the Consortium.

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:

<http://www.acf.hhs.gov/sites/default/files/fysb/prep-logic-model-ts.pdf>.

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

In this section:

- Discuss the unique challenges that you are likely to encounter in designing and implementing the activities described in your proposed work plan, and approaches that you will use to resolve such challenges.
- Cite specific examples of your experience in resolving similar challenges, when possible.

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

In this section, the proposed performance evaluation should (1) monitor ongoing processes and (2) measure the progress towards the goals and objectives of the Consortium. The Consortium's performance evaluation should align with the proposed logic model. For the Consortium, describe the following:

- Inputs (e.g., organizational profile, collaborative partners, key personnel, budget, and other resources), key processes, and expected outcomes of the funded activities.
- Data collection strategy to collect, analyze, and track data to measure processes and outcomes, and explain how the data will be used to inform program development and TA delivery.
- Systems and processes that will support your 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.
- Potential obstacles for implementing the program performance evaluation and your plan to address those obstacles.

Emphasis should be on experience related to data collection and analysis. The performance evaluation plan should describe how project personnel are qualified by training and experience to provide quality technical support for performing data collection, analysis, and interpretation.

▪ **ORGANIZATIONAL INFORMATION** -- *Corresponds to Section V's Review Criterion (5) [Resources/Capabilities](#)*

In this section, demonstrate the lead organization and all selected staff, including partner organizations, will be capable to initiate the project plan on day 1 of the period of performance.

- Describe your organization's capacity, understanding, and expertise to provide oversight and management of the project as described in this NOFO.

- Demonstrate, as lead organization, how, you have managed similar projects, properly accounted for the federal funds, and documented all costs to avoid audit findings.
- Succinctly describe each organization selected to participate as a Consortium partner, including each organization's current mission, structure, and scope of current activities, and how these elements all collectively contribute to the lead organization's ability to implement the program requirements and meet program expectations.
- Describe the structure of the Consortium and include a Consortium Organizational Chart as [Attachment 3](#), to include consultants if applicable. The organizational chart should address all three core functions, identifying placement of the separate bodies within the Consortium structure that are encouraged for Consortium oversight and national counsel (see Program Expectations, [Section IV.2](#)).
- Demonstrate how key project personnel, representing Consortium partners, will fulfill the needs and requirements of the proposed project. Include a staffing plan and job descriptions as [Attachment 4](#). The plan should list key personnel titles (e.g., program director, Consortium partner leads, oversight committee leads, communication specialist, data coordinator, biostatistical expert), the number of full-time equivalent (FTE) employees fulfilling the roles, and responsibilities of each position. In addition, include in table format the members selected to participate in the Consortium Management Team as well as the oversight committees; include name, organization, and expertise each member brings to their assignment.
- Include biographical sketches of key (lead) personnel and signed letters of commitment as [Attachment 5](#). Signed letters of commitment should indicate partner organization readiness on day 1 of the period of performance.
- Include, as [Attachment 6](#), Letters of Agreement, Memoranda of Understanding, and/or Description(s) of Proposed/Existing Contracts (project-specific) 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.
- Provide information on your ability, capacity, and past experience with respect to fostering partnerships between various professional organizations where information is shared, dialogue and debate encouraged, and decisions made.
- Include a list of federal and non-federal organizations that you propose as participants of a national advisory collective, with a brief explanation for their selection as [Attachment 7](#).

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 the 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.

OH3C Project: The total costs (inclusive of direct and indirect costs) incurred to carry out the OH3C Project will be included with your OH3C Project Budget and Budget Justification (see [Attachment 8](#)). This cost is **NOT** to be included in the total costs (inclusive of direct and indirect costs) that will support the Consortium.

The Further Consolidated Appropriations Act, 2020 (P.L. 116-94), Division A, § 202 states, “None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II.” See Section 4.1.iv Budget – Salary Limitation of HRSA’s [SF-424 Application Guide](#) for additional information. Note that these or other salary limitations may apply in the following fiscal years, as required by law.

iv. Budget Narrative

See Section 4.1.v. of HRSA’s [SF-424 Application Guide](#).

Reminder: Applications must include a budget narrative for all 3 years of the project period of performance (July 1, 2021 through June 30, 2024). The narrative for Years 2–3 should only include information that changes from the Year 1 budget narrative.

In addition, the ***National Maternal and Child Health Consortium for Oral Health Systems Integration and Improvement*** cooperative agreement expects the following:

- Identify a project director and/or project manager, permanent staff of your organization, who will devote no less than 1.0 FTE to the project, who will (together) have administrative and programmatic direction over funded activities. Clear and convincing justification must be included with any less than 1.0 FTE providing administrative and programmatic oversight of this project.
- Identify staff with qualified epidemiological/biostatistical expertise and include clear and convincing justification for time allotted to this project.
- Budget for funding to host an annual in-person, multi-day learning forum, and include a plan (to be approved by the project officer) for the re-direction of funds should an in-person gathering not be possible.
- If you will make subawards or expend funds on contracts, describe how your organization will ensure proper documentation of funds.

NARRATIVE GUIDANCE

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

Narrative Section

Review Criteria

| | |
|---|--|
| Introduction | (1) Need and (5) Resource/Capabilities |
| Needs Assessment | (1) Need |
| Methodology | (2) Response, (3) Evaluative Measures, and (4) Impact |
| Work Plan | (2) Response and (4) Impact |
| Resolution of Challenges | (2) Response |
| Evaluation and Technical Support Capacity | (3) Evaluative Measures and (5) Resources/Capabilities |
| Organizational Information | (5) Resources/Capabilities |
| Budget and Budget Narrative | (6) Support Requested |

v. Program-Specific Forms

Program-specific forms are **not** required for application.

vi. Attachments

Provide the following items in the order specified below to complete the content of the application. **Unless otherwise noted, attachments count toward the application page limit.** Indirect cost rate agreements and proof of non-profit status (if applicable) will not count toward the page limit. **Clearly label each attachment.**

Attachment 1: Work Plan

Attach the work plan for the project that includes all information detailed in [Section IV.2.ii. Project Narrative](#). If you will make subawards or expend funds on contracts, describe how your organization will ensure proper documentation of funds as detailed in [Section IV.2.iv. Budget Narrative](#).

Attachment 2: Logic Model

Attach the logic model for the project that includes all information detailed in [Section IV.2.ii. Project Narrative](#).

Attachment 3: Consortium Organization Chart and Consortium Management Team

Provide a one-page figure that depicts the organizational structure of the project, identifying the collaborative partnership between partner organizations as detailed in [Section IV.2.ii. Project Narrative](#). Include contract organizations if applicable. The organizational chart should address all three core functions, identifying placement for oversight and national perspective within the Consortium structure.

Attachment 4: 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 key 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. Include, in table format, members selected to participate in the

management and oversight, including member name, their organization, and expertise each member brings to their assignment.

Attachment 5: Key Personnel Biographical Sketches and Letters of Commitment

Include biographical sketches for persons occupying the key positions described in *Attachment 4*, not to exceed one page in length per person. Include letters of commitment from all key personnel, including staff yet to be hired.

Attachment 6: 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 7: National Advisory Collective

Provide a list of federal and non-federal organizations that you propose as participants to provide counsel for a national perspective in the preventive oral health care for MCH populations, with a brief explanation for their selection.

Attachment 8: The Oral Health Core Clinical Competencies (OH3C) Project Work Plan, Budget, and Budget Justification

This attachment is required to receive the OH3C Project funding. The OH3C Project Work Plan, Budget, and Budget Justification should be no longer than 5 pages, which **WILL** count against the 75-page limit of the National Maternal and Child Health Consortium for Oral Health Systems Integration and Improvement application.

The OH3C Project will fund targeted TA, to include a LC approach, to implement oral health core clinical competencies within primary care practices as described in HRSA's 2014 report, *Integration of Oral Health and Primary Care Practice*, should these funds become available and identified for such activity within the FY 2021 Appropriations bill (see Purpose, [Section I.1](#)).

The OH3C Project Work Plan, Budget, and Budget Justification narrative should include (at a minimum):

- **Introduction** — Provide a brief description of the purpose of the proposed OH3C Project.
- **Goal** — Identify a clear and convincing goal that addresses the intent of this additional funding.
- **Objectives** – Identify clear and measurable objectives to achieve the intent of this additional funding.
- **Activities** – Describe clear and succinct activities that will convincingly achieve the objectives, to include:
 - Title V MCH program selection process
 - Project administration and outreach
 - Targeted TA implementation

- **Evaluation** — Include an evaluation plan that addresses the project's performance through measurement of (1) organizational capacity and (2) implementation strategies to accomplish change.
- **Timeline** – Include a timeline, in table format, that will identify key activities and target dates for achievement, which will be used to monitor and assess progress in achieving project outcomes.
- **Budget and Budget Justification** — Include a line item budget, in table format, and budget justification for the proposed OH3C Project. The line item budget should include all categories, as appropriate, found in the SF-424A Budget Information – Non-Construction Programs form. You may request up to \$250,000 per year, inclusive of indirect costs, for your proposed OH3C Project. The total cost of the OH3C Project (direct and indirect costs) **SHOULD NOT** be included in the total cost of the Consortium.

Attachments 9–15: Other Relevant Documents

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

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. At a future, to-be-determined date, 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 pages: [Planned UEI Updates in Grant Application Forms](#) and [General Service Administration's UEI Update](#).

You must also 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 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)).

If you are chosen as a recipient, HRSA would not make an award until you have complied with all applicable DUNS (or UEI) and SAM requirements and, 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 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 (<http://www.dnb.com/duns-number.html>)
- System for Award Management (SAM) (<https://www.sam.gov>)
- Grants.gov (<http://www.grants.gov/>)

For further details, see Section 3.1 of HRSA's [SF-424 Application Guide](#).

[SAM.GOV](#) ALERT: For your SAM.gov registration, you must submit a [notarized letter](#) appointing the authorized Entity Administrator. The review process changed for the Federal Assistance community on June 11, 2018.

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 federal-wide. Effective January 1, 2020, the forms themselves are no longer part of HRSA's application packages and 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 located at [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 *February 17, 2021 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 National Maternal and Child Health Consortium for Oral Health Systems Integration and Improvement is not a program subject to the provisions of Executive Order 12372, as implemented by 45 CFR part 100.

See Section 4.1 ii of HRSA's [SF-424 Application Guide](#) for additional information.

6. Funding Restrictions

You may request funding for a period of performance of up to 3 years, at no more than \$1,325,000 per year, to include no more than \$1,075,000 per year for the Consortium (inclusive of direct **and** indirect costs) **and** no more than \$250,000 for the OH3C Project

(inclusive of direct **and** indirect costs). This program notice is subject to the appropriation of funds, and is a contingency action taken to ensure that, should funds become available for this purpose, HRSA can process applications and award funds appropriately. Awards to support projects beyond the first budget year will be contingent upon Congressional appropriation, satisfactory progress in meeting the project's objectives, and a determination that continued funding would be in the best interest of the Federal Government.

The General Provisions in Division A of the Further Consolidated Appropriations Act, 2020 (P.L. 116-94) and Continuing Appropriations Act, 2021 and Other Extensions Act (P.L. 116-159) are in effect at the time this NOFO is posted. Please see Section 4.1 of HRSA's [SF-424 Application Guide](#) for additional information. Awards will be made subsequent to enactment of the FY 2021 appropriation. The NOA will reference the FY 2021 appropriation act and any restrictions that may apply. Note that these or other restrictions will apply as required by law in subsequent appropriations acts for FY 2021.

You are required to have the necessary policies, procedures, and financial controls in place to ensure that your organization complies with all legal requirements and restrictions applicable to the receipt of federal funding including statutory restrictions on use of funds for lobbying, executive salaries, gun control, abortion, etc. Like those for all other applicable grants requirements, the effectiveness of these policies, procedures, and controls is subject to audit.

All program income generated as a result of awarded funds must be used for approved project-related activities. The program income alternative applied to the award(s) under the program will be the addition/additive alternative. You can find post-award requirements for program income at [45 CFR § 75.307](#).

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. Your proposal in its entirety, in response to both the Consortium and OH3C Project funding opportunities, will be considered during the objective review.

Review criteria are used to review and rank applications. The National Maternal and Child Health Consortium for Oral Health Systems Integration and Improvement cooperative agreement has six review criteria. See the review criteria outlined below with specific detail and scoring points.

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

The extent to which the application demonstrates an expert understanding of the problem and contributing factors associated with the problem.

- The extent to which the applicant describes challenges within state and local systems of care that staff and/or programs face to effect change that improves access to and utilization of preventive oral health care among MCH populations, including capacity among MCHB oral health SPRANS and Title V award recipients to accomplish system transformation and measure its performance. (5 points)
- The extent to which the applicant demonstrates expertise in targeted TA and resource development to increase knowledge and effect change among health professionals, program administrators, educators, and others working in or with MCH programs. (5 points)

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

The extent to which the proposed project responds to this NOFO's requirements and expectations outlined in the Purpose, Program Expectation, and Project Narrative (see Sections [I.1](#), [IV.2](#), and [IV.2.ii](#)). The strength of the proposed goals and objectives and their relationship to the identified project and the extent to which the activities described in the application are capable of addressing the problem and attaining the Program Goals and Objectives (see Section [I.1](#)), as follows:

Methodology (15 points)

- The extent to which the proposed plan clearly demonstrates the TA and resource support intended to increase sustainable access to and utilization of high-quality, integrated preventive oral health services within MCH systems of care, including detailed activities to execute the three core functions as anticipated (10 points):
 - Identify Gaps and Barriers
 - Improve MCH Systems of Care

- Translate Evidence into Practice
- The extent to which the methodology strongly supports achievable goals and objectives for both the Consortium and OH3C Project. (5 points)

Work Plan (10 points)

- The extent to which the proposed plan comprehensively describes a process for implementation of the Consortium and OH3C Project ([Attachment 1](#) and [Attachment 8](#), respectively). (5 points)
- The extent to which these work plans clearly align with the methodology and includes adequate time and staff support to accomplish the project tasks and activities. (5 points)

Resolution of Challenges (5 points)

- The extent to which the application discusses challenges that might be encountered in designing and implementing the activities described in the work plan, and describes approaches that will be used to resolve such challenges in a timely manner.

Criterion 3: EVALUATIVE MEASURES (15 points) – Corresponds to Section IV’s [Methodology](#) and [Evaluation and Technical Support Capacity](#)

The strength and effectiveness of the method proposed to track performance outcomes and evaluate the Consortium and OH3C Project results. The extent to which:

- Qualified personnel has adequate data management skill and accessible resources (e.g., software) to provide quality technical support for performing data collection and analysis with time allotted to the task of evaluation that allows accurate and timely reporting of performance outcomes. (5 points)
- The evaluative measures will be able to assess: 1) to what extent the Consortium and OH3C Project goals and objectives have been met, and 2) to what extent these achievements can be attributed to the Consortium and OH3C Project. (5 points)
- The data collection strategy to self-assess and analyze performance can inform program development and TA delivery, clearly providing an understanding of the impact of targeted TA and resources developed, and how this analysis informs program development and improvement in the TA delivery. (5 points)

Criterion 4: IMPACT (10 points) – Corresponds to Section IV’s [Methodology](#) and [Work Plan](#)

The extent to which the proposal in its entirety:

- Has a public health impact that is national in scope.
- Includes a realistic plan for broad dissemination of project results.
- Is sustainable beyond the federal funding period.

Criterion 5: RESOURCES/CAPABILITIES (25 points) – Corresponds to Section IV’s [Introduction](#), [Evaluation and Technical Support Capacity](#), and [Organizational Information](#)

The extent to which the applicant organization is capable of fulfilling the expectations of their proposal in its entirety, including both the Consortium and OH3C Project:

- The extent to which the applicant provides detailed information on the partner organizations’ current missions, structures, scope of current activities, and describes how these factors contribute to the lead organization’s collaborative plan

to conduct the project activities, which is clearly represented in the Consortium Organization Chart. (5 points)

- The extent to which the key personnel demonstrate expertise in, but not limited to, health systems integration, payment and data systems, data analysis and interpretation, state practice acts, MCH public policy, and provider/consumer education, and provide letters of agreement as a partner organization, participant in the Consortium Management Team, and/or one of the three oversight committees. (5 points)
- The extent to which the applicant demonstrates the experience to enhance knowledge and skill among professionals working in states and communities, with the goal of improving oral health services for pregnant women; infants, children, and adolescents, including those with special health care needs; and their families. (10 points)
- The extent to which the applicant demonstrates strong partnerships with relevant organizations, both federal and non-federal, that represent health professionals with expertise in oral health among MCH populations, public health professionals, and patient and consumer outreach at the national, state, and local levels, and demonstrates the leadership and skill in convening such stakeholders. (5 points)

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

The extent to which the applicant provides sufficient justification to determine the reasonableness of the proposed budget for each year of the 3-year period of performance in relation to the objectives, the complexity of the activities, and the anticipated results, including:

- The extent to which costs, as outlined in the individual budgets for the Consortium and OH3C Project, are reasonable given the scope of work. (5 points)
- The extent to which key personnel have adequate time devoted to the project to achieve project objectives. (5 points)

2. Review and Selection Process

The objective review process provides an objective evaluation to the individuals responsible for making award decisions. The highest ranked applications receive consideration for award within available funding ranges. HRSA may also consider assessment of risk and the other pre-award activities described in Section 3 below. See Section 5.3 of HRSA's [SF-424 Application Guide](#) for more details.

3. Assessment of Risk

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 \(FAPIS\)](#). 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 [FAPIS](#) in making a judgment about your organization’s integrity, business ethics, and record of performance under federal awards when completing the review of risk posed as described in 45 CFR § 75.205 HHS Awarding Agency Review of Risk Posed by Applicants.

HRSA will report to FAPIS a determination that an applicant is not qualified ([45 CFR § 75.212](#)).

VI. Award Administration Information

1. Award Notices

HRSA will issue the Notice of Award (NOA) prior to the start date of July 1, 2021. 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 Notice of Award, 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 Department regulations and policies in effect at the time of the award, and applicable statutory provisions.

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 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/FormAssignmentList/U44.html>. 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 | July 1, 2021 – June 30, 2024 <i>(administrative data and performance measure projections, as applicable)</i> | Period of performance start date | 120 days from the available date |
| b) Non-Competing Performance Report | July 1, 2021 – June 30, 2022 July 1, 2022 – June 30, 2023 | Beginning of each budget period (Years 2–3, as applicable) | 120 days from the available date |
| c) Project Period End Performance Report | July 1, 2023 – June 30, 2024 | 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).

- 2) **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. Additional instruction for reporting progress can be found in the list of cooperative agreement recipient's responsibilities (see Type of Application and Award, [Section II.1](#))
- 3) **Final Report.** The recipient must submit a final report narrative to HRSA after the conclusion of the project.
- 4) **Integrity and Performance Reporting.** The NOA will contain a provision for integrity and performance reporting in [FAPIS](#), as required in [45 CFR part 75 Appendix XII](#).

Please 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.

VII. Agency Contacts

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

Djuana Gibson
Grants Management Specialist
Division of Grants Management Operations, OFAM
Health Resources and Services Administration
5600 Fishers Lane, Mailstop 10SWH03
Rockville, MD 20857
Telephone: (301) 443-3243
Email: DGibson@hrsa.gov

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

Pamella Vodicka
Senior Public Health Analyst
ATTN: National Maternal and Child Health Consortium for Oral Health Systems
Integration and Improvement
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane, Room 18N-50
Rockville, MD 20857
Telephone: (301) 443-2753
Email: PVodicka@hrsa.gov

You may need assistance when working online to submit your application forms electronically. Always obtain a case number when calling for support. For assistance with submitting the application in Grants.gov, contact Grants.gov 24 hours a day, 7 days a week, excluding federal holidays at:

Grants.gov Contact Center
Telephone: 1-800-518-4726 (International Callers, please dial 606-545-5035)
Email: support@grants.gov
Self-Service Knowledge Base: <https://grants-portal.psc.gov/Welcome.aspx?pt=Grants>

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

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

VIII. Other Information

Technical Assistance

HRSA has scheduled the following technical assistance:

Webinar

Day and Date: Wednesday, December 16, 2020

Time: 3–4 p.m. ET

Call-In Number: 1-888-390-5922

Participant Code: 8656697

Weblink: https://hrsa.connectsolutions.com/hrsa-21-037_technical_assistance_webinar/

Instant Replay (Generally available 1 hour after a call ends.)

Call-In Number: 1-800-841-8614

Passcode: 21921

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: Oral Health Quality Indicators for the MCH Population³⁵

Quality Indicators for Women of Child-Bearing Age and Pregnant Women

Access

- Percentage of pregnant women reporting difficulty getting dental care during pregnancy (Data source: PRAMS)
- Percentage of pregnant women who had insurance to cover dental care during pregnancy (Data source: PRAMS)

Utilization

- Percentage of pregnant women who reported having their teeth cleaned by a dentist or dental hygienist during pregnancy (Data source: PRAMS)
- Percentage of women of child-bearing age (ages 18–44) who report having a visit to a dentist or dental clinic in the past year (Data source: BRFSS)

Outcome

- Percentage of pregnant women reporting that they needed to see a dentist for a problem during pregnancy (Data source: PRAMS)

Quality Indicators for Children

Access

- Dentists who actively participate in Medicaid per 1,000 EPSDT-eligible enrolled children (Data source: Medicaid enrollment and claims)

Utilization

- Percentage of children who had a dental visit in the last 12 months (Data source: Medicaid enrollment and claims)*
- Percentage of children at elevated risk receiving preventive dental services (Data source: Medicaid enrollment and claims)*

Process

- Percentage of children at elevated risk receiving at least two topical fluoride applications as a dental service (Data source: Medicaid enrollment and claims)*
- Percentage of children at elevated risk receiving at least two topical fluoride applications as an oral health service (Data source: Medicaid enrollment and claims)*
- Percentage of children who have ever received sealants on permanent first molar teeth by the 10th birthdate (Data source: Medicaid enrollment and claims)*
- Percentage of children who have ever received sealants on permanent second molar teeth by the 15th birthdate (Data source: Medicaid enrollment and claims)*

Outcome

- Percentage of kindergarten children with dental caries experience (treated or untreated tooth decay) (Data source: Basic Screening Survey [BSS])
- Percentage of third-grade children with dental caries experience (treated or untreated tooth decay) (Data source: BSS)
- Percentage of kindergarten children with urgent dental treatment needs (Data source: BSS)
- Percentage of third-grade children with urgent dental treatment needs (Data source: BSS)

*Developer and steward: DQA

³⁵ National Maternal and Child Oral Health Resource Center and Dental Quality Alliance. 2020. An Overview of Oral Health Quality Indicators for the Maternal and Child Health (MCH) Population. Washington, DC: National Maternal and Child Oral Health Resource Center, and Chicago, IL: Dental Quality Alliance. <https://www.mchoralhealth.org/PDFs/OHQI-overview.pdf>