U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

HRSA

Health Resources & Services Administration

Maternal and Child Health Bureau
Division of Healthy Start and Perinatal Services

Healthy Start Initiative: Eliminating Disparities in Perinatal Health

Funding Opportunity Number: HRSA-19-049
Funding Opportunity Type(s): Competing Continuation and New
Catalog of Federal Domestic Assistance (CFDA) Number: 93.926

NOTICE OF FUNDING OPPORTUNITY

Fiscal Year 2019

Application Due Date: November 27, 2018

MODIFIED on October 16, 2018: See Executive Summary for list.

*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: September 28, 2018

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Authority: Public Health Service Act, Title III, Part D, § 330H (42 U.S.C. 254c-8).

EXECUTIVE SUMMARY

Modifications:

- **Added TA information (pp. ii and 42).**
- **Increased funding in support of hiring clinical service providers (pp. i, 3-4, 24, 25, 27-28, 30, and 35).**
- **Clarified data in the Eligible Applicants' Eligibility Factors Demonstrating Need section (p. 6).**
- **Updated attachments (pp. 18 and 27-28).**
- **Clarified funding factors (pp. 27 and 34-35)**

The Health Resources and Services Administration (HRSA) is accepting applications for fiscal year (FY) 2019 Healthy Start Initiative: Eliminating Disparities in Perinatal Health. The purpose of this Healthy Start (HS) program is to improve health outcomes before, during, and after pregnancy, and reduce racial/ethnic differences in rates of infant death and adverse perinatal outcomes.

Funding Opportunity Title:	Healthy Start Initiative: Eliminating Disparities in Perinatal Health
Funding Opportunity Number:	HRSA-19-049
Due Date for Applications:	November 27, 2018
Anticipated Total Annual Available FY 2019 Funding:	$95,000,000
Estimated Number and Type of Award(s):	Approximately 100 Grants
Estimated Award Amount:	Up to: Year 1: $950,000 Years 2-5: $980,000 per year Funding amounts are subject to the availability of appropriated funds.
Cost Sharing/Match Required:	No
Period of Performance:	April 1, 2019 through March 30, 2024 (5 years)
Eligible Applicants:	Eligible applicants include any domestic public or private entity. Domestic faith-based and community-based organizations, tribes, and tribal organizations are also eligible to apply. See Section III-1 of this notice of funding opportunity (NOFO) for complete eligibility information.

Application Guide

You (the applicant organization/agency) are responsible for reading and complying with the instructions included in HRSA's *SF-424 Application Guide,* available online 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: Thursday, October 25, 2018
Time: 2 p.m. – 4 p.m. ET
Call-In Number: 1-888-790-2035
Participant Code: 7526454

Weblink: https://hrsaseminar.adobeconnect.com/healthystart_nofo_ta/

The recording will be posted in 5 business days on the MCHB website at https://mchb.hrsa.gov/fundingopportunities/default.aspx.

Table of Contents

I. Program Funding Opportunity Description

1.   **Purpose**

This notice announces the opportunity to apply for funding under the *Healthy Start Initiative: Eliminating Disparities in Perinatal Health program.* The purpose of this Healthy Start (HS) program is to improve health outcomes before, during, and after pregnancy, and reduce racial/ethnic differences in rates of infant death and adverse perinatal outcomes.

The HS program provides grants to high-risk communities with infant mortality rates at least 1.5 times the U.S. national average and high rates of other adverse perinatal outcomes (e.g., low birthweight, preterm birth, maternal morbidity and mortality). HS works to reduce the disparity in health status between the general population and individuals who are members of racial or ethnic minority groups.

Beginning in FY 2019, the HS program will serve infants and families for the **first 18 months after birth.** This is a change from the current program design, which includes support for infants and families up to 2 years after birth. Since the HS program emphasis is on infant mortality/women's health/perinatal health, this change allows the program to focus resources on these key purposes and associated milestones (e.g., provision of interconception care), while ensuring support for children through critical milestones (e.g., immunization milestones established by American Academy of Pediatrics (AAP)). This change also reflects feedback from current recipients in the field to increase program capacity to serve more pregnant women within the project period and promote healthy pregnancy outcomes. HRSA will continue to ensure collaboration with other programs supporting early childhood (including the HRSA-funded Title V and Maternal, Infant, and Early Childhood Home Visiting (MIECHV) programs) to ensure continued support and healthy development for children born to HS participants.

The HS program aims to address its purpose by:
▪   improving access to quality health care and services for women, infants, children, and families through outreach, care coordination, health education, and linkage to health insurance;
▪   strengthening the health workforce, specifically those individuals responsible for providing direct services;
▪   building healthy communities and ensuring ongoing, coordinated, comprehensive services are provided in the most efficient manner through effective service delivery; and
▪   promoting and improving health equity by connecting with appropriate organizations.

Success in these aims should lead to reduced infant mortality, improved birth outcomes, improved maternal/family health, improved child health, and reduced disparities in maternal, infant and child health in HS communities.

HS Program Activities

Applicants shall propose projects that include the following core elements, which reflect input from the field and HRSA's experience with current and previous HS recipients. These core elements maintain the HS services that are currently being provided, but clarify the program's focus on improving infant mortality through a lifecourse approach emphasizing women's health, family health, and community/population health.

- Improve Women's Health: Activities to improve coverage, access to care, and health promotion and prevention, and health for women before, during, and after pregnancy.

- Improve Family Health and Wellness: Activities to improve infant health and development using a two-generation approach. Acknowledging the health of families are interrelated, applicants shall support the parental and community factors that promote family health and wellness, including system coordination/integration, health promotion and prevention, and social support services that protect and advance parental and infant/child health and wellbeing.

- Promote Systems Change: Activities to maximize opportunities for community action to address social determinants of health (SDOH), including systems coordination and integration among health and social services, other providers, and key leaders in the community and their states. Applicants shall provide regional and national leadership within the greater HS community and field of maternal and child health (MCH).

Assure Impact and Effectiveness: Activities to conduct ongoing HS workforce development, data collection, Quality Improvement, performance monitoring, and evaluation activities in order to identify best practices, demonstrate implementation of evidence-based practices, and report on results.

Every HS project funded under this notice should serve no less than: 300 pregnant women; 300 infants/children up to 18 months, preconception women, and interconception women (combined); and 100 fathers/male partners affiliated with HS women/infants/children, for a total of at least 700 program participants per calendar year. These targets are based on a review of performance data regarding numbers served by HS recipients with the greatest success in achieving program outcomes. Targets may be adjusted to reflect available funding.

Failure to meet service numbers may result in restriction of funding, or drawdowns.

2. **Background**

This program is authorized by the Public Health Service Act, Title III, Part D, § 330H (42 U.S.C. 254c-8).

HS is a community-based program dedicated to reducing disparities in maternal and infant health. Created as a demonstration project in 1991, the program has grown from

15 pilot sites to a network of 100 HS programs in 37 states and the District of Columbia. Over its first 25 years, HS evolved from a program focused primarily on improving pregnant women's access to prenatal care to a program seeking to improve women's and children's health from preconception to early childhood, creating the foundation for optimal infant and young child health and development.[1] Current HS programs serve women of reproductive age, pregnant women, mothers who have just given birth, and infants and families from birth to the child's second birthday.[2] HS also involves fathers/male partners and supports couples with reproductive life planning.

Approximately four million women give birth each year in the United States.[3] While most women have a safe pregnancy and deliver a healthy infant, that is not the experience for all women. Major and persistent racial and ethnic disparities exist for pregnancy-related maternal morbidity and mortality, infant mortality, and other adverse outcomes such as low birthweight and preterm birth.

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 grant.

2. **Summary of Funding**

HRSA expects approximately $95,000,000 to be available annually to fund approximately 100 recipients. You may apply for a ceiling amount of up to: $950,000 for Year 1 and up to $980,000 for each out year, Years 2-5 (includes both direct and indirect, facilities and administrative costs). The actual amount available will not be determined until enactment of the final FY 2019 federal appropriation.

In addition, HRSA will increase its support to HS grant recipients in support of hiring clinical service providers (e.g., nurse practitioners, certified nurse midwives, physician assistants, and other maternal-child advance practice health professionals) within each of its program sites nationwide. As a result, you may request up to $120,000 per year, above the base HS award described, to hire clinical service providers (directly or through a contract) to provide direct access to well-woman care and maternity care services. These activities are to be funded through the additional $12 million provided to HRSA in the fiscal year 2019 appropriation. You should provide a plan to support these activities in Attachment 11 of your application, as well as a separate delineated budget narrative. Additional information about how to apply for this funding is provided in Section IV-2 (Content and Form of Application Submission) of this NOFO. ***Applying for this funding will not impact the Healthy Start Initiative: Eliminating Disparities***

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[1] https://www.hrsa.gov/advisorycommittees/mchbadvisory/InfantMortality/Meetings/20120710/reflectionsinitiative.ppt
[2] Through March 2019. Grants beginning in FY19 will serve children though 18 months of age.
[3] National Center for Health Statistics. Retrieved from: https://www.cdc.gov/nchs/fastats/births.htm

in Perinatal Health application score. HRSA staff will evaluate your plan for these additional funds separately.

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 in a timely manner. The period of performance is April 1, 2019 through March 31, 2024 (5 years). Funding beyond the first year is subject to the availability of appropriated funds for *Healthy Start Initiative: Eliminating Disparities in Perinatal Health* in subsequent fiscal years, satisfactory recipient performance, and a decision that continued funding is in the best interest of the Federal Government.

HRSA plans to award up to 25 grants for projects serving rural communities (as defined below under eligible project area) in an effort to address unique needs and challenges, such as access to care and changing population characteristics. Fewer grants may be funded depending on the number of applications received and the outcome of the Objective Review Committee's scoring of applications. In addition, HRSA will award no more than six (6) grants per state, and only one (1) project will be funded per project area. Only one (1) application per organization will be accepted under this NOFO. These factors will allow HRSA to increase the geographic distribution of the HS program and will be taken into consideration in making funding decisions. Additional information about how HRSA will make funding decisions is provided under Section V. 2. (Review and Selection Process) of this NOFO.

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

III. Eligibility Information

1.   **Eligible Applicants**

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

You must define both your project area <u>and</u> target population using the criteria below.

Eligible Project Area

You must identify your organization as serving an urban, rural, or other project area. A project area is defined as a geographic community in which the proposed services are to be implemented. A project area must represent a reasonable and logical catchment area, but the defined areas do not have to be contiguous. A map of the proposed project area and a list of zip codes must be included in the application.

<u>Urban</u> – Territory, population, and housing units located within an urbanized area (UA) or an urban cluster (UC), which has: a population density of at least 1,000 people per

square mile; and surrounding census blocks with an overall density of at least 500 people per square mile.

Rural – To determine whether the Census tract or County for your proposed project area is defined as a rural area , visit the webpage Rural Health Grants Eligibility Analyzer and enter the project area address. Link: http://datawarehouse.hrsa.gov/RuralAdvisor/ruralhealthadvisor.aspx?ruralByAddr=1

Other – A project area that does not fit either the urban or rural definitions above, and meets the other criteria provided.

Eligible Target Population

The target population is the population that you will serve within your geographic project area and will determine your eligibility. Your application must clearly identify the project area for which you are applying **and** the proposed target population **within** that project area to confirm eligibility. The target population should be the population with the highest infant mortality rate (IMR) within the project area. The majority of the HS program services and resources should be focused on the target population.

Eligibility Factors Demonstrating Need

HRSA must be able to verify submitted data with the appropriate state/local government agency responsible for vital statistics. In all instances, the IMR (and number of infant deaths) must be the primary statistic used to indicate eligibility, if the data are available. "Other" area applicants that cannot provide this verifiable data may use the other indicators specified in the second section below. Your application **must** include data for the eligibility factors in the application's transmittal letter (**Attachment 1**) and in the needs assessment section of the submitted application. You should describe the existing racial/ethnic disparities or other perinatal indicators in the needs assessment section of the application.

Applications that do not provide this information, in the manner described within this NOFO, will be considered ineligible and the application will not proceed to the Objective Review Committee.

Your target population within your proposed project area must meet the following criteria using the smallest geographical area with verifiable data—not to be any larger than a combination of counties.

Urban and Rural Communities

Using verifiable 3-year average data for calendar years 2013 through 2015, the proposed project area for communities which meet the urban or rural area definition **must meet the following indicators from the list below.**

    i.   The **2013 through 2015** combined 3-year infant mortality rate (IMR, infant deaths per 1,000 live births over 3 years) must be equal to or more than **8.8**

deaths per 1,000 live births (1.5 times the national average[4]) **AND** there must be 20 or more infant deaths in the target population during the 3-year period, 2013 through 2015.

ii. **If the combined 2013 through 2015 number of infant deaths are less than (<)20, then to be eligible the following must be met:**

    a. The 2013 through 2015 3-year low birthweight (LBW) rate is equal to or more than 12.1 percent (1.5 times the national average[5]) **AND** there must be 100 or more LBW births in the target population during the 3-year period, 2013 through 2015.

    OR

    b. The 2013 through 2015 preterm birth (PTB) rate is equal to or more than 14.4 percent (1.5 times the national average) **AND** there must be 100 or more PTB births in the target population during the 3-year period, 2013 through 2015.

Applicants submitting proposals under **other criteria**

Using verifiable data for 2016, the proposed target population for project areas, which meet the "other" area definition, must have at least 1,000 births for the 1-year period **AND** meet at least three indicators from the list below. If vital statistics are not available from state/local government agencies, other area applicants can use other verifiable data.

1. *Percentage of pregnant women with diabetes is 10.2 percent or more*;
2. *Percentage of pregnant women who are obese is 39.2 percent or more*;
3. *Percentage of pregnant women entering prenatal care in the first trimester is less than 38.6 percent*;
4. *Percentage of births to women who had no prenatal care is 2.4 percent or more; and*
5. *Percentage of births to women who used tobacco during pregnancy is 10.8 percent or more.*

Transmittal Letter
Your required transmittal letter, which accompanies your application as **Attachment 1**, must clearly indicate:

The project area for which you are applying and the proposed target population within that project area confirms eligibility. The target population is the population you will serve and will determine your eligibility. **The recipient must direct the majority of their services towards the target population that makes their application eligible.**

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[4] Data Source: United States Department of Health and Human Services (US DHHS), Centers of Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics (DVS). Linked Birth / Infant Death Records 2007-2015, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program, on CDC WONDER On-line Database. Accessed at http://wonder.cdc.gov/lbd-current.html

[5] Data Source: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Natality public-use data 2007-2016, on CDC WONDER Online Database, February 2018. Accessed at: http://wonder.cdc.gov/natality-current.html

That the indicator for IMR, LBW, or PTB for the target population is at least 1.5 times the national rate AND meets the number of deaths or births for the period 2013 through 2015 as indicated in the eligibility criteria. **No other combination of years, and only a 3-year average, will be accepted to confirm eligibility – any deviation from this will result in an ineligible application.**. (You must submit the statement of eligibility as **Attachment 1**).

> Examples of verifiable and acceptable data sources:
> 1) Centers for Disease Control and Prevention (CDC): https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm
> 2) Your state's public health/vital statistics office.

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

IV. Application and Submission Information

1. **Address to Request Application Package**

HRSA *requires* you to apply electronically. HRSA encourages you to apply through Grants.gov using the SF-424 workspace application package associated with this NOFO following the directions provided at http://www.grants.gov/applicants/apply-for-grants.html.

If you are reading this notice of funding opportunity (NOFO) (also known as "Instructions" on Grants.gov) and reviewing or preparing the workspace application package, you will automatically be notified in the event HRSA changes and/or republishes the NOFO on Grants.gov before its closing date. Responding to an earlier version of a modified notice may result in a less competitive or ineligible application.

Please note you are ultimately responsible for reviewing the [For Applicants](#) page for all information relevant to desired opportunities.

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 may not exceed the equivalent of **80 pages** when printed by HRSA. The page limit includes the abstract, project and budget narratives, attachments, and letters of commitment and support required in the *Application Guide* and this NOFO. Standard OMB-approved forms that are included in the workspace application package do not count in the page limit. Indirect Cost Rate Agreement and proof of non-profit status (if applicable) do not count in the page limit. **We strongly urge you to take appropriate measures to ensure your application does not exceed the specified page limit.**

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

Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification
1) The prospective recipient certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
2) 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 the prospective recipient is unable to attest to the statements in this certification, an explanation shall be included in Attachment 12: Other Relevant Documents.

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

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

i. Project Abstract
See Section 4.1.ix of HRSA's *SF-424 Application Guide*.

You must also identify as serving an urban, rural, or other community project area.

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.

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

- *INTRODUCTION -- Corresponds to Section V's Review Criterion 1 (Need)*
You should briefly describe the purpose of your proposed project. Your application should include a discussion that exhibits a complete expert understanding of the issues related to improving perinatal outcomes, promoting women's, infant and family health, and the purpose of the program. As an applicant for this notice, you **must** also state whether you are serving an urban, rural, or other community project area.

- *NEEDS ASSESSMENT – Corresponds to Section V's Review Criterion 1 (Need)*
This section outlines the needs of your community and/or organization. Your target population and its unmet health needs must be described and documented in this section. You should use and cite demographic data whenever possible to support the information provided. While your program cannot deny services to any eligible member of the community, your HS project under this competition may focus its efforts and interventions on a particular subpopulation of your community that exhibits disparities in infant, perinatal or interconception health. Your narrative in this section should help reviewers understand the community that your proposed project will serve.

Your application should provide a clear description of the current status, capacity and needs of your proposed geographic project area and the current perinatal system serving that area. Include demographic and health statistics to demonstrate current prevalent disparities. For comparison to other applications, your application must present data minimally from 2013 through 2015 (3-year average). If data that are more current are available, e.g., 2014 – 2016, you may also include it. Describe (by race/ethnic origin) the perinatal health indicators including, 3-year averages (2013 through 2015) for live births, infant deaths (under 1 year of age), neonatal and post neonatal mortality rates, as well as the incidence of low birth weight, sudden unexpected infant death (SUID) births to teenagers 18 years and younger, trimester of initiation of prenatal care and adequacy of prenatal care. Highlight current trends in morbidity, including such areas as birth defects, infant/child abuse and neglect, accidents, HIV, other communicable diseases and other prevalent factor(s) affecting your project area.

Briefly describe the size, demographic characteristics, prevalent norms, and health

behaviors of your targeted population(s). You should also include data on poverty status, average education level, employment status, and major industries of employment for women of childbearing age as well as demographics of fathers/male partners.

List the population(s) your HS program will target for your activities to improve women's health, and infant health and wellness (e.g., all pregnant and interconception women at risk for a poor perinatal outcome, at risk for developmental delay or special health care needs infants and toddlers, other women of reproductive age, fathers/male partners; etc.).

▪ *METHODOLOGY -- Corresponds to Section V's Review Criterion 2 (Response)* Propose methods that you will use to address the stated needs and meet each of the previously described program requirements and expectations in this NOFO. *.* Your application should also include a description of any innovative methods that you will use to address the stated needs. As appropriate, include development of effective tools and strategies for ongoing staff training, outreach, collaborations, clear communication, and information sharing/dissemination with efforts to involve participants, families and communities. If applicable, include a plan to disseminate reports, products, and/or project outputs so key target audiences receive the project information.

You must also propose a plan for project sustainability after the period of federal funding ends. HRSA expects recipients to sustain key elements of their projects, e.g., strategies or services and interventions, which are effective in improving practices, and those that led to improved outcomes for the target population.

This section of your application should be organized by the following categories: Improve Women's Health, Improve Family Health and Wellness, and Promote Systems Change. The HS EPIC Center includes HS resources that may be useful for preparing your application (see Appendix B).

1. Improve Women's Health

You are expected to use a lifecourse approach[6] in delivering services and address the social determinants that impact health outcomes.[7] It is critical that you target women who are at highest risk for adverse perinatal health outcomes within your community. Please respond using the corresponding outline numbers under each category (e.g., 1.i., 1.ii., 1.iii…):

a. *Access to health insurance to improve women's health*
   i. Describe how you will facilitate enrollment in Medicaid or other linkages with the financial supports needed to promote access to clinical health services.
   ii. Provide details about how you will train your staff on state eligibility rules.

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[6] https://mchb.hrsa.gov/training/lifecourse.asp

[7] https://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health

iii. Describe how your program will increase participant knowledge and awareness of Medicaid or other insurance/health care financing options.
iv. Provide details on the barriers/challenges your organization faces internally, as well as in the community at large, related to health insurance education, enrollment and referrals.

b. A*ccess to health care services for women*
i. Describe how your program will conduct and provide outreach and recruitment to women program participants.
ii. Explain how your project will utilize community-based outreach to identify high-risk women for enrollment in HS who have such risk factors as prior poor birth outcomes and possess unhealthy behaviors, which can lead to adverse health outcomes.
iii. Describe your project's proposed intake and enrollment process for program participants, including who performs these activities.
iv. Explain how your project will conduct comprehensive assessments using the HS standardized tools[8].
v. Explain how you will use HS assessment and case management information to improve care effectiveness and service coordination (e.g., communication and linkages with primary care providers).
vi. Identify and describe any tools your program will use for care coordination/case management, planning and monitoring, in addition to the HS standardized tools.
vii. Detail your care coordination/case management process.
viii. Discuss how your program will determine differing levels of client risk and the type, timing, duration, and intensity of services matched to the risk levels. Detail the projected number of program participants in the prenatal and interconception periods, as well as each level of risk.
ix. Provide details on your approach to promote service coordination and systems integration. Explain how your project will ensure a full range of services is available for women before, during, and after pregnancy.
x. Describe your process for ensuring your HS participants have a medical home.
xi. Discuss how your approach will improve access to medical, social, developmental, behavioral, educational, and informal support services.

c. *Preventive services and health promotion to improve women's health*
i. Describe how you will promote and track the use of women's clinical preventive services, including prenatal care, preconception care, family planning, and well-woman visits.
ii. Describe how you will promote and monitor interconception health among high-risk women, including chronic disease management and reduction of reproductive health risks.

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[8] https://healthystartepic.org/healthy-start-implementation/screening-tools/

iii. Describe how you will provide health promotion and education to improve women's health,

iv. Describe how you will promote and monitor reproductive life planning, including the tools and staffing approach you will use.

v. Describe how you will augment community-wide health education and promotion in the suggested areas for woman and their partners.

vi. Describe how you will increase provider awareness of best practices in preconception, prenatal care, birth, postpartum, interconception, well-woman care, and reproductive life planning.

vii. Identify evidence-based curricula your program intends to use.

viii. Identify and justify other evidence-based models and approaches proposed for use (e.g., Centering Pregnancy, MIECHV evidence-based home visiting models, Bright Futures guidelines for health supervision).

d. Collaboration with local, state, and national initiatives that support women's health

i. Describe how you will connect with local, state, and national MCH initiatives and stay abreast of current guidelines and activities focused on women's health.

ii. If your program is located within a state that has enrolled in Alliance on Innovation Maternal Health (AIM), describe how you will collaborate with your State's Perinatal Quality Collaborative and assist in the adoption of the Maternal Safety Bundle(s)[9].

iii. Describe how your program will support the Women's Preventive Services Initiative[10] that provides recommendations to update the Women's Preventive Services Guidelines[11] and develop new recommendations.

iv. If your program is located within a state with the Infant Mortality Collaborative Improvement and Innovation Network (IM CoIIN)[12], describe how you will support the team topic of reducing infant mortality by addressing SDOH, sudden unexpected infant death, early prenatal care, or preconception health.

v. Describe how your program will support the Ryan White HIV/AIDS Program Part D that provides funding to improve access to family-centered HIV medical care for low income, uninsured, underinsured, and medically underserved women (25 years and older) living with HIV and their infants (up to 2 years of age) exposed to or living with HIV.

See Section VI.3. Reporting for a list of performance measures associated with the Improve Women's Health approach.

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[9] https://www.acog.org/About-ACOG/ACOG-Departments/Patient-Safety-and-Quality-Improvement/What-is-AIM

[10] https://www.womenspreventivehealth.org/

[11] https://www.hrsa.gov/womens-guidelines/index.html

[12] https://mchb.hrsa.gov/maternal-child-health-initiatives/collaborative-improvement-innovation-networks-coiins

2. **Improve Family Health and Wellness**

Please respond using the corresponding outline numbers under each category (e.g., 1.i., 1.ii., 1.iii…):

a. Access to health care services for infants and children under 18 months
   i. Describe the process for ensuring that infants and children under 18 months have a medical home. Discuss how your project will connect infants and children **under 18 months**[13] to medical care by providing on-site primary health services, if applicable, or assuring linkages to a community provider to provide such services.

b. Prevention and health promotion
   i. Describe how you will provide health education and promotion for women, infants, and families for the topics below
   1. Maternal Care – well-woman care; family planning; reproductive life planning; prenatal care; childbirth education; breastfeeding; postpartum care; oral health; mental health promotion; perinatal depression and anxiety screening, referral, and follow-up; prevention of substance-exposed pregnancies, including the prevention of fetal alcohol spectrum disorder.

   2. Infant Care – well child visits; immunizations; oral health; infant growth and development; safe sleep; nutrition; car and home safety; lead poisoning, and the five domains of child development (physical/motor development, social-emotional development, approaches to learning, language development and cognition, and general knowledge), including the importance of reading to a child to promote early literacy.

   3. Family Wellness – effective parenting practices; infant attachment; mental health promotion; healthy weight; smoking and e-cigarette cessation; perinatal transmission, screening, and referral; sickle cell disease screening and referral; sexually transmitted disease prevention(e.g., HIV), screening, and referral; domestic violence screening and follow up; and behavioral health screening, referral and follow up.
   ii. Describe any additional health education topics you plan to address.
   iii. Describe how your project will conduct social-emotional development screening for child participants. Specify the tool(s) your program will use, intervals for screening, and case management\care coordination approaches to assure completed service of referrals and follow up.
   iv. Discuss your program materials, including evidence of effectiveness, cultural and linguistic appropriateness, and other characteristics.
   v. Describe how you will augment community-wide health education and promotion for each woman, infant, and family (described above).

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[13] This is a change from the previous period of performance. Beginning in FY19, HS programs will serve infants and children up to 18 months.

c. Behavioral health support and services
   i.   Describe how your project will conduct screening of female participants for depression and anxiety. Specify the screening tools, intervals for screening, and specific case management\care coordination approaches to assure completed service referrals and follow up.
   ii.   Describe how your project will conduct screening of female participants for substance use/misuse. Specify the screening tools, intervals for screening, and specific case management\care coordination approaches to assure completed service referrals and follow up.
   iii.   Describe how your project will use the evidence-based practice of screening, brief intervention, and referral to treatment when conducting standardized screening.
   iv.   Describe linkages and service coordination activities with mental and substance use disorder treatment behavioral health providers, and recovery support providers (e.g., peer support groups) who may improve access to such services. Provide details on proposed activities to increase the availability of these services, if local resources are unavailable.
   v.   Describe your efforts to integrate, co-locate behavioral health services, as well as facilitating linkages to any tele-behavioral health services in your state or region.
   vi.   Discuss how you intend to assess and document risks related to toxic stress as part of your case management\care coordination approach.
   vii.   Describe how you will augment community-wide knowledge, awareness, education, support, and services of toxic stress, adverse childhood experiences (ACEs), trauma-informed care, and parent-child interventions for two-generation impact.
   viii.   Discuss how you will use partnerships, linkages, and system coordination to increase access to trauma-informed care.

d. Father/partner involvement
   i.   Discuss how your program will engage and promote fathers/male partners involvement in HS education, activities, services, and events for at least 100 fathers/male partners affiliated with HS women and infants/children annually.
   ii.   Identify and describe the assessment tools and evidence-based curriculum your program will use with HS fathers/male partners (e.g., 24/7 Dad, Responsible Fatherhood, Family Spirit, Wise Guys, and Nurturing Fathers Program).
   iii.   Describe your specific activities intended to improve the health, mental health, and resilience of fathers/male partners by supporting healthy relationships between parents/partners, strengthening life skills, and supporting opportunities for self-sufficiency and economic stability of the family.
   iv.   Discuss how you intend to engage community partners in strategies to encourage paternal involvement in supporting the well-being of HS women and child participants.

     v.   Describe specific community-based activities intended to improve the health, behavioral health, and resilience of fathers/male partners.
   vi.   Describe how you intend to involve fathers/male partners across all perinatal phases – preconception, prenatal, postpartum and parenting.

e. Parent education
     i.   Describe how your program will deliver parenting education, including timing, standardized curricula, tools, staff, and materials proposed for use.
    ii.   Discuss how your program will promote protective factors such as nurturing and attachment, appropriate limit setting, knowledge of child development, parental resilience, social connections, and concrete support for parents.
   iii.   Identify and justify your program's proposed evidence-based models and approaches.
   iv.   Describe how your program will include partners of women participants who are co-parenting in parent education, activities and events.
    v.   Describe how you will collaborate and integrate with other community organizations providing parenting education (e.g., home visiting, Early Head Start, Strengthening Families).

f. Improve service coordination and systems integration for women, their infants and children under 18 months, and their families

     i.   Describe your approach to service coordination and systems integration.
    ii.   Describe how your program will ensure significant involvement with MCH activities in your community, in particular Community Health Centers (CHC), other HRSA, and federally-funded investments in your state[14].
   iii.   Describe how you will ensure that your program supports, but does not duplicate MCH activities in the community.
   iv.   Describe how your program will support coordination and systems integration among health, social services, and other providers in the community to address social determinants, while supporting improved access to these services.

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[14] https://datawarehouse.hrsa.gov/

3. Promote Systems Change

Please respond using the corresponding outline numbers under each category (e.g., 1.i., 1.ii., 1.iii…):

a. Community Action Network

    i. Provide details on how you will identify/select members of the community action network (CAN), including: type of partner organizations and community members, recruitment and retention plans, racial/ethnic breakdown of membership, management procedures, and participation in review of community assets.

    ii. Provide a list of CAN members. For each CAN member include their name and agency or organization represented. Also indicate whether they are state or local government, program participant , community participant, community-based organizations CHCs, private agencies or organizations (not community-based), other service providers, or other partner.

    iii. Describe how your program will collaboratively engage partners to develop a common goal and objectives with shared outcomes and facilitate community collaboration, information sharing, and advocacy among this network.

    iv. Provide details on how your program will revise, update, and monitor activities, and develop/implement/evaluate the 5-year CAN action plan to address barriers to care and improve the local system of care and/or address SDOH.

    v. Describe how your program will convene and facilitate collaborative partnerships to fulfill the approaches of HS. Describe how your program will engage a diverse group of partners who can contribute to shared outcomes that address the environmental and social needs that promote service utilization, and promotes overall health of the target population and/or service area.

    vi. Describe your role in other community coalitions, collaboratives, and activities intended to affect systems change with identified priority areas and yearly goals that should be based on a needs assessment. Reporting on progress will occur annually, along with any revisions to the approved proposal.

    vii. Describe how you will provide leadership for the CAN. Provide details on past performance that demonstrate your capacity to lead collaborative community initiatives.

The restrictions on lobbying apply, and none of the activities described in this NOFO should be related to lobbying.

b. Local, State, Regional, and National Leadership

As a HS recipient, you are required to attend regional and national meetings sponsored by the national HS program. These are forums wherein your program can share and learn from others' HS-related successes, best practices, promising innovations, and lessons. You are also encouraged to

share your findings through publications and/or presentations at regional and national MCH and/or public health meetings.

i. Describe the collaboration efforts with others in the community to educate, establish, maintain, and make available a comprehensive perinatal system of care while serving as a leader for state, regional, and/or national action in support of HS and other community/state/regional/national organizations working to improve perinatal outcomes.

ii. Describe how your program will coordinate and align with State Title V Maternal and Child Health Block Grant programs, connect and coordinate with other federally-supported MCH programs and initiatives, and establish linkages with key state and local services and resources.

iii. Discuss how your program will participate in at least one of the following activities: Fetal Infant Mortality Review (FIMR), Maternal Morbidity and Mortality Review (MMMR), or Periodic Periods of Risk (PPOR).

FIMR: Specify whether your program will participate in an existing FIMR project or develop your own FIMR. Discuss your program's role and involvement. Identify the community/geographic area of focus; identify community resources/assets; determine the type and number of cases to be reviewed; determine FIMR's relationship to other types of review; identify and address legal and institutional issues related to the review; establish systems to maintain confidentiality and anonymity; establish a system to identify cases; select data collection and processing methods; designate the appropriate staff; formalize policies and procedures; and build in opportunities for initial and ongoing training.

MMMR: Provide details on how your program will be involved in M M M R , i.e., participate in an existing MMMR project OR develop a new MMMR in your community. Discuss your program's role, involvement, and the steps you will take to develop a new project, if applicable.

PPOR: Provide details on how your program will: assess community readiness; conduct analytic phases of PPOR; develop strategic actions for targeted population; strengthen existing and/or launch new prevention initiatives; and repeat annually.

iv. Discuss your program's interest in participating in either the HS Collaborative Innovation Network (HS COIN) and/or HS Mentoring Program in which recipients must apply through the HS Technical Assistance Center15 to join in these activities. Identify topics for the HS COIN to address.

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[15] https://healthystartepic.org/

- *WORK PLAN -- Corresponds to Section V's Review Criterion 2 (Response)*

Describe the activities or steps that your program will use to achieve each of the objectives proposed during the entire period of performance in the Methodology section. Use a time line that includes each activity and identifies your responsible staff. As appropriate, identify meaningful support and collaboration with key stakeholders in planning, designing, and implementing all activities, including developing the application. In this section, you should identify measurable, realistic, time-framed project objectives (if applicable) and performance measure objectives. Your objectives should be responsive to the approaches of the HS program, your identified need(s), and strengths/resources of your target population. Each objective should be clearly stated, outcome-oriented, and realistic for your available resources. Each period of performance objective must have associated calendar year objectives for each year of requested HS funding. You may detail this information on a separate worksheet, referenced in the narrative in this section, and placed in **Attachment 2**. Your budget narrative (described in subsection iv) should reflect the strategies described in the work plan. Your proposed position descriptions, protocols, and/or training curricula should align with and support your narrative.

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

Discuss challenges that you are likely to encounter in designing and implementing the activities described in the work plan, and approaches that you will use to resolve such challenges.

Your application must address:
- Program participant barriers such as enrollment and retention in the HS program, barriers to establishing a medical home, and challenges to obtaining health and social services in the community, with proposed resolutions.
- Community barriers such as lack of resources (human and financial), political environment, and transportation.

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

Please respond using the corresponding outline numbers under each category (e.g., 1.i., 1.ii., 1.iii…):

1. *HS workforce development*

   i. Describe how the program will train and continue to develop HS staff in the following areas:
       o HS core competencies (i.e., HS Community Health Worker (CHW) Course)[16].

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[16] https://healthystartepic.org/training-and-events/healthy-start-community-health-worker-course/

- Evidence-based approaches and/or curricula.
- Case management\care coordination approaches.
- Parent education.
- Trauma-informed care.
  ii. Describe how the program will apply core competencies for continued HS workforce development.
  iii. Describe how your program leadership/supervisors will support implementation of core competencies for the HS workforce, including CHW, nurses, social workers, and other staff. Include a description of team approaches or tiered (or triage) case management\care coordination approaches to be used.
  iv. Define how you will provide testing and remediation to assure competence among your HS workforce.
  v. Describe how you will work with the HS Technical Assistance Center to identify technical assistance with the core competencies.

2. *Data Collection and Performance Monitoring*

Objectives and Performance Measures

The application should include baselines and targets for all performance measures in the work plan, (see section VI.3 for a list of the performance measures). Both period of performance and calendar period objectives should relate to the performance measures. Objective statements should clearly describe what your program will achieve and by when as well as the target population. Each objective should include a numerator, a denominator, time frame, and data source including year.

The initial proposed objective(s) for each calendar year should include baseline data, utilizing the most current data source available prior to implementation of services using HS funds). Competing Continuations must use calendar year 2017 as the baseline. When utilizing baseline data, you must document the date source. If baseline data sources are older than 2010 please explain why more current estimates are not unavailable. If percentages are used, the relevant numerator and denominator must be provided. Each period of performance objective should have a performance measure, which is the statistic, or quantitative value that expresses the result of the objective.

The following example may assist you in the development of the project objectives and measures:

Period of performance Objective: By 3/31/2024, increase proportion of HS women participants that receive a well-woman visit to 80 percent.

Calendar Year 1 Objective: By 12/31/2019, increase proportion of HS women participants that receive a well-woman visit to 45 percent.

Calendar Year 2 Objective: By 12/31/2020, increase proportion of HS women participants that receive a well-woman visit to 55 percent.

Calendar Year 3 Objective: By 12/31/2021, increase proportion of HS women participants that receive a well-woman visit to 65 percent.

Calendar Year 4 Objective: By 12/31/2022 increase proportion of HS women participants that receive a well-woman visit to 75 percent.

Calendar Year 5 Objective: By 12/31/2023, increase proportion of HS women participants that receive a well-woman visit to 80 percent.

Baseline: For calendar year 2017, baseline is 40 percent (Source: Program Data System, obtained 10/1/2017)

Benchmarks

Applicants shall report annually on progress toward achieving the 19 HS benchmark goals. Failure to ensure compliance with reporting requirements once an award is made may result in further actions or conditions during post-award monitoring. (see 45 CFR § 75.371 Remedies for noncompliance).

i.   Increase the proportion of HS women and child participants with health insurance to 90 percent (reduce uninsured to less than 10 percent).
ii.   Increase the proportion of HS women participants who have a documented reproductive life plan to 90 percent.
iii.   Increase the proportion of HS women participants who receive a postpartum visit to 80 percent.
iv.   Increase proportion HS women and child participants who have a usual source of medical care to 80 percent.
v.   Increase proportion of HS women participants that receive a well-woman visit to 80 percent.
vi.   Increase proportion of HS women participants who engage in safe sleep practices to 80 percent.
vii.   Increase proportion of HS child participants whose parent/ caregiver reports they were ever breastfed or pumped breast milk to feed their baby to 82 percent.
viii.   Increase proportion of HS child participants whose parent/ caregiver reports they were breastfed or fed breast milk at 6 months to 61 percent.
ix.   Increase the proportion of pregnant HS participants that abstain from cigarette smoking to 90 percent.
x.   Reduce the proportion of HS women participants who conceive within 18 months of a previous birth to 30 percent.
xi.   Increase proportion of HS child participants who receive the last age-appropriate recommended well child visit based on AAP schedule to 90 percent.
xii.   Increase the proportion of HS women participants who receive depression screening and referral to 100 percent.

xiii. Increase proportion of HS women participants who receive intimate partner violence (IPV) screening to 100 percent.

xiv. Increase proportion of HS women participants that demonstrate father and/or partner involvement (e.g., attend appointments, classes, etc.) during pregnancy to 90 percent.

xv. Increase proportion of HS women participants that demonstrate father and/or partner involvement (e.g. attend appointments, classes, infant/child care) with their child participant to 80 percent.

xvi. Increase the proportion of HS child participants aged <24 months who are read to by a parent or family member 3 or more times per week to 50 percent.

xvii. Increase the proportion of HS programs with a fully implemented Community Action Network (CAN) to 100 percent.

xviii. Increase the proportion of HS programs with at least 25 percent community members and HS program participants serving as members of their CAN to 100 percent.

xix. Increase the proportion of HS programs who establish a QI and performance monitoring process to 100 percent.

Use standardized HS screening tools for data collection

Your program must use the standardized HS screening tools[17] for collection of universal data elements. Your program must be ready and able to report on data collected through the screening tools. Your program must ensure organizational approvals are in place to do so (e.g., Internal Review Board, data use agreements, etc.).

Please respond using the corresponding outline numbers under each category (e.g., 2.i., 2.ii., 2.iii…):

i. Describe your system for acquiring or collecting client/participant-level data and monitoring individual and participant group outcomes, including reports to HRSA. This data will be collected monthly.

ii. Provide details on your program's data collection system, including case management\care coordination, process, and outcome data.

iii. Describe how your program will measure progress towards achieving the benchmarks.

iv. Describe your process and plan for program monitoring activities, which includes process and outcome measurements.

v. Discuss your proposed process for assessing community resources, capacities, and risks (e.g., mapping).

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[17] https://healthystartepic.org/healthy-start-implementation/screening-tools/

3. *Quality Improvement*

Your program is expected to engage in quality improvement (QI) efforts informed by participant-level, program-level and community-level data.

i. Describe how your program will identify opportunities for QI (i.e., to close the gap between knowledge and practice) related to your activities, services, and supports, as well as for the program as a whole.

ii. Describe the systems and processes your program will implement to support QI activities deciding on a methodology to use, stating metrics for change, implementing the project, measuring progress through analysis, and then data reporting.

iii. Describe how your program will 1) have the capacity and leadership support to collect and analyze data (including at the individual program participant level) in order to identify opportunities for QI; 2) describe how you will collect and use "real time" data for QI and must identify specific QI aims and measures your program intends to use during the grant period; and 3) describe how you will collect data in a way that facilitates reporting and data submission to HRSA.

iv. Describe how your program will use ongoing QI processes, including a process for submitting to HRSA an annual QI plan. Provide details on the collaborative QI activities your program will undertake with community partners or other service providers. Your plan should include overall management approach, specific aims and measures, process and activities, measurement plan and analysis. Provide details on results of past QI activities, if applicable. Please submit the QI plan in Attachment 7.

4. *Conduct Local Evaluation*

Your local evaluation should be an assessment of HS recipient activities during the 5-year period of performance. The findings from the local evaluation should cascade from the initial needs assessment submitted at the beginning of the period of performance. Your HS program should continue to refer to the needs assessment findings throughout the period of performance and monitor progress to identify opportunities for QI.

Your local evaluations must be conducted by an independent evaluator. Your application is expected to include an evaluation plan for the 5-year period of performance. A description of progress to implement the evaluation plan will be due annually, when submitting your annual non-competing progress report.

Your application must describe your plan for program evaluation. This plan should document process, impact, and outcomes. The program evaluation should monitor ongoing processes and the progress towards the goals and objectives of the project. Include descriptions of the inputs (e.g., organizational profile, collaborative partners, key staff, budget, and other resources), key processes, and expected outcomes of the funded activities.

See Section <u>VI.3. Reporting</u> for a list of performance measures associated with the Assure Impact and Effectiveness approach.

▪ *ORGANIZATIONAL INFORMATION -- Corresponds to Section V's Review Criterion 5 (Resources and Capabilities)*

Applicant organizations should have sound systems, policies, and procedures in place for managing funds, equipment, and personnel to receive grant support.

All successful recipients must perform a substantive role in carrying out project activities and not merely serve as a conduit for an award to another party or to provide funds to an ineligible party.

The recipient organization will hire key personnel, will be responsible for communication with the consortium organization (if applicant is a consortium, it will be responsible for communication within the consortium and with the community), and will coordinate the preparation and submission of required reports and continuation grant applications for future years. The recipient will have primary responsibility for monitoring the progress of the project toward its objectives, including monitoring contract deliverables.

Please respond using the corresponding outline numbers (e.g., i., ii., iii…):

i. Succinctly describe your organization's current mission and structure, scope of current activities, and how these elements all contribute to the organization's ability to conduct the program requirements and meet program expectations.
ii. Describe your (applicant) agency, its history, past experiences, and current capacities in MCH, especially in community-based initiatives.
iii. Discuss how the organization will follow the approved plan, as outlined in the application, properly account for the federal funds, and document all costs to avoid audit findings.
iv. Provide an organizational chart of the agency, including how the administration and the fiscal management of the proposed project will be integrated into the current administration.
v. Include a brief synopsis of the Project management approach/activities planned for this project. Also, include a chart to show communication and supervision/monitoring pathways with project staff, contractors, and the Consortium.
vi. Summarize the coordination among key program, fiscal, and evaluation staff. Identify to what extent members of each group will work jointly on monitoring and technical assistance activities; outline the methodologies for soliciting, awarding, and the fiscal and program monitoring of contracts and subcontracts.
vii. Briefly describe methodologies that will be used for monitoring utilization of services and quality assurance (including client satisfaction) of all activities and services.

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.	

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

Additional Funding to Address Maternal Mortality and Severe Maternal Morbidity

The HS program is an important resource for addressing maternal mortality and severe maternal morbidity within the communities served by HS projects. HRSA will increase support to HS recipients to hire clinical service providers (e.g., nurse practitioners, certified nurse midwives, physician assistants, and other maternal-child advance practice health professionals). These clinical providers will enable HS recipients nationwide to expand their capacity to provide direct access to well-woman care and maternity care services to reduce barriers and help address health disparities among high-risk and underserved women. These clinical providers will also support health educators by conducting training on the identification of maternal early warning signs in order to prevent obstetric emergencies. You may request up to $120,000 above the base HS award for each year to support these activities in your application submitted under this NOFO. You must provide a plan to support these activities in Attachment 11 of your application, as well as a separate budget narrative and budget forms.

iii. Budget

See Section 4.1.iv of HRSA's *SF-424 Application Guide*. Please note: the directions offered in the SF-424 Application Guide may differ from those offered by Grants.gov. Follow the instructions included in the 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 can 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) incurred by the recipient to carry out a HRSA-supported project or activity. Total project or program costs include costs charged to the award and costs borne by the recipient to satisfy a matching or cost-sharing requirement, as applicable.

The Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019 (P.L. 115-245), Division B, § 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 FY, as required by law.

iv. Budget Narrative

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

Include a separate budget narrative for your plan to *Plan to Expand Clinical Support To Address Maternal Mortality and Severe Maternal Morbidity* provided in Attachment 11.

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. You must clearly label **each attachment**.

Attachment 1: Transmittal Letter
Your transmittal letter is a required attachment to your application. It must clearly and completely address the eligibility criterial described in Section III.

Attachment 2: Work Plan
Attach the work plan for your project that includes all information detailed in Section IV. ii. Project Narrative. If you will make subawards or expend funds on contracts, describe how your organization will ensure proper documentation of expenditures.

Attachment 3: Staffing Plan and Job Descriptions for Key Personnel (see Section 4.1. of HRSA's SF-424 Application Guide)
Keep each job description to one page in length as much as is possible. Include the role, responsibilities, and qualifications of proposed project staff. Also, please include a description of your organization's timekeeping process to ensure that you will comply with the federal standards related to documenting personnel costs.

Attachment 4: Biographical Sketches of Key Personnel
> Include biographical sketches for persons occupying the key positions described in Attachment 3, not to exceed two pages in length per person. In the event that a biographical sketch is included for an identified individual not yet hired, include a letter of commitment from that person with the biographical sketch.

Attachment 5: 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 6: Project Organizational Chart
> Provide a one-page figure that depicts the organizational structure of the project.

Attachment 7: Tables, Charts, etc.
> To give further details about the proposal (e.g., Gantt or PERT charts, flow charts).

Attachment 8: For Multi-Year Budgets--5th Year Budget (NOT counted in page limit),
> After using columns (1) through (4) of the SF-424A Section B for a 5-year period of performance, you will need to submit the budget and narrative justification for the 5th year as an attachment. Use the SF-424A Section B. See Section 4.1.iv of HRSA's *SF-424 Application Guide*.

Attachment 9: Request for Funding Factors (for competing continuations only)
> To receive a funding priority, include a statement that you are eligible for a funding priority and identify the priority. Include documentation of this qualification. See Section V.2.

Attachment 10: Progress Report

(FOR COMPETING CONTINUATIONS ONLY)

A well-documented progress report is a required and important source of material for HRSA in preparing annual reports, planning programs, and communicating program-specific accomplishments. The accomplishments of competing continuation applicants are carefully considered; therefore, you should include previously stated goals and objectives in your application and emphasize the progress made in attaining these goals and objectives. HRSA program staff reviews the progress report after the Objective Review Committee evaluates the competing continuation applications. See Section V.2 Review and Selection Process for a full explanation of funding factors.

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

(1) <u>The period covered</u> (dates).

(2) <u>Specific objectives</u> - Briefly summarize the specific objectives of the project.

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

HRSA will assign up to 3 priority points for prior performance. Priority points will be given based on data submitted to HRSA in the last progress report (Benchmarks), and the HS aggregate data reporting (total served).

For current recipients with an April 1 budget period start date: Benchmark data reporting period is January 1, 2016 - December 31, 2016.

For current recipients with a November 1 budget period start date: Benchmark data reporting period is January 1, 2017- December 31, 2017.

Priority 1: Number of pregnant program participants served. (1 point)
You can request priority points (via **Attachment 9**) if: In CY2017, you met the required number of pregnant program participants served. Priority 1 will be verified by monthly aggregate and/or the Healthy Start Monitoring and Evaluation Data monthly client-level data.

Priority 2: Total number of total participants served. (1 point)
You can request priority points (via **Attachment 9**) if: In CY2017, you met the required total number of program participants served

Priority 3: Benchmarks. (1 point)
You can request priority points (via **Attachment 9**) if: In CY2017, you met 14 out of 19 program performance measures (benchmarks)

Attachment 11: Plan to Expand Clinical Support To Address Maternal Mortality and Severe Maternal Morbidity

(THIS ATTACHMENT IS ONLY REQUIRED IF YOU WOULD LIKE TO BE CONSIDERED FOR THE ADDITIONAL ANNUAL FUNDING OF $120,000. Applying for this funding will not impact the Healthy Start Initiative: Eliminating Disparities in Perinatal Health application score. HRSA staff will evaluate your plan separately.)

Provide a plan for the use of additional funds to hire clinical professionals (directly or through contract) to expand your capacity to provide direct access to well-woman care and maternity care services to reduce barriers and help

address health disparities among high-risk and underserved women. These clinical providers will also support health educators by conducting training on the identification of maternal early warning signs in order to prevent obstetric emergencies. The plan should:

    i.   Discuss the need for these services in the community and among the population that you plan to serve.

    ii.   Discuss your current capacity to provide these services, including the types of services currently provided and the number and type of staff who provide those services.

    iii.   Discuss activities you will undertake to expand your capacity to provide these services, including, as appropriate, the number and type of clinical practitioners to be hired, the types of services that will be provided to clients and Healthy Start staff members.

    iv.   Indicate whether you will use the funds directly to hire clinical practitioners or provide a sub-award to a health service provider in the community.

    v.   Discuss how your plan will improve direct access to well woman care and maternity care services for high-risk clients, how additional clinical practitioners will expand staff and community knowledge by providing information and training on maternal early warnings, and your plan will improve maternal and infant health outcomes for program participants.

    vi.   Indicate the number of at high risk for maternal mortality, severe maternal morbidity and infant mortality who will receive clinical services needed to reduce their level of risk as a result of this effort.

You will also need to submit a separate delineated budget narrative to support your plan. See instructions for the budget narrative and budget forms above. Please detail in the budget narrative how you will seek 3rd party reimbursements for the services provided by the new clinical service providers.

Attachments 12-15: Other Relevant Documents

3. Dun and Bradstreet Data Universal Numbering System (DUNS) Number and System for Award Management

You must obtain a valid DUNS number, also known as the Unique Entity Identifier, for your organization/agency and provide that number in the application. You must also register with the System for Award Management (SAM) and continue to maintain active SAM registration with current information at all times during which you have an active federal award or an application or plan under consideration by an agency (unless the applicant is an individual or federal agency that is exempted from those requirements under 2 CFR § 25.110(b) or (c), or has an exception approved by the agency under 2 CFR § 25.110(d))**.**

HRSA may not make an award to an applicant until the applicant has complied with all applicable DUNS and SAM requirements and, if an applicant has not fully complied with

the requirements by the time HRSA is ready to make an award, HRSA may determine that the applicant is not qualified to receive an award and use that determination as the basis for making an award to another applicant.

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

The Grants.gov registration process requires information in three separate systems:
- Dun and Bradstreet (http://www.dnb.com/duns-number.html)
- System for Award Management (SAM) (https://www.sam.gov)
- Grants.gov (http://www.grants.gov/)

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

UPDATED <u>SAM.GOV</u> ALERT: For your SAM.gov registration, you must submit a <u>notarized letter</u> appointing the authorized Entity Administrator. The review process changed for the Federal Assistance community on June 11, 2018. Read the <u>updated FAQs</u> to learn more.

SAM.gov is experiencing high volume and delays. If you have tried to create or update your SAM.gov registration but have not been able to complete the process, you may not be able to apply for a HRSA funding opportunity via Grants.gov in a timely manner prior to the application deadline. If so, please email DGPwaivers@hrsa.gov, per the instructions in Section 3.6 of your HRSA Application Guide.

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 *November 27, 2018 at 11:59 p.m. Eastern Time*. HRSA suggests submitting applications to Grants.gov at least **3 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 *Healthy Start Initiative: Eliminating Disparities in Perinatal Health Program* is 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 5 years, at no more than $950,000 for year 1 and up to $980,000 for years 2 – 5 (inclusive of direct **and** indirect costs). 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.

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 of applications and to assist you in understanding the standards against which your application will be reviewed. HRSA has developed 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. See the review criteria outlined below with specific detail and scoring points.

These criteria are the basis upon which the reviewers will evaluate and score the merit of the application. The entire proposal will be considered during objective review, except for the competing continuations' progress report, which will be reviewed by HRSA program staff after the objective review process.

Review criteria are used to review and rank applications. The *Healthy Start Initiative: Eliminating Disparities in Perinatal Health program* has six review criteria:

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

The extent to which the application demonstrates the problem and associated contributing factors to the problem.

- ▪ The extent to which the proposed plan describes improving perinatal outcomes,

promoting women's, infant and family health, and reducing racial/ethnic differences in rates of infant death (2 points).

- The extent to which the application demonstrates the need(s) of the target population, and are adequately described and supported with demographic and health statistics in the needs assessment (3 points).

- The extent to which the application describes the size, demographic characteristics, prevalent norms, health behaviors, assets, and problems of the target population (3 points).

- The extent to which the proposed plan addresses the documented need(s) of the target population including attention to the cultural and linguistic needs of program participants (2 points).

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

The extent to which the proposed project responds to the program requirements and expectations included in the program description. The strength of the proposed goals and objectives and their relationship to the identified project. The extent to which the activities (scientific or other) described in the application are capable of addressing the problem and attaining the project objectives.

- The extent to which the proposed plan comprehensively describes methods to address the multiple components of three HS approaches: improving women's health, improving family health and wellness, and promoting systems change (10 points).

- The extent to which the project objectives incorporate the specific HS program purposes and are measurable, logical, and appropriate in relation to both the specific problems and interventions identified (5 points).

- The extent to which the work plan activities proposed for each HS approach appear feasible and likely to contribute to the achievement of the project's objectives within each budget period (5 points).

- The extent to which the application has identified challenges and proposed feasible responses to resolve challenges (5 points).

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

The strength and effectiveness of the method(s) proposed to improve, monitor, and evaluate the project results. Evidence that the evaluative measures will be able to assess: 1) the extent the program met its objectives, and 2) the extent to which these changes can be attributed to the program.

- The extent to which the proposed evaluation plan addresses the HS approach to assure impact and effectiveness that includes a feasible and valid plan for program evaluation that monitors the progress towards goals and objectives (5 points).

- The extent to which the program has the necessary infrastructure and plan to collect, maintain, and report quality program data (e.g., a functional electronic data system, program capacity to analyze and report data on a routine basis) (5 points).

- The extent to which the proposed QI plan describes an ongoing/continuous overall management approach, monitoring plan, process and activities, measurement and analysis, and quality assurance activities to support improvement (5 points).

Criterion 4: IMPACT (15 points) – Corresponds to Section IV's Evaluation and Technical Support Capacity

The extent to which the proposed project has a public health impact and the project will be effective, if funded. This may include: the effectiveness of plans for dissemination of project results, the impact results may have on the community or target population, the extent to which project results may be national in scope, the degree to which the project activities are replicable, and the sustainability of the program beyond the federal funding.

- The extent to which the proposed plan describes sustainable and/or replicable activities in the areas of improving women's health, improving family health and wellness, and assuring impact and effectiveness through workforce development, data collection, QI, performance monitoring, and evaluation (5 points).

- The extent to which the community action plan proposes to work with other programs and activities serving the MCH population to promote systems change through community, regional, and national level leadership (5 points).

- The extent to which the application describes how the program will sustain the project efforts through new or existing sources and/or to acquire additional resources, and the strength/feasibility of the proposed sustainability plan (5 points).

Criterion 5: RESOURCES/CAPABILITIES (25 points) – Corresponds to Section IV's Organizational Information

The extent to which the project personnel are qualified by training and/or experience to implement and carry out the project. The capabilities of the applicant organization and the quality and availability of facilities and personnel to fulfill the needs and requirements of the proposed project.

- The extent to which the proposed approach delineates the interventions included in the plan, and identifies the actual or anticipated agencies and resources that will be used to implement those strategies (5 points).

- The extent to which the program design and staffing plan will fully meet all program approaches, services, and functions (5 points).

- The extent to which the application has demonstrated the successful ability to maximize and coordinate existing resources, provide fiscal and programmatic contract monitoring system, and acquire additional resources (5 points).

- The extent to which the program demonstrates expertise and experience of the applicant agency to carry out, and manage a maternal and child health promotion, case management\care coordination and service coordination approach supporting the proposed activities within the proposed target area directed at the proposed target population (5 points).

- The extent to which the program demonstrates the capacity, expertise and experience of the applicant agency to carry out, coordinate, and lead a complex, integrated, community-driven approach to the proposed activities within the proposed target area directed at the proposed target population (5 points).

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

The reasonableness of the proposed budget for each year of the period of performance in relation to the objectives, the complexity of proposed activities, and the anticipated results.

- The extent to which the costs, as outlined in the budget and resources sections, are reasonable to improving perinatal outcomes, promoting women's, infant and family health, and reducing racial/ethnic differences in rates of infant death.

- The extent to which key personnel have adequate time devoted to the project to achieve project objectives, and deliver quality outcomes to address the HS approaches: improving women's health, improving family health and wellness, promoting systems change, and assuring impact and effectiveness.

2. Review and Selection Process

The independent 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. In addition to the ranking based on merit criteria, HRSA approving officials will apply other factors below in award selection (e.g., past program performance, geographic dispersion, preference for rural areas etc.).

In making final award decisions, HRSA will take into consideration the number of awards for projects serving rural areas, the number of awards per state, and the number of awards proposing to serve any given service area. Specifically:

- HRSA plans to fund approximately 100 grant awards, depending on the availability of funds. Absent other considerations, HRSA will fund approximately the 100 highest scoring applications to achieve this goal.
- Up to 25 applications proposing to serve rural areas will be funded.
- If there are not 25 applications proposing to serve rural areas among the highest scoring applications, HRSA may fund applications with lower scores in order to reach 25 grants serving rural areas. However, HRSA will only do this if there are applications proposing to serve rural areas that score within 5 points of the cut off score for the highest scoring applications that would be funded absent other considerations.
- An application will not be funded if there are 6 other applications from the state that receive a higher score.
- An application will not be funded if a higher scoring application is received that proposes to serve any of the same service area. If multiple applications are submitted that propose to serve any of the same overlapping target area, HRSA will only fund the highest scoring application.

In making final award decisions, HRSA may take into consideration the geographic distribution of applicants, per 45 CFR part 75, Appendix 1 (E) (2).

PLEASE NOTE: In order to achieve the distribution of awards as stated above, HRSA may need to fund out of rank order.

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

Funding Factors
This program includes priority points. Priority points are the favorable adjustment of combined review scores of individually approved applications when applications meet specified criteria. The Healthy Start Initiative program has three funding priorities. HRSA will assign up to 3 priority points for prior performance. Priority points will be given based on data submitted to HRSA in the last progress report (Benchmarks), and the HS aggregate data reporting (total served).

For current recipients with an April 1 budget period start date: Benchmark data reporting period is January 1, 2016-December 31, 2016.

3. Assessment of Risk and Other Pre-Award Activities

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.

Effective January 1, 2016, HRSA is required to review and consider any information about your organization that is in the [Federal Awardee Performance and Integrity Information System (FAPIIS)](). You may review and comment on any information about your organization that a federal awarding agency previously entered. HRSA will consider any of your comments, in addition to other information in [FAPIIS]() in making a judgment about your organization's integrity, business ethics, and record of performance under federal awards when completing the review of risk posed as described in 45 CFR § 75.205 HHS Awarding Agency Review of Risk Posed by Applicants.

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

4. Anticipated Announcement and Award Dates

HRSA anticipates issuing/announcing awards prior to the start date of April 1, 2019.

VI. Award Administration Information

1. Award Notices

HRSA will issue the Notice of Award prior to the start date of April 1, 2019. 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]()*.

Requirements of Subawards
The terms and conditions in the Notice of Award (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. See [45 CFR § 75.101 Applicability]() for more details.

Human Subjects Protection
Federal regulations ([45 CFR part 46]()) require that applications and proposals involving human subjects must be evaluated with reference to the risks to the subjects, the adequacy of protection against these risks, the potential benefits of the research to the subjects and others, and the importance of the knowledge gained or to be gained. If you anticipate research involving human subjects, you must meet the requirements of the HHS regulations to protect human subjects from research risks.

3. **Reporting**

The Discretionary Grant Information System (DGIS) reporting system will continue to be available through the Electronic Handbooks (EHBs). HRSA enhanced the DGIS and these improvements are available for recipient reporting. The agency will communicate with recipients and provide instructions on how to access the system for reporting. HRSA will also provide technical assistance via webinars, written guidance, and one-on-one sessions with an expert, if needed.

The updated and final reporting package incorporating all OMB-accepted changes can be reviewed at:

https://mchb.hrsa.gov/data-research-epidemiology/discretionary-grant-data-collection (OMB Number: 0915-0298 Expiration Date: 06/30/2019).

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

1) **Progress Report(s)**. The recipient must submit a progress report to HRSA on an **annual** basis, which should address progress against program outcomes, including any expected outcomes in the first year of the program. Further information will be available in the award notice.

2) **Final Report Narrative.** The recipient must submit a final report narrative to HRSA 90 days after the conclusion of the project.

3) **Performance Reports.** HRSA modified its reporting requirements for Special Projects of Regional and National Significance projects, Community Integrated Service Systems projects, and other grant/cooperative agreement programs to include national performance measures that were developed in accordance with the requirements of the Government Performance and Results Act (GPRA) of 1993 (Public Law 103-62). GPRA requires the establishment of measurable goals for federal program that can be reported as part of the budgetary process, thus linking funding decisions with performance. Performance measures for states have also been established under the Block Grant provisions of Title V of the Social Security Act.

a) **Benchmarks, Performance Measures and Program Data**

The HS Program established benchmarks and goals for performance. Achievement of benchmarks will be evaluated using the data submitted for the HS performance measures. Data for the performance measures is reported in the Discretionary Grants Information System (DGIS). Your HS program is required to collect data and demonstrate progress towards meeting program goals. Your program will collect and report data to HRSA in three ways.

You are expected to:
- Use the HS Screening Tools to collect individual client-level data.

- Submit HS aggregate data on a monthly basis (e.g., participant demographics, number of participants served, live births, low birth weight births, preterm births, infant deaths, breastfeeding initiation and duration, prenatal care, tobacco use, abstaining from substance use, postpartum care visits, etc.).
- Collect data to report indicators for the HS performance measures.

A listing of administrative forms and performance measures for this program are presented in the table below, to assist successful applicants awarded a grant. This information may also be accessed at https://perf-data.hrsa.gov/mchb/DgisApp/FormAssignmentList/h49_4.HTML.

Prorgram reporting requirements may be updated during the project period.

Administrative Forms:

Form 1	MCHB Project Budget Details for FY____	Reporting Period
Form 2	Project Funding Profile	Budget Year
Form 3	Budget Details By Types Of Individuals Served For Projects Providing Direct Health Care, Enabling, or Population-based Services	Budget Year
Form 4	Project Budget And Expenditures By Types Of Services	Budget Year
Form 5	Number Of Individuals Served (Unduplicated) By Type Of Individual And Source Of Primary Insurance Coverage For Projects Providing Direct Health Care, Enabling Or Population-Based Services	Calendar Year
Form 6	Maternal & Child Health Discretionary Grant Project Abstract For FY____	Budget Year
Form 7	Discretionary Grant Project Summary Data	Calendar Year

Additional Data Elements:

Products, Publications, and Submissions Data Collection Form	Budget Year
Healthy Start Site Form	Budget Year

Performance Measures:

PM	Topic	*Assigned Sections	Reporting Period
Core 1	Grant Impact	Tier 1	Calendar Year
Core 2	Quality Improvement	All	Calendar Year
Core 3	Health Equity – MCH Outcomes	All	Calendar Year
CB 4	The percent of MCHB funded initiatives working to promote sustainability of their	Tier 1 and 2	Calendar Year

	programs or initiatives beyond the life of MCHB funding.		
CH 1	Well Child Visit	Tier 1, 2, 3, and % of children who received recommended well child visits in Tier 4	Calendar Year
LC1	Adequate Health Insurance Coverage	Tier 1, Tier 2, 3, and *percent with health insurance* in Tier 4	Calendar Year
LC2	Tobacco and eCigarette Cessation	Tier 1, Tier 2, and *percent of prenatal program participants that abstain from smoking cigarettes in their third trimester* in Tier 4	Calendar Year
WMH1	Prenatal Care	Tier 1, Tier 2, 3, and Tier 4	Calendar Year
WMH2	Perinatal/ Postpartum Care	Tier 1, Tier 2, 3, and Tier 4	Calendar Year
WMH3	Well Woman Visit/ Preventive Care	Tier 1, Tier 2, 3, and Tier 4	Calendar Year
WMH4	Depression Screening	Tier 1, Tier 2, 3, and Tier 4	Calendar Year
PIH1	Safe Sleep	Tier 1, Tier 2, 3, and Tier 4	Calendar Year
PIH2	Breast Feeding	Tier 1, Tier 2, 3, and Tier 4	Calendar Year
HS 01	Reproductive Life Plan	ALL	Calendar Year
HS 02	Usual Source of Care		Calendar Year
HS 03	Interconception Planning	ALL	Calendar Year
HS 04	Intimate Partner Violence Screening	ALL	Calendar Year
HS 05	Father/ Partner Involvement during Pregnancy	ALL	Calendar Year
HS 06	Father and/or Partner Involvement with Child 0-24 Months	ALL	Calendar Year
HS 07	Daily Reading	ALL	Calendar Year
HS 08	CAN implementation	ALL	Calendar Year
HS 09	CAN Participation	ALL	Calendar Year

Although Tier 4 is Optional in the EHB, HS recipients are required to complete Tier 4, where indicated.

b) **Performance Reporting Timeline**

Successful applicants receiving HRSA funds will be required, within 90 days of the period of performance start date, to register in HRSA's EHBs and electronically complete the program-specific data forms that are required for this award. You are required to provide budget breakdowns in the financial forms based on the award amount, your project abstract and other grant/cooperative agreement summary data, as well as providing objectives for the performance measures.

You must submit a performance report annually, for each performance year.   You are required to log into HRSA's EHBs and complete the program-specific forms, within 90 days of the budget period start date. You will provide expenditure data, a final abstract summarizing your program, grant/cooperative agreement summary data, and final indicators/scores for each performance measure.

c) **Period of Performance End Performance Reporting**

Successful applicants who receive HRSA funds will be required, within 90 days from the end of the performance period, to electronically complete the program-specific data forms that appear for this program in EHB. The requirement includes providing expenditure data for the final year of the period of performance, the project abstract and grant/cooperative agreement summary data as well as final indicators/scores for the performance measures. Failure to comply with grant requirements may result in the restriction of funds or a withholding of future funds.

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

VII. Agency Contacts

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

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

Email: TRandall@hrsa.gov

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

Benita Baker, MS
Chief, West Branch, Division of Healthy Start and Perinatal Services
Attn: Healthy Start
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane, Room 18N-23
Rockville, MD 20857
Telephone: (301) 443-0543
Email: MCHBHealthyStart@hrsa.gov

M. Sonsy Fermin, MSW, LCSW
Acting Chief, East Branch, Division of Healthy Start and Perinatal Services
Telephone: (301) 443-1504
Email: MCHBHealthyStart@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 HRSA's 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

<mark>HRSA has scheduled following technical assistance:</mark>

<mark>*Webinar*</mark>

<mark>Day and Date: Thursday, October 25, 2018</mark>
<mark>Time: 2 p.m. – 4 p.m. ET</mark>
<mark>Call-In Number: 1-888-790-2035</mark>
<mark>Participant Code: 7526454</mark>
<mark>Weblink: https://hrsaseminar.adobeconnect.com/healthystart_nofo_ta/</mark>

<mark>The recording will be posted in 5 business days on the MCHB website at</mark>
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 A: Glossary of Terms

Adverse Childhood Experiences (ACE): Exposure to abuse, neglect, violence, and other stressors.

Aim Statement: A written, measurable, and time-sensitive description of the accomplishments the team expects to make from its improvement efforts. This statement answers the question: "What are we trying to achieve?"

Annual Performance Indicator: For each HS performance measure, the percentage or rate resulting from dividing the numerator by the denominator as specifically defined in the measure. This indicator should show how your project is progressing towards achieving one of your period of performance objectives.

Below 100 Percent of the Federal Poverty Guidelines: Annual income for the client's family compared to the federal poverty guidelines. Record at enrollment as percentage of level for a family of the same size. Annual income data can be estimated from monthly data, if necessary (Monthly income x 12). Recipients may wish to record information on income and family size and calculate poverty levels separately, or enter only the computed poverty level for the client. The federal poverty level is updated annually in January and published in the Federal Register.

Benchmarks: A means of assessing progress on a select group of outcomes and activities, which are common to all HS projects.

Budget Period: The interval of time (usually 12 months) into which the period of performance is divided for budgetary and funding purposes.   For the purposes of this NOFO, the Budget Period is April 1 – March 31.

Community Action Network (CAN) Training (Number of Individual Members Trained): Number of individual CAN members participating in formalized HS funded CAN training.

Capacity: Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policymaking activities. Program capacity measures the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcomes, and risk factors. Program capacity results should answer the question, "What does the Project Area need to achieve the desired results?

Case Management\Care Coordination **Services**: Healthy Start's Case Management/Care Coordination is the provision of services in a coordinated, culturally competent manner. The collaborative process and relationship between (a) Healthy Start-affiliated provider(s) and a Healthy Start enrolled participant [and their family] during which services are provided that assist in the management of health and social needs, including participant risk screens, family needs assessments, establishment of care plans, and ensuring maintenance of referrals, tracking and follow-up systems. There must be face-to-face contacts between the provider and the participant.

Childbirth Education: Receipt of child-birth information per a pre-designed schedule/curriculum as an ongoing part of prenatal care or a formal Childbirth Education program. Childbirth education information may be provided in classes, support groups, or in one-on-one sessions. Information may be offered either directly or through an outside referral source.

Collaborative Improvement and Innovation Network (CoIIN): Teams of federal, state, and local leaders working together to tackle a common problem. Using technology to remove geographic barriers, participants with a collective vision, share ideas, best practices, and lessons learned, and track their progress toward similar benchmarks and shared goals. CoIIN provides a way for participants to self-organize, forge partnerships, and take coordinated action to address complex issues through structured collaborative learning, quality improvement, and innovative activities. Source: http://mchb.hrsa.gov/maternal-child-health-initiatives/collaborative-improvement-innovation-networks-coiins

Collaborative Innovation Network (COIN): A cyberteam of self-motivated people with a collective vision, enabled by the Web to collaborate in achieving a common goal by sharing ideas, information, and work. Source: Gloor, P.A. (2006). Swarm Creativity: Competitive Advantage through Collaborative Innovation Networks. Oxford University Press; New York, NY.

Completed Service Referral: A referral is considered completed, when the client received the services from provider(s) to whom she was referred either within or outside of the program/agency. The purpose of these referrals can be either treatment-related or preventive.

Comprehensive Approach to Women's Health Care: A system that provides a full array of health services utilizing linkages to all programs serving women.   The system must address gaps/barriers in service provision. Services provided must be appropriate to women's age and risk status, emphasizing preventive health care.   It must include the full biological life cycle of the woman and concomitant physical, mental, and emotional changes that occur.

Community Action Network (CAN): An existing, formally organized partnership, advisory board, coalition or consortia of organizations and individuals representing consumers, appropriate agencies at the State, Tribal, county, city government levels, public and private providers, churches, local civic/community action groups, and local businesses which identify themselves with the project's target project area, and who unite in an effort to collectively apply their resources to the implementation of one or more common strategies for the achievement of a common goal within that project area. The CAN should have current approved by-laws, which include policies regarding conflict of interest, to serve the needs as identified by its mission and/or statement. If the project area lies either in a federally designated Empowerment Zone/Enterprise Community, at least one member of that collaborative should also be on the HS CAN.

Community Participant: An individual who attends a HS sponsored event or participates in CAN activities, etc.

Contractor: An entity/individual with whom the recipient organization enters a binding agreement to perform one or more of the proposed services for the project according to the proposed plan, and fiscal and data reporting requirements established (and monitored) by the recipient organization. The scope of one contractor's proposed services cannot constitute the bulk of services for the proposed HS project; such sub-granting is not allowed under HRSA.

Coordinated and Integrated Systems: A component of a community's overall primary health care system which connects and offers a linked array of medical and other services to address the comprehensive needs of women and their families throughout the childbearing process (including counseling and services related to: prenatal, delivery, and postpartum periods, newborn/well baby care through the infant's first year of life, and, interconception care including family planning).

Cultural Competence: A set of values, behaviors, attitudes, and practices within a system, organization, program or among individuals which enables them to work effectively cross culturally. Further, it refers to the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time.

Direct Care: Those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, and specialty registered dietitians.

Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services.

Extremely Low Birth Weight: Live births with birth weight less than 1,000 grams. This measure is usually reported as a percentage of all live births.

Family-Centered Care: A system or philosophy of care that incorporates the family as an integral component of the health care system.

Fetal Alcohol Spectrum Disorder An umbrella term which describes a continuum of permanent birth defects caused by maternal consumption of alcohol during pregnancy, which includes, but is not limited to fetal alcohol syndrome (FAS).

Government Performance and Results Act (GPRA): Federal legislation enacted in 1993 that requires federal agencies to develop strategic plans, prepare annual plans setting performance objectives, and report annually on actual performance.

Health Disparity: As defined by Healthy People 2020 - "A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."

https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

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

Hispanic: Persons of any race who report/identify themselves as Mexican-American, Chicano, Mexican, Puerto Rican, Cuban, Central or South American (Spanish countries) or other Hispanic origin.

Infant Mortality Collaborative Improvement and Innovation Network (IM CoIIN): An MCHB-sponsored CoIIN supporting four teams to reduce infant mortality and improve birth outcomes. Participants learn from one another and national experts, share best practices and lessons learned, and track progress towards common aims using shared benchmarks.

Infant Mortality Rate: The number of deaths to infants from birth through 364 days of age. This measure is reported per 1,000 live births.

Ladder of Opportunity: The process of social advancement or the elevation to higher social classes (low, middle classes etc.) through investments such as increased access to high-quality early childhood education and strengthening families by supporting the role of fathers/male partners.

Lifecourse Theory: A multidisciplinary paradigm for conceptualizing health care needs and services that evolved from research documenting the important role early life events play in shaping an individual's health trajectory. The interplay of risk and protective factors, such as socioeconomic status, toxic environmental exposures, health behaviors, stress, and nutrition, influence health throughout one's lifetime.

Low Birthweight: The number of live births less than 2,500 grams. This measure is usually reported as a percentage of total live births.

Medical Home (AHQR):   The medical home encompasses five functions and attributes:

i. *Comprehensive Care*: The primary care medical home is accountable for meeting the large majority of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care. Providing comprehensive care requires a team of care providers.
ii. *Patient-Centered:* The primary care medical home provides primary health care that is relationship-based with an orientation toward the whole person. Partnering with patients and their families requires understanding and respecting each patient's unique needs, culture, values, and preferences.
iii. *Coordinated Care:* The primary care medical home coordinates care across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services and supports.
iv. *Accessible Services:* The primary care medical home delivers accessible services with shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team, and alternative methods of communication such as email and telephone care.
v. *Quality and Safety:* The primary care medical home demonstrates a commitment to quality and quality improvement by ongoing engagement in activities such as using evidence-based medicine and clinical decision-support tools to guide shared decision making with patients and families, engaging in performance measurement and improvement, measuring and responding to patient experiences and patient satisfaction, and practicing population health management.

Needs Assessment: A study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is aimed at determining: 1) what are prevalent and otherwise unmet needs of the target population; 2) what is essential in terms of the provision of health services to address those prevalent or unmet needs; 3) what is available; and, 4) what is missing.

Neonatal Mortality: Number of deaths reported by vital records, program records, caregiver from birth to 28 days.

Objectives: Descriptions of what is to be achieved in measurable, time framed terms. Based upon a performance indicator, objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of achievement, and target population. Each objective should include a numerator, a denominator, time frame, and a baseline with data source including year. Projects are expected to monitor their progress in accomplishing their approved period of performance objectives through the measurement of their budget period objectives.

Other eligible project area: A project area that does not fit neither the urban nor the rural definitions, and meets the other eligibility criteria.

Performance Indicator: A measurable variable developed by the recipient to measure the result or the impact, which the model is having on the target population. Example: Number of pregnant participants who report decreased smoking at a given time over the total number of pregnant participants who report that they smoke during their initial assessment.

Performance Measure: A narrative statement that describes a specific maternal and child health need, or requirement, that when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or project area and generally within a specific time frame. (Example: HS women participants that have a documented reproductive life plan.).

Performance Objective: A statement of intention against which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, and the extent of the achievement, and target populations.

Perinatal Health Systems Infrastructure: The base of the MCH pyramid of health services and form its foundation by means of activities that are directed at improving and maintaining the health status of all women and children and provide support for development and maintenance of comprehensive health services' systems and resources including development and maintenance of health services' standards/guidelines, training, data and planning systems. Examples of activities that

build infrastructure include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care.

Perinatal Period: The period occurring from preconception through the first year of life (for the infant and its family).

Period of Performance: The total time for which HS funding has been programmatically approved for a project (e.g., 4 years, 2 years). A period of performance may consist of one or more budget periods (defined above). The total period of performance comprises the original period of performance and any extensions. For the purpose of this NOFO, the 5-year period of performance is April 1, 2019 – March 31, 2024.

Post-neonatal Mortality: Number of deaths reported by vital records, program records, caregiver from 29 days to 364 days after birth.

Pregnant Woman: A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Prenatal Care: Prenatal care is medical supervision of the pregnant woman by a physician or other health care provider during the pregnancy.

Preterm Births: Live births that occur at 17 through 36 weeks of gestation.

Program Participant: An individual having direct contact with HS staff or subcontractors and receiving HS case management\care coordination services on an ongoing systematic basis to improve perinatal and infant health. Specifically, program participants are pregnant women and women of reproductive age, infants, and children up to 18 months. Participants also include fathers/male partners who are affiliated with women and/or infants who receive services from HS. Your HS program must serve, per calendar year, at least 300 pregnant women; 300 infants/children up to 18 months and preconception/interconception women; and 100 fathers/male partners. *You must case manage your program participants, and your program must be able to collect data on all HS program participants.*

Project Area: A geographic area for which improvements have been planned and are being implemented with the HS principles of: innovation, community commitment and involvement, increased access, service integration, and personal responsibility. A project area must represent a reasonable and logical catchment area. The proposed project area is identified and approved through the initial HS funding application

process.   HS services can only be provided to residents of the approved project area. Changes to this project area cannot be made without prior approval of HRSA.

Quality Improvement (QI): A process of systematic and continuous actions that lead to measurable improvement, particularly around health care services and the health status of the targeted population.

Race: Racial and ethnic categories reflect Federal Register Notice "Office of Management and Budget: Revisions to Standards for Classification of Federal Data on Race and Ethnicity; Notices" issued October 30, 1997. The response should reflect what the person considers herself to be and is not based on percentages of ancestry. Hispanic refers to those people whose origins are from Spain, Mexico, or the Spanish speaking countries of Central and South America. Origin can be viewed as the ancestry, nationality, lineage, or country in which the person or his or her ancestors were born before their arrival in the United States.

Reproductive Life Plan: A tool to assist women in determining if or when they plan to have children in the future, and in identifying family planning methods to help them fulfill their plan.

Rural Area: Project area determined rural as defined by Rural Health Grants Eligibility Advisor.

Smoking Cessation (Number of Participants Who Received):   Number of participants who have attended support groups, or one-on-one counseling sessions providing information to pregnant women, their partners, or parents of infants on a regular basis about the risks to the fetus and infant of smoking parents; and provided support and information on how to quit.

Social Capital: The expected collective or economic benefits derived from cross-sector community engagement.

Social Determinants of Health: As defined by Healthy People 2020 – "Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood) have been referred to as "place."[5] In addition to the more material attributes of "place," the patterns of social engagement and sense of security and well-being are also affected by where people live. Resources that enhance quality of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins."

Sustainability: Projects should foster community partnerships and build capacity and/or program resources that continue as needed in that community after federal funds discontinue. A sustained project is one that demonstrates the continuation of key elements of program/service components started under the HRSA-supported project.

Sustainability Plan: A set of administrative actions designed to identify and negotiate the continued financing and/or transition of project components to other entities to continue the provision of successful project services in the project area beyond the federal HS-funded period of performance.

Technical Assistance: The process of providing recipients with expert assistance of specific health related or administrative services that include: systems review planning, policy options analysis, coordination coalition building/training, data systems development, needs assessment, service cost analysis, and performance indicators.

Toxic Stress: Stress caused by extreme poverty, neglect, abuse, exposure to violence, or severe maternal depression can weaken the architecture of the developing brain, with long-term consequences for learning and both physical and mental health.

Trauma-Informed Care: An approach that is welcoming and appropriate for trauma survivors (e.g., those with ACEs or toxic stress), including avoiding re-traumatization. A trauma-informed child- and family-service approach is one in which all parties involved recognize and respond to the impact of ACEs, trauma, and toxic stress on children, caregivers, and service providers.

Urban: Territory, population, and housing units located within an urbanized area (UA) or an urban cluster (UC), which has:

  i.   a population density of at least 1,000 people per square mile; <u>and</u>
  ii.   surrounding census blocks with an overall density of at least 500 people
        per square mile.

Very Low Birth Weight: Live births with birth weight less than 1,500 grams. This measure is usually reported as a percentage of all live births.

Well Woman Visit: A preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception care and many services necessary for prenatal care.

APPENDIX B: Resource List

This is a list of some, but not all, resources that applicants may wish to consult for program development and training purposes. HRSA does not endorse or favor one over another.

Maternal/Infant Resources

Alliance for Innovation on Maternal Health (AIM):

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

AIM is a national maternal safety and quality improvement initiative focused on reducing maternal deaths and severe maternal morbidity by engaging provider organizations, state-based public health systems, consumer groups, and other stakeholders within a national partnership to assist state-based teams in implementing evidence-based maternal safety bundles. AIM is funded through a cooperative agreement with HRSA.

Centering Parenting:

http://centeringhealthcare.org/pages/centering-model/parenting-overview.php

A group model of care in which mothers and babies receive well woman/baby care as a dyad, health education, and social support. The program spans the first year of the baby's life.

Centering Pregnancy:

http://centeringhealthcare.org/pages/centering-model/pregnancy-overview.php

A program of group prenatal care in which women receive health care, education, and social support.

Collaborative Improvement & Innovation Networks (CoIINs):

https://mchb.hrsa.gov/maternal-child-health-initiatives/collaborative-improvement-innovation-networks-coiins

A list of CoIINs that are multidisciplinary teams of federal, state, and local leaders working together to address complex issues.

Infant Mortality CoIIN Prevention Toolkit:

https://www.nichq.org/infant-mortality-prevention-toolkit

This interactive toolkit features case studies, change ideas, videos, and key insights from teams who participated in the national Collaborative Improvement and Innovation Network to Reduce Infant Mortality (Infant Mortality CoIIN).

Less Than 39 Weeks Toolkit:

http://www.marchofdimes.com/professionals/less-than-39-weeks-toolkit.aspx

This toolkit, developed by the California Maternal Quality Care Collaborative and the March of Dimes, provides resources to reduce early elective deliveries before 39 weeks.

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

Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT) Program:

https://www.sophe.org/focus-areas/script/

This smoking cessation program is designed to be implemented as part of a prenatal care provider's health education program.

SUIDS/SIDS Training Toolkit:
http://www.sidscenter.org/trainingtoolkit.html

This toolkit is a collection of resources, curriculum, and programs to reduce SUIDS/SIDS.

Behavior Health Resources

Behavioral Health Workforce Scope of Practice Data Visualizations:
http://www.behavioralhealthworkforce.org/practice-data-visualizations/
a nation-wide database that identifies the behavioral health workforce by state (professionals and paraprofessionals (e.g., peer recovery support specialists).

Breastfeeding Resources

CDC Guide To Breastfeeding Interventions:
http://www.cdc.gov/breastfeeding/resources/guide.htm

This guide provides state and local communities the information to select the breastfeeding promotion strategy that best meets their needs. The guide contains affective programs targeting a range of settings.

Certified Lactation Counselor:
http://centerforbreastfeeding.org/About.htm

The Healthy Children's Center for Breastfeeding provides resources leading to certification as a Certified Lactation Counselor, (CLC) and is the premier National Certification in Lactation Management for the United States.

Cultural Competence Resources

Culturally Effective Care Toolkit:

https://www.aap.org/en-us/professional-resources/practice-transformation/managing-patients/Pages/effective-care.aspx

This toolkit by the AAP provides resources for providing culturally effective care to patients and their families.

Effective Communication Tools for Healthcare Professionals:

https://psnet.ahrq.gov/resources/resource/6442/effective-communication-tools-for-healthcare-professionals-addressing-health-literacy-cultural-competency-and-limited-english-proficiency

This free online training from HRSA aims to improve health communication through focusing on cultural competence, linguistic competence, and health literacy.

National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care:

https://www.thinkculturalhealth.hhs.gov/

These standards aim to improve health equity by providing a guide for individuals and health and healthcare organizations to promote culturally and linguistically appropriate services.

Fatherhood Resources

Fatherhood E-Learning Module:

https://www.hhs.gov/ash/oah/resources-and-training/online-learning-modules/fatherhood/index.html

An online course to educate organizations on the importance of fatherhood involvement

InsideOut Dad:

http://store.fatherhood.org/c-106-insideout-dad-program.aspx

An evidence based program for incarcerated dads to improved father involvement

National Fatherhood Initiative's 24/7 Dads:

http://store.fatherhood.org/c-2-247-dad-second-edition.aspx

Developed by fathering and parenting experts, it focuses on the characteristics men need to be good fathers/male partners 24 hours a day, 7 days a week.

Promundo:

https://promundoglobal.org/

Promundo is a global leader working to engage men and boys in partnership with women and girls for the promotion of gender justice and violence prevention.

Responsible Fatherhood Toolkit: Resources from the Field:

http://www.fatherhood.gov/toolkit

A toolkit to create a fatherhood program.

Wise Guys:

https://www.chsnc.org/educational-programs-and-training/youth-programs/wise-guys/

A curriculum which teaches young men about healthy relationships and making wise sexual decisions.

Infant/Child Resources

AAP: Healthy Child Care America: HCCA Back to Sleep Campaign:
http://www.healthychildcare.org/sids.html

A free online training on creating a safe sleep environment

Bright Futures:
http://brightfutures.aap.org/materials.html

A set of principles, strategies, and tools to promote and improve infant and child health in the context of family and community.

Connected Kids:

https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Pages/Connected-Kids.aspx

This program offers child healthcare providers a comprehensive approach to integrating violence prevention efforts in practice and the community. A central goal of the program is helping parents and families raise resilient children.

Early Brain and Child Development:

http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/EBCD/Pages/default.aspx

This initiative by the AAP strives to educate both providers and communities on the importance of the early childhood development period for future wellbeing.

Learn the Signs. Act Early.

https://www.cdc.gov/ActEarly

A program designed to improve early identification of young children with developmental delays and disabilities by promoting parent-engaged developmental monitoring and facilitating early action on concerns.

Other Resources

Florida State University Partners for a Healthy Baby:

https://www.cpeip.fsu.edu/

A home visiting curriculum from prenatal through age 3.

Healthy Start EPIC Center:

http://healthystartepic.org/

The HS EPIC Center provides support to Healthy Start recipients via training, consultation, and technical resources.

Home Visiting Evidence of Effectiveness:

https://homvee.acf.hhs.gov/

The Home Visiting Evidence of Effectiveness (HomVEE) provides an assessment of the home visiting models.

Mental Health First Aid USA:

http://www.mentalhealthfirstaid.org/cs/rural

Mental Health First Aid is a training course specifically geared towards the unique needs of rural communities. The course aims to increase mental health literacy and improve community capacity around mental health issues.

Mental Rural Community Health Workers Toolkit:

https://www.ruralhealthinfo.org/toolkits/community-health-workers

A toolkit that provides resources and best practices developed by successful community health worker programs.