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

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

Healthy Start Initiative: Eliminating Disparities in Perinatal Health

Announcement Type: New and Competing Continuation

Announcement Numbers:
HRSA-14-121, HRSA-14-120, HRSA-14-122

Catalog of Federal Domestic Assistance (CFDA) No. 93.926

FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2014

Letter of Intent Due Date: March 3, 2014

Application Due Date: March 31, 2014

Ensure your Grants.gov registration and passwords are current immediately!
Deadline extensions are not granted for lack of registration.
Registration may take up to one month to complete.

Release Date: February 14, 2014

Issuance Date: February 14, 2014

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Authority: Public Health Service Act, Title III, Part D, § 330H (42 U.S.C. 254c-8), as amended by the Healthy Start Reauthorization Act of 2007 (P.L. 110-339)

EXECUTIVE SUMMARY

HRSAs' Maternal and Child Health Bureau (MCHB), Division of Healthy Start and Perinatal Services is releasing three new and competing continuation Funding Opportunity Announcements (FOAs) for the Healthy Start Initiative: Eliminating Disparities in Perinatal Health, HRSA-14-121, HRSA-14-120 and HRSA-14-122. These three FOAs are announcing potentially available funds for the same programs as the FOAs released on December 5, 2013: HRSA-14-020, HRSA-14-112 and HRSA-14-113. The number of applications received for HRSA-14-020, HRSA-14-112 and HRSA-14-113 was much less than expected. As a result, HRSA anticipates that funds will be available to support additional applicants after completing reviews and funding decisions of applications submitted for HRSA-14-020, HRSA-14-112 and HRSA-14-113. Funding under this FOA is for an initial period of nine months (September 1, 2014 to May 31, 2015), with potential for annual continuation for an additional four years (through May 31, 2019) subject to availability of funds.

The Health Resources and Services Administration, Maternal and Child Health Bureau, Division of Healthy Start and Perinatal Services is accepting applications for fiscal year (FY) 2014 for the Healthy Start Initiative: Eliminating Disparities in Perinatal Health program. The purpose of this grant program is to improve perinatal health outcomes and reduce racial and ethnic disparities in perinatal health outcomes by using community-based approaches to service delivery, and to facilitate access to comprehensive health and social services for women, infants, and their families.

This funding opportunity announcement includes instructions for three (3) **separate grant competitions**. **Applicants are only allowed to submit <u>one</u> (1) application for <u>one</u> (1) of the Healthy Start program levels.**

HRSA-14-121: Level 1: Community-based Healthy Start (HS) Program activities will support the implementation of essential HS program activities needed to achieve five (5) approaches of the HS Model which are to: 1) improve women's health, 2) promote quality services, 3) strengthen family resilience, 4) achieve collective impact, and 5) increase accountability through quality improvement, performance monitoring, and evaluation. The Level 1 program will be responsible for individual level effects.

HRSA-14-120: Level 2: Enhanced Services Healthy Start Program activities will provide the essential HS program activities listed under Level 1: Community-based Healthy Start listed above. In addition, Level 2 program will engage in additional activities, such as stimulate community collaboration to develop a common agenda, shared measurement approach, coordinate resources, and conduct performance measurement through FIMR, PPOR, and/or MMMR. This program will be accountable to reach the entire community, thereby driving collective impact and supporting community change. Level 2 program is responsible for community level effect.

HRSA-14-122: Level 3: Leadership and Mentoring Healthy Start Program activities will provide the essential HS program activities listed under Level 1: Community-based Healthy Start and Level 2: Enhanced Services Healthy Start listed above. In addition, Level 3 supports the

provision of expanded maternal and women's health services and will support the development of a place-based initiative that will serve as the backbone or hub for the establishment of collaborative networks of organizations serving the various needs of the community – health, education, housing, labor, transportation, etc. These centers will also serve as regional and national resources in support of other Healthy Start programs and organizations working towards improving perinatal outcomes. Level 3 programs will 1) serve as a resource site for state, regional, and national action in support of other HS grantees and organizations working to improve perinatal outcomes, 2) serve as leaders and participate in the development of state/ regional/ national programs and policies, and 3) participate with other Level 3 Leadership and Mentoring HS grantees, and the Supporting Healthy Start Performance Project, in the development and implementation of a HS Collaborative and Innovation Improvement Network (HS CoIIN).

Funding Opportunity Title:	Healthy Start Initiative: Eliminating Disparities in Perinatal Health
Funding Opportunity Numbers:	**HRSA-14-121**: Level 1: Community-based Healthy Start **HRSA-14-120**: Level 2: Enhanced Services Healthy Start **HRSA-14-122**: Level 3: Leadership and Mentoring Healthy Start
Due Date for Applications:	March 31, 2014
Anticipated Total Annual Available Funding:	**HRSA-14-121**: Level 1: Community-based Healthy Start ($24,000,000) **HRSA-14-120**: Level 2: Enhanced Services Healthy Start ($4,800,000) **HRSA-14-122**: Level 3: Leadership and Mentoring Healthy Start ($8,000,000)
Estimated Number and Type of Awards:	**HRSA-14-121**: Level 1: Community-based Healthy Start (up to 32 grants) **HRSA-14-120**: Level 2: Enhanced Services Healthy Start (up to 4 grants) **HRSA-14-122**: Level 3: Leadership and Mentoring Healthy Start (up to 4 grants)
Estimated Award Amounts:	**HRSA-14-121**: Level 1: Community-based Healthy Start (up to $562,500 for the first nine months and up to $750,000 per year for the remaining four years) **HRSA-14-120**: Level 2: Enhanced Services Healthy Start (up to $900,000 for the first nine months and up to $1,200,000 per year for the remaining four years **HRSA-14-122**: Level 3: Leadership and Mentoring Healthy Start (up to $1,500,000 for the first nine months and up to $2,000,000 per year for the remaining four years)

Cost Sharing/Match Required:	No
Length of Project Period:	**HRSA-14-121**: Level 1: Community-based Healthy Start (up to four years and nine months) **HRSA-14-120**: Level 2: Enhanced Services Healthy Start (up to four years and nine months) **HRSA-14-122**: Level 3: Leadership and Mentoring Healthy Start (up to four years and nine months)
Project Start Date:	September 1, 2014
Eligible Applicants:	This competition is open to new applicants and competing continuations. An eligible applicant for funding in this competition under the Healthy Start program is any public or private entity, including an Indian tribe or tribal organization (as those terms are defined at 25 U.S.C. 450b). Community-based organizations, including faith-based organizations, are eligible to apply. An eligible applicant must have both direct fiduciary and administrative responsibility over the project. [See Section III-1 of this funding opportunity announcement (FOA) for complete eligibility information.]

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

MCHB will also host a technical assistance webcast on **Friday, February 21, 2014 from 2:00 – 4:00 pm EST** to review the FOA and answers applicants' questions. Applicants can access the webcast at : **https://hrsa.connectsolutions.com/healthystart_ta/**. Click "Enter as a Guest" and type in name. If an applicant is unable to attend the live webcast, a recording of the webcast will be available on http://www.hrsa.gov/grants/apply/assistance/healthystart/ after February 24, 2014.

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I. Funding Opportunity Description

1. Purpose

This announcement solicits applications for the *Healthy Start Initiative: Eliminating Disparities in Perinatal Health* program. The Healthy Start (HS) program aims to reduce disparities in infant mortality and adverse perinatal outcomes by: 1) improving women's health, 2) promoting quality services, 3) strengthening family resilience, 4) achieving collective impact, and 5) increasing accountability through quality improvement, performance monitoring, and evaluation. HS grants are provided to communities with rates of infant mortality at least 1½ times the U.S. national average and high rates for other adverse perinatal outcomes (e.g., low birthweight, preterm birth, maternal morbidity and mortality) in order to address the needs of high-risk women and their families before, during, and after pregnancy. HS works to reduce "the disparity in health status between the general population and individuals who are members of racial or ethnic minority groups." 42 U.S.C. § 254 c-8(e)(2)(B). HS services begin in the prenatal period and follow the woman and child through two years after the end of the pregnancy.

The Healthy Start Approach
Changes in the HS program are needed to apply lessons from emerging research and act on national recommendations. The HS approach for FY 2014 and future years will build on the long-standing program structure of focusing on individual/family health, adding greater emphasis to evidence-based practice, standardized approaches, and quality improvement. Grantees operating at each of the three levels (see Methodology in Section IV for more information on the levels) also will have increasing roles in driving community change, accountability, and collective impact.

HS is being reframed in response to both the Secretary's Advisory Committee on Infant Mortality's (SACIM) recommendations (http://www.hrsa.gov/advisorycommittees/mchbadvisory/InfantMortality/Correspondence/recommendationsjan2013.pdf) and national HS evaluation findings (available upon request) emphasizing the need for strong and ongoing evaluation and accountability at the local and Federal levels to show effectiveness and community impact. These recommendations and lessons learned from the field re-emphasize the importance of a focus on HS improving women's health before, during, and after pregnancy as a means to improve perinatal outcomes and reduce infant mortality. These recommendations also call for HS to be a community hub and assist in achievement of collective impact.

HS has a key role in strengthening families and creating the foundation for optimal infant and young child health and development, including early learning. Successful applicants will include activities and components that will support the Administration's early childhood priority on building a ladder of opportunity for all children and families. HS will be the first rung of that ladder beginning before, during, and after pregnancy and serving families for the first two years of a child's life.

HS will use the following five approaches: 1) improve women's health, 2) promote quality services, 3) strengthen family resilience, 4) achieve collective impact, and 5) increase accountability through quality improvement, performance monitoring, and evaluation. Each of the three levels of HS grantees will use these five approaches:

1. Improve Women's Health: To improve coverage, access to care, and health promotion and prevention, and health for women before, during, and after pregnancy.
2. Promote Quality Services: To provide the delivery of quality intervention services designed to link families to a medical home, focus on health promotion and prevention, and advance service coordination and systems integration, while also supporting the improved access to these services.
3. Strengthen Family Resilience: To support the ability of an individual, family, and community to cope with adversity and adapt to challenges or change.
4. Achieve Collective Impact: To maximize opportunities for community action to address social determinants of health and achieve collective impact, HS grantees will support coordination, integration, and mutually reinforcing activities among health, social services, and other providers and key leaders in the community.
5. Increase Accountability through Quality Improvement, Performance Monitoring, and Evaluation: To conduct ongoing quality improvement, performance monitoring, and evaluation activities in order to identify best practices, demonstrate implementation of evidence-based practices, and report on results.

HS grantees will provide individual services and community support to women, infants, and families using **only one** of the three levels of funding that reflect escalating levels of engagement and competencies.

HRSA-14-121: Level 1: Community-based Healthy Start (up to $562,500 for the first nine months and up to $750,000 per year for the remaining four years)

HRSA-14-120: Level 2: Enhanced Services Healthy Start (up to $900,000 for the first nine months and up to $1,200,000 per year for the remaining four years)

HRSA-14-122: Level 3: Leadership and Mentoring Healthy Start (up to $1,500,000 for the first nine months and up to $2,000,000 per year for the remaining four years)

Support of HRSA Strategic Goals
The following HRSA Strategic Goals are supported by the *Healthy Start Initiative: Eliminating Disparities in Perinatal Health:*

Goal # 1: Improve Access to Quality Health Care and Services
The HS program enhances access to care for women, infants and their families by facilitating linkages to ensure access to continuous, comprehensive health care. The program ensures that the care received is responsive to the needs of individuals in the community and is delivered or directed by well-trained providers who are able to manage or facilitate essentially all aspects of women, infant, and family health.

Goal # 2: Strengthen the Health Workforce
The HS program helps to strengthen the health workforce, specifically those individuals responsible for providing direct services, and managing program components by requiring minimum educational and training levels for all staff.

Goal # 3: Build Healthy Communities
The HS program ensures communities have a perinatal system that is responsive to the health and social needs of the MCH population, and is sustainable and robust in order to provide ongoing, coordinated, comprehensive services in the most efficient manner through effective service delivery.

Goal # 4: Improve Health Equity
The HS program promotes health equity by identifying health and social circumstances that place an individual at a disadvantage that does not allow them to achieve their full health potential. HS provides and facilitates connections and linkages with appropriate organizations to strengthen the MCH system and promote community transformation

2. Background

The Maternal and Child Health Bureau
The Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB) is charged with promoting and improving the health of the Nation's women and children by providing national leadership, and by working in partnership with States, communities, public-private partners, and families. In support of this mission, MCHB's Division of Healthy Start and Perinatal Services (DHSPS) provides administrative oversight of the federal HS program which makes available grants to communities to reduce infant mortality, reduce health disparities, and improve perinatal health outcomes.

Need for Program
Each year in the United States, approximately four million women give birth, according to data from National Center for Health Statistics. 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.

Following a plateau between 2000-2005, the infant mortality rate declined 12% overall and 16% for black infants between 2005-2011. However, the black infant mortality rate continues to be more than twice that for whites. Five leading causes account for more than half of all infant deaths; these are birth defects, short gestation and low birthweight, Sudden Infant Death Syndrome (SIDS), maternal complications, and unintentional injuries (accidental deaths).[1] There is a potential for reducing each of these causes of death, particularly among low-income families and communities.

Preterm birth (defined as birth at less than 37 completed weeks of gestation) is a key risk factor for infant death. More than two-thirds of all infant deaths occur among infants born preterm. After more than two decades of increase, there was a 9% decrease in the preterm birth rate from 2006-2011, and preterm-related infant deaths have declined most for black infants.[2] However,

[1] MacDorman M, Hoyert DL, Mathews TJ. Recent Declines in Infant Mortality in the United States, 2005-2011. *NCHS Data Brief*. No 120. Hyattsville, MD: National Center for Health Statistics. 2013. http://www.cdc.gov/nchs/data/databriefs/db120.pdf

[2] MacDorman M. National Center for Health Statistics. Presentation to the Secretary's Advisory Committee on Infant Mortality. April, 2013.

non-Hispanic black women continue to be more likely to experience preterm birth than their non-Hispanic white and Hispanic counterparts (16.8, 10.5 and 11.7 percent respectively in 2011).[3] Greater rates of preterm birth and preterm-related infant deaths among non-Hispanic blacks account for over half of the infant mortality gap compared to non-Hispanic whites.

Differences in perinatal health indicators also are related to maternal education, age (being younger than 18 or older than 35 years), income,[4] [5] disability, stress, or living in isolated urban or rural areas[6]. These are among the range of socioeconomic factors that cluster as influencing social determinants.[7] [8] Emerging research indicates that environmental, biological, and behavioral stressors occurring over the lifespan of the mother from her earliest life experiences until she delivers her own child affect pregnancy outcome.

While not all of the causes of preterm birth, birth defects, SIDS, and other causes of infant mortality are well understood, much is known about how to intervene. The HS program focuses on the factors which research shows influence the perinatal trends in high-risk communities.

Healthy Start Program
Over the past two decades, HS has evolved from a demonstration project in 15 communities to a national program of 105 grants serving communities in 196 counties across 39 States, the District of Columbia and Puerto Rico. Healthy Start grantees continue to reduce high infant mortality rates (IMR) by assuring access to culturally competent, family-centered, and comprehensive health and social services to women, infants, and their families through a community-based participatory approach. Additionally, HS grantees foster systems integration, coordination, and collaboration to advance community change and increase collective impact. HS grantees also coordinate and align with State Title V Maternal and Child Health Block Grant programs to promote cooperation, integration, and dissemination of information with statewide systems and with other community services funded under Title V.

II. Award Information

1. Type of Award

Funding will be provided in the form of a grant.

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[3] Martin JA, Hamilton BE, Ventura SJ, Osterman MHS, and Mathews TJ. Births: Final data for 2011. *National Vital Statistics Reports*; Vol 62 No 1. Hyattsville, MD: National Center for Health Statistics. 2013. http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_01.pdf
[4] Olson ME, Diekema D, Elliott BA, Renier CM. Impact of income and income inequality on infant health outcomes in the United States. *Pediatrics*. 2010 Dec; 126(6):1165-73.
[5] Smith LK, Manktelow BN, Draper ES, Springett A, Field DJ. Nature of socioeconomic inequalities in neonatal mortality: population based study. *BMJ*. 2010 Dec 2; 341:c6654.
[6] Sparks PJ, McLaughlin DK, Stokes CS. Differential neonatal and postneonatal infant mortality rates across US counties: the role of socioeconomic conditions and rurality. *J Rural Health*. 2009 Fall; 25(4):332-41.
[7] Braveman PA, Cubbin C, Egerter S, Williams DR, Pamuk E. Socioeconomic disparities in health in the United States: what the patterns tell us. *Am J Public Health*. 2010 Apr 1; 100 Suppl 1:S186-96.
[8] Livingood WC, Brady C, Pierce K, Atrash H, Hou T, Bryant T 3rd. Impact of preconception health care: evaluation of a social determinants focused intervention. *MaternMaternal Child Health J*. 2010 May; 14(3):382-91.

2. Summary of Funding

This program will provide funding during Federal fiscal years 2014 - 2018. Approximately $37 million is expected to be available annually to fund approximately forty (40) grantees under this FOA (see breakdown below). The actual amount available will not be determined until applications for the previous FOAs (HRSA-14-020, HRSA-14-112 and HRSA-14-113) are reviewed and funding decisions are made. This program announcement is subject to the appropriation of funds, and is a contingency action taken to ensure that, should funds become available for this purpose, applications can be processed, and funds can be awarded in a timely manner. Applicants may apply for a ceiling amount of up to $2 million per year, depending on the level to which the applicant applies (see below for more information on ceiling amounts for each level). The project period is four years and nine months. Funding beyond the first nine months is dependent on the availability of Congressionally-appropriated funds for "*Healthy Start Initiative: Eliminating Disparities in Perinatal Health Program*" in subsequent fiscal years, grantee satisfactory performance, and a decision that continued funding is in the best interest of the Federal Government.

HS grantees will provide individual services and community support to women, infants, and families using **only one** of the three levels of funding that reflect escalating levels of engagement and competencies.

HRSA-14-121: Level 1: Community-based Healthy Start (Ceiling amount of up to $562,500 for the first nine months and up to $750,000 per year for the remaining four years)

HRSA-14-120: Level 2: Enhanced Services Healthy Start (Ceiling amount of up to $900,000 for the first nine months and up to $1,200,000 per year for the remaining four years)

HRSA-14-122: Level 3: Leadership and Mentoring Healthy Start (Ceiling amount of up to $1,500,000 for the first nine months and up to $2,000,000 per year for the remaining four years)

It is anticipated that funding will be available for up to thirty two (32) grants for Level 1, four (4) grants for Level 2 and four (4) grants for Level 3. Level 1 grants will serve no less than 500 program participants per year. Level 2 grants will serve no less 800 program participants per year. Level 3 grants will serve no less than 1,000 program participants per year. For all levels, at least 50% of program participants should be pregnant women. Program participants must be case managed and the program must be able to collect data on all program participants.

Applicants applying for funding under this announcement must choose which Level their organization will implement in their chosen project area. **Applicants are only allowed to submit one (1) application for one (1) of the HS program levels.** If an organization submits more than one application, HRSA will consider the last application as the final submission.

Funds will be set aside for up to three (3) grants on the US/Mexico border for Level 1 funding. Funds will also be set aside for up to twenty (20) grants for projects serving rural communities for Level 1 funding. Fewer grants may be funded, depending on the outcome of the Objective Review Committee's scoring of applications. There are no set asides for Levels 2 and 3 funding.

Although it may be less, no more than a combined total of six (6) applications will be funded per state. And only one (1) project will be funded per project area. An applicant/organization/agency may only submit one (1) application.

III. Eligibility Information

1. Eligible Applicants

This is a full and open competition. New applicants and competing continuations will be considered for this funding. An eligible applicant for funding in this competition under the Healthy Start program is any public or private entity, including an Indian tribe or tribal organization (as those terms are defined at 25 U.S.C. 450b). Community-based organizations, including faith-based organizations, are eligible to apply. An eligible applicant must have both direct fiduciary and administrative responsibility over the project.

Eligible Project Area
All applicants applying for funding under this grant announcement must identify themselves as serving an urban, rural, or border community 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 must be included in the application.

Urban – 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 (RA), visit the webpage Rural Health Grants Eligibility Analyzer (http://datawarehouse.hrsa.gov/RuralAdvisor/ruralhealthadvisor.aspx?ruralByAddr=1) and enter the project area address.

US/Mexico Border – Border communities are those communities located within 62 miles/100 kilometers of the U.S./Mexico border. In order to be considered for Border Community funding, the project area and the target population to be served both have to reside within 62 miles/100 kilometers of the U.S./Mexico border.

Eligible Target Population
The target population is the population that the applicant will serve within their geographic project area. The target population may range from a single racial/ethnic group to the entire project area population. The project area for which the applicant is applying and the proposed target population within that project area must be clearly identified to confirm eligibility.

Eligibility Factors Demonstrating Need
HRSA/MCHB must be able to verify submitted data with the appropriate state/local government agency responsible for vital statistics. Border community applicants that cannot provide this

verifiable data may use the other indicators specified in the second section below. Project data for the eligibility factors for all applicants **must** be included in the application's transmittal letter and in the needs assessment section of the submitted application. The existing racial/ethnic disparities in these or other perinatal indicators should also be described in the needs assessment section of the application.

Applications that do not provide this information, in the manner described within this Funding Opportunity Announcement (FOA), will be considered ineligible and the application will be returned without review.

An applicant's target population within their proposed project area must meet the following verifiable criteria using the smallest statistical level of verifiable data available -- not to be any larger than a combination of counties (e.g. a city project should not report county-level data).

Urban and Rural Communities

Using verifiable three-year average data for calendar years 2007 through 2009, the proposed project area for communities which meet the urban or rural community definition **must meet the following indicators from the list below.**

- The **2007-2009** combined three-year infant mortality rate (IMR, infant deaths per 1,000 live births over three years) must be equal to or more than **9.9 deaths per 1,000 live births** (1.5 times the national average) **AND** there must be 20 or more infant deaths over the three years for the targeted population.

- **If the combined 2007-2009 number of infant deaths are less than (<)20, then to be eligible the following must be met:**
    - The 2007-2009 three-year average low birthweight (LBW) is equal to or more than 12.3% (1.5 times the national average) **AND** there must be 100 or more LBW births in the targeted population for the three-year period, 2007 to 2009 **OR**
    - The 2007-2009 preterm births (PTB) is equal to or more than 18.6% (1.5 times the national average) **AND** there must be 100 or more PTB births in the targeted population for the period, 2007 to 2009

- **For Levels 2 and 3, if the combined 2007-2009 IMR is less than 9.9 deaths per 1,000 live births, then to be eligible the following must be met:**
    - The applicant must demonstrate a 20% decrease in IMR in their target population for **2005-2009** (five-year combined average) and discuss how they were a significant contributor to this reduction
      AND meet at least one of the following criteria:

    - The 2007-2009 three-year average low birthweight (LBW) is equal to or more than 12.3% (1.5 times the national average) **AND** there must be 100 or more LBW births in the targeted population for the three-year period, 2007 to 2009 **OR**
    - The 2007-2009 preterm births (PTB) is equal to or more than 18.6% (1.5 times the national average) **AND** there must be 100 or more PTB births in the targeted population for the period, 2007 to 2009

US/Mexico Border Communities

Using verifiable three-year average data for 2007 through 2009, the proposed target population for project areas which meet the border community definition (i.e., within 62 miles of the U.S./Mexico border) **must have at least 1,000 births for the three year period and meet at least three (3) indicators from the list below**. If vital statistics are not available from state/local government agencies, border community applicants can use other verifiable data.

- *Percentage of women of childbearing age with diabetes is 3.1% or more*;
- *Percentage of women of childbearing age who are obese is 31.8% or more*;
- *Percentage of pregnant women entering prenatal care in the first trimester is less than 80%;*
- *Percentage of births to women who had no prenatal care is greater than 2%;*
- *Percentage of births to women who smoke is greater than 20*%;
- *Percentage of children 0-2 years old with a completed schedule of immunization is less than 60%;*
- *Percentage of children under 18 years of age with family incomes below the Federal Poverty Level exceeded 25% for 2010. If more recent verifiable poverty data is available, please provide this data and identify year and source;*
- *Percent of infants born large for gestational age (LGA) is 9.4 or greater*.

Transmittal Letter

The required transmittal letter which accompanies the application submission must clearly indicate:

- The project area for which the applicant is applying and the proposed target population within that project area that confirms eligibility. The target population is the population that the applicant will serve and will determine their eligibility. The grantee must direct the majority of their services towards the target population that makes their application eligible;
- 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 2007 through 2009 as indicated in the eligibility criteria. **No other combination of years and only a three-year average for the IMR will be accepted to confirm eligibility – any deviation from this will result in the application found to be ineligible**. (The transmittal letter is to be submitted as **Attachment 1**).

2. Cost Sharing/Matching

Cost Sharing/Matching is not required for this program.

3. Other

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

Any application that fails to satisfy the deadline requirements referenced in *Section IV.3* will be considered non-responsive and will not be considered for funding under this announcement.

NOTE: Only one application per organization may be submitted. If an organization submits more than one application, HRSA will consider the last application as the final submission.

IV. Application and Submission Information

1. Address to Request Application Package

HRSA ***requires*** applicants for this funding opportunity announcement to apply electronically through Grants.gov. Applicants must download the SF424 application package associated with this funding opportunity following the directions provided at Grants.gov.

2. Content and Form of Application Submission

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

Application Page Limit
The total size of all uploaded files may not exceed the equivalent of 100 pages when printed by HRSA. The page limit includes the abstract, project and budget narratives, attachments, and letters of commitment and support required in the *Application Guide* and this FOA. Standard OMB-approved forms are NOT included in the page limit. **We strongly urge you to print your application to ensure it does not exceed the specified page limit.**

Applications must be complete, within the specified page limit, and submitted prior to the deadline to be considered under the announcement.

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

i. Project Abstract
See Section 4.1.ix of HRSA's *SF-424 Application Guide*. Applicants **must** indicate which level of funding their organization will implement in their chosen project area. All applicants applying for funding under this grant announcement **must** also identify themselves as serving an urban, rural, or border 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 and well organized so that reviewers can understand the proposed project. Every Healthy Start project funded under this competition is **required** to address the five approaches of HS:

1. Improve women's health,

2. Promote quality services,
3. Strengthen family resilience,
4. Achieve collective impact, and
5. Increase accountability through quality improvement, performance monitoring, and evaluation.

Improve Women's Health: Four areas of activity are key for HS grantee efforts to improve the health of women before, during, and after pregnancy: a) outreach and enrollment in health coverage, b) coordination and facilitation of access to health care services; c) support for prevention, including clinical preventive services, interconception health, and health promotion; and d) assistance with reproductive life planning.

Successful applicants are encouraged to play a role in supporting the implementation of the ACA by ensuring that their participants enroll in expanded health insurance coverage beginning in 2014, use clinical preventive services, and understand the ACA consumer protections. HS grantees are urged to support program participants in applying to, and benefiting from, new affordable health care options through the Health Insurance Marketplace. Grantees also are encouraged to connect individuals with Navigators (Federally-facilitated Marketplace) or Non-Navigator Assistance Personnel (State based Marketplace or State Partnership Marketplace). These Navigators and Non-Navigator assistance personnel play a vital role in helping consumers prepare applications and find out if they qualify for premium tax credits, cost sharing reductions, Medicaid, or CHIP. In addition, HS grantees are encouraged to apply to be designated certified application counselor (CAC) organization in States with Federally-facilitated Marketplaces or State Partnership Marketplaces. As a CAC organization, HS staff will help people understand, apply, and enroll for health coverage through the Marketplace. (HS grantees can apply to be a CAC at http://marketplace.cms.gov/help-us/cac.html. Additional information can be found at http://marketplace.cms.gov).

HS supports coordination and facilitation of access to health care services for women. HS grantees will work to ensure women and families have a comprehensive medical home, as well as access to related medical, social, developmental, behavioral, educational, and informal support services. This work is grounded in HS case management/care coordination services and begins with comprehensive assessments to identify the needs of the program participant. A plan will be developed with input and sign-off by participants for multi-faceted care and support self-management goals established by the individual. HS will identify appropriate services in the community, facilitate linkages to those services, and monitor, follow-up and respond to changes in needs.

Health promotion is essential to achieving the goals of the HS program. HS grantees will promote use of ACA-defined clinical preventive services – including preconception, prenatal, and well woman care. For women with a prior adverse pregnancy outcome and/or high risks, interconception care is a core component of the HS program. To augment and reinforce clinical health care services, HS grantees will offer health promotion and education through the implementation of a participant/family-centered and inclusive team-based approach. Health promotion and education will be based on standardized curricula and core competencies to assure and enhance quality.

Unplanned or unintended pregnancies are more likely to result in adverse pregnancy outcomes, maternal stress, delayed child development, and other negative consequences.[9] Moreover, a short interval (less than 18 months) between pregnancies is a well-established risk factor for preterm birth, low birthweight, and other complications of pregnancy. A "reproductive life plan" is 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.[10] In recent years, many HS grantees have introduced reproductive life plan tools into their services. Future HS grantees will use reproductive life planning routinely.

Promote Quality: Four areas of activity are required for HS grantees to promote quality. These activities will: a) improve service coordination and systems integration, b) focus on prevention and health promotion (e.g. breastfeeding, immunization, safe sleep, family planning, smoking cessation, FASD), c) apply core competencies for the HS workforce, and d) use standardized curricula and interventions.

Service coordination and systems integration have long been a part of HS grantee efforts. While HS grantees may directly provide only limited services, they are actively involved in coordinating, linking, and integrating services at the individual and community level. This approach links women, infants, and families to community health, social, and mental health services. Building on the connections between individuals, families, and communities, HS also develops linkages to community resources. These resources are vital to the HS program, especially for strengthening local perinatal health systems infrastructure.

Integrated services include housing, employment, transportation, child care, and early childhood development services. Successful applicants should demonstrate significant involvement with MCH activities in their community, in particular Community Health Centers (CHC) and other HRSA investments. Some examples of these activities are the Title V MCH block grant, the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, and the MCHB Collaborative Innovation and Improvement Network (CoIIN) to Reduce Infant Mortality. Outside HRSA/MCHB, successful applicants will also support other HHS programs serving the MCH population such as the US Department of Agriculture Women, Infants, and Children (WIC) program, the Centers for Disease Control and Prevention (CDC) National Preconception Health and Health Care (PCHHC) Initiative, Agency for Children and Families (ACF) Early Head Start Program, and the Title X Family Planning Programs. Successful applicants will ensure that their program supports, but does not duplicate MCH activities in the community. For example, if a MIECHV program is co-located in the community, describe how Healthy Start home visiting services would be coordinated with, and not duplicative of, MIECHV services.

Through service coordination and systems integration, the focus on the continuum of care over the life course will shift the framework for prevention of adverse maternal and infant outcomes from prenatal care to the general promotion of health and wellness for all women, particularly those of reproductive age. HS supports health promotion through the implementation of a participant/family centered and inclusive team based approach to educational support through

[9] Brown, SS. The best intentions: unintended pregnancy and the well-being of children and families. Washington, DC: National Academy Press, 1995.
[10] Centers for Disease Control and Prevention (CDC). My Reproductive Life Plan. http://www.cdc.gov/preconception/reproductiveplan.html

skill building and knowledge transfer/information sharing. Topics include, but are not limited to breastfeeding, immunization, safe sleep, family planning, smoking cessation, and FASD.

The HS staff has been the backbone of the program. Staff training has long been integral to developing a competent HS workforce. The HS program will continue to emphasize workforce development by applying core competencies for HS staff. The Supporting Healthy Start Performance Project will define core competencies for HS staff at all levels, identify training opportunities, and provide technical assistance to facilitate the implementation of standardized training curricula. Providing standardized staff training across all HS programs will ensure all HS staff have appropriate training and skills to deliver standardized interventions to address the five HS approaches.

Strengthen Family Resilience: Four areas of activity are required for HS grantees to strengthen family resilience. These are activities to: a) address toxic stress and support trauma-informed care, b) support mental and behavioral health, c) promote father involvement, and d) improve parenting.

Resilience refers to a dynamic process encompassing positive adaptation in the context of significant adversity, the ability of an individual, family, organization, or community to cope with adversity and adapt to challenges or change. HS will support the ability of an individual, family, or community to cope with adversity and make positive adaptations. Reducing risks and advancing positive opportunities are key to fostering resilience. A hallmark of HS is empowering individuals, families, and communities through education, skills building, and building a community voice.

For children, learning how to cope with adversity is an important part of healthy development and might be called "positive stress." However, high levels of unmitigated adversity and stress can result in unrelieved activation of the body's stress management system. "Toxic 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.[11] HS grantees will provide support for interventions to mediate the effects of toxic stress.

Exposure to abuse, neglect, violence, and other stressors are sometimes called "adverse childhood experiences" or ACE. Caring adults can provide support, responsive relationships, and interventions to prevent or reverse the potentially damaging effects of both toxic stress and ACE. A history of ACE can have a lifelong impact on one's health. As the number of ACE increase, the risk for health problems (e.g., heart disease, depression, smoking, intimate partner violence, risky sexual behavior, and alcohol or drug abuse) increases.

"Trauma-informed care" is an approach that is welcoming and appropriate for trauma survivors (e.g., those with ACE 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 ACE, trauma, and toxic stress on children, caregivers, and service providers. Many

[11] Center on the Developing Child. The Impact of Early Adversity on Children's Development. Issue Brief. Harvard University.
http://developingchild.harvard.edu/resources/briefs/inbrief_series/inbrief_the_impact_of_early_adversity/

women participating in HS have histories of physical and sexual abuse and other types of trauma-inducing experiences, often contributing to adverse pregnancy outcomes, chronic health conditions, substance abuse, eating disorders, mental health, and other conditions. Trauma-informed service providers: 1) screen for trauma exposure and related symptoms, 2) use culturally appropriate, evidence-based assessment and treatment for traumatic stress and associated symptoms. 3) make trauma-related resources available to children, families, and providers, 4) engage in efforts to strengthen the resilience and protective factors of children and families affected by, and vulnerable to, trauma, 5) address parent and caregiver trauma and its impact on the family system, 6) emphasize continuity of care and collaboration across systems, and 7) maintain an environment for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff resilience.[12]

Support for mental and behavioral health services is a key part of any effort to promote resilience and provide trauma-informed care. The HS health promotion and education activities will promote individual use of mental and behavioral health services, as well as decrease the need for such services. Through case management and system coordination activities, HS grantees connect women and their families to integrated mental and behavioral health services, as well as engage in activities to increase the availability of such services in the high-risk communities where they work. For the HS population, mental and behavioral health services must include: 1) perinatal depression screening, referral, follow up and treatment, 2) trauma-informed care, and 3) parent-child interventions for two-generation impact.

HS grantees are required to provide perinatal depression screening and will give greater attention to assuring completed referrals, follow up, and treatment. Developmental screening and linkages to early childhood mental health services are also important for two-generation impact.

Another area to strengthen family resilience is to promote father involvement. In the past, HS grantees have engaged in efforts to involve fathers in program activities, to increase paternal involvement with children, and to promote responsible fatherhood with or without marriage. As in the National Fatherhood Initiative, the goal of these activities is to improve the well-being of children by increasing the proportion of children growing up with involved, responsible, and committed fathers. This includes involving fathers in providing practical support during pregnancy and in raising children, as well as helping parents develop supportive and effective relationships with each other and their children. [13] [14] HS grantees will provide a male involvement program that provides opportunities for men to engage in the well-being of children, supports healthy relationships between parents, and provides an opportunity for self-sufficiency and the economic stability of the family. Through the engagement of fathers, HS grantees will strive to improve men's health and provide support for strengthening life skills.

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[12] Harris & Fallot, SAMHSA National Center for Trauma-Informed Care Website, 2012.

[13] Lu M, Jones L, Bond, MJ, Wright K, Pumpuang M, Maidenberg M, Rowley D L. Where is the F in MCH: Father involvement in African American families? *Ethnicity & Disease*. 2010; 20(Suppl. 2): 49-61.

[14] Bond MJ. The Missing Link in MCH: Paternal involvement in pregnancy outcomes. American Journal of Men's Health. 2010; 4(4):285-286 http://www.jointcenter.org/hpi/sites/all/files/The%20Missing%20Link%20in%20MCH%20Paternal%20Involvement%20in%20Pregnancy%20Outcomes.pdf

All HS grantees will provide parent education. Parent education will promote healthy attachment, reducing toxic stress, and building social-emotional competence/skills. The purpose of parent education is to strengthen and support families and communities, to promote health and development, and to prevent child abuse and neglect. Effective parent education programs help parents acquire skills and promote protective factors which lead to positive child and family outcomes. Protective factors include: nurturing and attachment, knowledge of child development, parental resilience, social connections, and concrete supports for parents. [15]

A number of parenting education programs or curricula have been found to be effective (e.g., Strengthening Families, The Incredible Years, Triple P – Positive Parenting Program, Parents as Teachers, Systematic Training for Effective Parenting – STEP, STAR Parenting, The Nurturing Parent Programs, Effective Black Parenting Program, Touchpoints).[16] [17] [18] The Centers for Disease Control and Prevention's (CDC) also developed Legacy for Children™ (Legacy) which is an evidence-based, parent-focused intervention approach aimed at improving child outcomes by fostering positive parenting and community among low-income mothers of infants and young children.[19]

Achieve Collective Impact: All HS grantees will work to achieve collective impact; however, grantees at different levels will play different roles.

•At Level 1, HS grantees will be active and participate in community collaboration, information sharing, and advocacy through a Community Action Network (CAN) which involves consumers and community leaders to engage consumers, providers, and others in community change. In order to achieve this goal, Level 1 grants will serve no less than 500 program participants per year. **At least 50% of program participants should be pregnant women. Program participants must be case managed and the program must be able to collect data on all program participants.**

•At Level 2, HS grantees will stimulate community collaboration to focus on working with the relevant partners to develop a common agenda, shared measurement approach, and coordinate resources. In order to achieve this goal, Level 2 grants will serve no less than 800 program participants per year. **At least 50% of program participants should be pregnant women. Program participants must be case managed and the program must be able to collect data on all program participants.**

•At Level 3, HS grantees will be conveners and leaders to serve as the backbone organization providing leadership and structure for collective impact, including overall strategic direction, dedicated staff, coordination of communication and outreach, data collection and analysis, and

[15] U.S. Department of Health and Human Services. Administration on Children and Families. "Parent Education Programs. "Issue Brief. Child Welfare Gateway. https://www.childwelfare.gov/preventing/programs/types/parented.cfm
[16] Collins CL. A Review and Critique of 16 Major Parent Education Program. *Journal of Extension*. 2012, August; 50(4)4FEA8. http://www.joe.org/joe/2012august/a8.php
[17] Barth RP. Preventing Child Maltreatment. *Future of Children*. 2009, Fall; 19(2).
[18] Centers for Disease Control and Prevention. *Parent Training Programs: Insight for Practitioners*. Centers for Disease Control; 2009. http://www.cdc.gov/violenceprevention/pdf/parent_training_brief-a.pdf
[19] Centers for Disease Control and Prevention. *Child Development: Legacy for Children*. http://www.cdc.gov/ncbddd/childdevelopment/legacy.html

mobilization of funding and other resources. A backbone organization supports the development of civic infrastructure to have collective impact. In addition to providing the activities on the first two levels, grantees will align with other place-based initiatives such as Promise Zones. In order to achieve this goal, Level 3 grants will serve no less than 1,000 program participants per year. **At least 50% of program participants should be pregnant women. Program participants must be case managed and the program must be able to collect data on all program participants.**

Refer to Methodology in Section IV for more information on the Healthy Start Levels.

Community engagement for HS grantees starts with the formal development of a cross-sector CAN. The focus of the CAN is reducing disparities in perinatal outcomes through cross-sector information sharing, collaboration, and linkages. The CAN is intended to: increase trust among community partners/members, use data to assess and "map" the community, encourage effective and equitable allocation of limited resources, ensure that the contributions of community partners/members are valued and respected, and use varied communication modalities and technologies to provide community partners/members with full and timely access to information. HS participants, as consumers of community services, must be active members of each grantee CAN. It is also expected that CHCs and other HRSA investments in the community will have an active role in CAN activities.

Beyond the CAN, HS will engage in specific activities to contribute to the achievement of collective impact. Collective impact is the result of having organizations from different sectors agree to solve a specific social problem using a common agenda, align their efforts, and use common measures of success.[20] Collective impact begins by setting a goal and then builds a network of nonprofits, government agencies, schools, businesses, philanthropists, faith communities, and key community leaders who create common strategies and coordinate integrated activities among them to achieve the goal, over time. The five conditions for collective impact are: 1) a common agenda, 2) shared measurement system, 3) mutually reinforcing activities, 4) continuous communication, and 5) backbone organization support.[21] Influential champions, resources, and a sense of urgency for change contribute to success. Communities across the country are developing tools for success.[22]

All HS grantees will support community action to strengthen the development of local, state, and national perinatal health systems programs and policies. HS grantees should be the leaders of change and/or be part of collaborative efforts. Achieving results will require cross-sector, community engagement to maximize social capital in order to promote positive (and reduce negative) social determinants of health. No one organization alone can shift the impact of social determinants of health. By contributing to the achievement of collect impact, HS grantees will build social capital in their communities. Social capital refers to the expected collective or

[20] Kania J and Kramer M. Collective Impact. *Stanford Social Innovation Review*. 2011; 60. http://www.ssireview.org/articles/entry/collective_impact

[21] Hanleybrown F, Kania J, Kramer M. Channeling Change: Making Collective Impact Work. *Stanford Social Innovation Review*. 2012. http://www.ssireview.org/blog/entry/channeling_change_making_collective_impact_work

[22] The White House Council for Community Solutions. Resources. http://www.serve.gov/?q=site-page/council-resources#maincontent

economic benefits derived from cross-sector community engagement. This community engagement increases social interactions to promote positive (and reduce negative) social determinants of health. No one organization can shift the impact of social determinants of health. However, HS grantees will work to build the social cohesion that is critical to strengthen their community.[23]

Increase Accountability through Quality Improvement, Performance Monitoring, and Evaluation: Three areas of quality improvement and evaluation activities are required for HS grantees to increase accountability. These are activities to: a) apply quality improvement, b) conduct performance monitoring, and c) conduct local evaluation.

HS grantees will implement quality improvement (QI) activities to focus on prevention and health promotion (breastfeeding, immunization, safe sleep, family planning, smoking cessation). Systems and processes that will support the organization's quality improvement (QI) activities include selecting/defining a problem/issue appropriate for a QI project, setting an aim statement, deciding on a methodology to use, stating metrics for change, implementing the project, measuring progress through analysis, and then data reporting. Overall, each HS grantee should have the capacity and leadership support to collect and analyze data (including at the individual program participant level) in order to identify opportunities for quality improvement. Applicants must describe how they will collect and use "real time" data for quality improvement and must identify specific QI aims and measures they intend to use during the grant period. These data should be collected in such a way that would allow for their submission to MCHB/DHSPS, if requested.

The local evaluation should be an interim assessment of HS grantee activities during the four years and nine months project period.. The findings from the local evaluation should cascade from the initial needs assessment submitted at the beginning of the project period. HS grantees should continue to refer to the needs assessment findings and monitor progress to identify areas of quality improvement. As populations change, new trends emerge, system capacity shifts, etc., it is critical the HS grantees conduct local evaluations. The findings from the local evaluation should reflect the following:

- Any changes in the population strengths and needs.
- Any changes in the community MCH program or system capacity.
- A brief description of any activities undertaken to operationalize the needs assessment, such as: 1) ensuring that the HS grantee and/or CAN addresses the findings and recommendations resulting from the needs assessment, 2) monitoring the timelines of the action plans, 3) reporting by a designated person or group responsible for accountability, and 4) linking the needs assessment process back into HS program planning.

[23] The World Bank. What is Social Capital? http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTSOCIALDEVELOPMENT/EXTTSOCIALCAPITAL/0,,contentMDK:20185164~menuPK:418217~pagePK:148956~piPK:216618~theSitePK:401015,00.html

- A brief description of ongoing activities to gather information from the community and to evaluate implementation of the needs assessment. Examples of these activities include: data collection and analysis, key informant interviews, public forums, establishing an advisory group, and surveys. It is important to gather input from general community members as well as providers and community leaders.

- The local evaluation should also examine the extent to which Healthy Start participants received services, promising and best practices in implementation, the obstacles encountered by the HS project when implementing, and the factors associated with fidelity of implementation. This component of the local evaluation will be used in future national evaluations of HS to examine how implementation is occurring across all HS projects and whether implementation is occurring as intended according to HS guidance. It can also provide insight into the factors associated with implementation best practices.

The design of the HS national evaluation requires selection of comparison communities and individuals for participation in the study. The variables listed in the Needs Assessment section of the FOA represent the *potential* variables for matching communities and individuals. The variables will be selected based on availability, data quality, and study needs.

A mixed methods approach is necessary to address the evaluation goals. The evaluation approach will be particularly helpful in accounting for the interactions between organizational, community, MCH and social sector systems to achieve community transformation as well as individual- and population-level outcomes. Within the mixed methods approach, the design components were chosen based on several related factors, including the evaluation questions, the program components to be evaluated, the data available to answer the questions, and the outcomes prioritized for assessing performance.

The overall mixed methods design is composed of four individual evaluation design components: (1) outcomes study, (2) multilevel study, (3) network study, and (4) implementation study. Together, the four design components provide MCHB with the evidence needed to assess (1) whether the transformed Healthy Start program is successful in achieving better health outcomes (outcomes study); (2) components that are most associated with success in improving the outcomes at individual, grantee, and community levels (multilevel study), (3) the interrelationships between organizations and how systems influence outcomes (network study); and (4) best practices in program implementation (implementation study).

Use the following section headers for the Narrative:

- ***INTRODUCTION -- Corresponds to Section V's Review Criterion 1***

This section should briefly describe the purpose of the proposed project. The applicant should include a discussion that exhibits a complete expert understanding of the issues related to improving perinatal outcomes and promoting women's health. Applicants **must** indicate which level of funding their organization will implement in their chosen project area. All applicants applying for funding under this grant announcement **must** also identify themselves as serving an urban, rural, or border community project area.

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

For this section of the narrative, the applicant must identify and justify the selection of the targeted at-risk or high risk community for which HS services will be provided. A map of the proposed project area as well as the projected number of eligible participants must be included in the application. The target population and its unmet health needs must be described and documented in this section. Include social determinants of health and health disparities impacting the population or communities served and unmet.

The purpose of the needs assessment is to identify the needs of the MCH population in the community, produce a four year, nine month community-wide action plan to address the unique needs of the communities' MCH population and describe how funds will be allocated for the provision and coordination of services to carry out the action plan. This assessment also provides an opportunity for HS grantees to acknowledge their strengths, identify emergent priorities, improve outcomes and leverage partnerships. Additionally, the products from this assessment (community-level priorities, HS project/community-specific performance measures and outcomes) inform the HRSA/DHSPS strategic planning related to setting priorities, performance measures/benchmarks, and health indicators for the Nation.

Community-level Variables

The section should include detailed information regarding current community risk factors, other characteristics and strengths, the need for the HS program, and service systems currently available for families in that community, including the operation of similar programs and other social services currently operated or discontinued. Please discuss any relevant barriers in the service area that the project hopes to overcome.

For the proposed targeted community, please provide the following information:

Organizational Matching Variables:

- Organization characteristics
  - Project area (e.g., US/Mexico border, urban/rural)
  - Organization type (e.g., state agency, community government agency)
  - Funding for MCH services by source
  - MCH services provided
  - Staffing
- MCH client characteristics
  - Demographic and socioeconomic status (e.g., age, race/ethnicity, primary language, marital status, education, health insurance status, income, employment, housing, receipt of public assistance)
  - Family structure (e.g., number and age of children, child health status, household members)
  - Health status
  - Baseline pregnancy outcomes (e.g., pregnancy status, live births within the past two years, gestational age/low birthweight, early elective delivery)
  - Baseline pregnancy health behaviors and conditions (e.g., breastfeeding, smoking status, birth spacing, gestational diabetes, preeclampsia, depression, intimate partner violence)
  - Baseline pregnancy health care utilization (e.g., usual source of care, primary care provider, postpartum visit, well-woman visit, well-child visit/immunizations)

Community Matching Variables

- Community Resources
  - HRSA MCH programs, initiatives, and services (e.g., Healthy Start, Community Health Centers, Federally-Qualified Health Centers, Patient Centered Medical Home, Family-to-Family Health Information Center, MIECHV program, Healthy Tomorrows)
  - Other HHS programs (e.g., WIC, family planning, Early Head Start)
  - Collaboratives, Systems, and Networks (e.g., Hospitals or health systems, Perinatal Quality Collaborative, FIMR)
- Community Characteristics
  - Population demographic characteristics (e.g., age, race/ethnicity, primary language, marital status, education, health insurance status, income, employment, housing, receipt of public assistance)
  - MCH population outcomes (e.g., live births, infant mortality, low birthweight, preterm birth, SIDS, teenage pregnancy, trimester of prenatal care, immunization, birth defects, infant/child abuse, HIV/AIDS, STDs, unintentional injuries)
  - Socioeconomic condition (e.g., poverty, crime, housing/homelessness, unemployment, food access, education resources, health insurance availability)

Individual-level Variables

Provide a clear and complete description of those served by Healthy Start along demographic, socioeconomic, service utilization, and health dimensions. Include verifiable health statistics to support the presentation and to demonstrate current prevalent disparities. Demographic data should be used and cited whenever possible to support the information provided. For comparison to other applications, applicants must present data from (three-year average) **2007-2009**. If more current data are available, they may also be included. However, 2007-2009 data must be presented, regardless if more recent data are also submitted.

For the proposed targeted community, please provide the following information:

- Demographic and socioeconomic characteristics (e.g., age, race/ethnicity, primary language, marital status, education, health insurance status, income, employment, housing structure, receipt of public assistance, zip code of residence/distance to Healthy Start eligible organization)
- Family structure (e.g., number and age of children, child health status, household members)
- Health status
- Pregnancy status and previous pregnancy history outcomes (e.g., live births, gestational age/low birthweight, early elective delivery)
- Previous pregnancy health behaviors and conditions (e.g., breastfeeding, smoking status, birth spacing, gestational diabetes, preeclampsia, depression, intimate partner violence)
- Receipt of social services (e.g., Healthy Start, home visiting, food assistance, WIC, family planning, patient navigation)

All Variables are to be reported for each of the following racial categories: American Indian/Alaska Native; Asian; Black or African American; Native Hawaiian or other Pacific

Islander; and White. For each racial category you should also identify ethnicity, e.g. Hispanic/Latino.

Include information about the primary languages of the proposed target population, including the percentage of the clients who speak each of these languages. List the population(s) the HS grantee will target for its HS outreach and enrollment activities. This must be the same population that will be used to determine your eligibility.

- ***METHODOLOGY -- Corresponds to Section V's Review Criterion 2 and 4***

*All applicants, **at all three (3) levels** are expected to:*

Describe the proposed mechanism(s) and activities to identify, engage, recruit, and retain perspective program participants from the community the project will serve. Discuss how these activities will be culturally and linguistically appropriate for chosen target population. Include information on the utilization of Community Health Worker (CHWs) or patient navigators to provide services. Discuss if CHWs will be involved in enrolling women and their families into health insurance through the ACA, if applicable. Provide details on ongoing training of core competencies and education for CHWs and the communication strategy with program staff.

Provide information on the health promotion and health education activities and topics they will undertake. This should include, at a minimum, topics covered, proposed schedule, and a staffing plan. All HS projects are required to provide education including, but not limited to:

- Maternal Care - breastfeeding, family planning, reproductive life planning, prenatal care, postpartum care, and well- woman care, fetal alcohol spectrum disorder, and perinatal depression screening, referral and follow up.
- Infant Care – well child visits, immunizations, oral health, infant growth & development, safe sleep, nutrition, car and home safety, and the five domains of child development (physical/motor development, social-emotional development, approaches to learning, language development, and cognition and general knowledge[24]).
- Family care – effective parenting practices, infant attachment, healthy weight, smoking cessation, HIV screening and referral, sickle cell disease screening and referral, STD prevention, screening and referral, domestic violence screening and follow up, and behavioral/mental health screening, referral and follow up.

Document commitment to required data collection. (See Appendix A: Benchmarks and Benchmark Table) Applicants will be expected to collect data utilizing a uniform data collection form. The form is under development, but will be provided during the project period to those applicants that receive HS funding. MCHB/DHSPS will also make software available, to grantees that choose to use it, that will assist in uniform data collection. This platform will allow

[24] National Association for the Education of Young Children. Principles of child development and learning that inform appropriate practice. NAEYC Position Statement. http://oldweb.naeyc.org/about/positions/dap3.asp Also see: Indiana Department of Education. The Five Domains of School Readiness. http://www.doe.in.gov/sites/default/files/earlylearning/schoolreadiness1v2.pdf

HS grantees to perform real-time internal analysis and uniformly share these data. This process will meet the needs of grantees in managing their projects, and will allow MCHB/DHSPS to pool data and get a snapshot of what is happening at both the national and project levels.

HRSA-14-121: Level 1 Funding: Community-based Healthy Start. Funding for this level of activities will support the implementation of essential HS program activities needed to achieve five (5) approaches of the HS Model, which are to: 1) improve women's health, 2) promote quality services, 3) strengthen family resilience, 4) achieve collective impact, and 5) increase accountability through quality improvement, performance monitoring, and evaluation. Level 1 applicants must provide the following information:

1. **Improve Women's Health**
    a. *Outreach and enrollment in health coverage*
        i. Describe if the grantee will work with other entities in the community who are designated navigators, CACs, etc. If applicable, include the number of individuals the applicant directly enrolled into ACA and/or the number of individuals the applicant referred for enrollment into ACA.
        ii. Provide details about how staff will be trained regarding state eligibility rules for pregnant women, parents, infants, and children, including Medicaid, exchange plans, CHIP, and other state-specific plans for low-income and uninsured individuals. Include information on the role 3rd party payers in the community.
        iii. Describe how the grantee will increase participant knowledge and awareness of affordable coverage options, including Medicaid, exchange plans, CHIP, or other state-specific plans. If applicable, include the number of individuals the applicant informed/educated regarding ACA.
        iv. Provide details on the barriers/challenges the applicant organization faces internally, as well as in the community at large, relating to ACA education, enrollment and referrals (to either navigators, certified application counselors and/or marketplace assisters).
    b. *Coordination and facilitation of access to health care services*
        i. *Comprehensive Assessment* – Explain how the project will conduct comprehensive assessment and identify the tool to be used in this process. Provide details on risk factors included in the assessment (e.g., medical risks and conditions, psychosocial risks, mental health conditions, substance use) and/or protective factors.
        ii. *Case management* – Identify and justify the specific tool that will be used for case management planning and monitoring. Provide details on the process for performing assessment of participant needs and goals, creation of care plan, identification of appropriate resources and services in the community, facilitation of linkages to appropriate services and resources, and process for monitoring and follow-up. Discuss how the program will determine differing levels of client risk and the type, timing, duration, and intensity of services matched to the risk level. Detail the projected number of program participants in the prenatal and interconception periods as well as each level of risk.

c. *Support for prevention, including clinical preventive services, interconception health, and health promotion; and assistance with reproductive life planning*
    i. Describe how the grantee 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 the grantee will promote and monitor interconception health among high risk women including chronic disease management, behavioral/ mental health, and reduction of reproductive health risks.
    iii. Describe how the grantee will provide health promotion and education to improve women's health, including the approach for using the HS standardized curriculum, local staffing patterns, and additional topics.
    iv. Describe how the grantee will promote and monitor reproductive life planning, including the tools and staffing approach to be used.

2. **Promote Quality Services**
    a. *Service coordination and systems integration, with a medical home for every family*
        i. Describe the process for ensuring that program participants (women, children, and families) have a medical home. Discuss how the project will provide on-site primary health services or assure linkages to a community provider to provide such services.
        ii. Provide details on the grantee's approach to service coordination and systems integration, including care coordination/case management, memoranda of understanding with other providers/agencies, co-location of services, and other specific mechanisms to support linkages.
        iii. Please include applicant's previous experience and knowledge, including individuals on staff, materials published, and progress on previous MCH project activities**.** Also, include relative quantitative and qualitative data as it relates to accomplishing project objectives, performance measures, and utilization of services. Applicants are encouraged to use the MCH community activity checklist to identify other MCH activities in their community (Appendix C).
        iv. Describe how the grantee will ensure that their program supports, but does not duplicate MCH activities in the community. For example, if a MIECHV program is co-located in the community, describe how Healthy Start home visiting services would be coordinated with, and not duplicative of, MIECHV services.
    b. *Focus on prevention and health promotion*
        i. Describe how the grantee will provide health education and promotion in the required areas for women, infants, and families, of breastfeeding, immunization, safe sleep, family planning, smoking cessation, and FASD, as well as any additional areas proposed.
        ii. Describe how the grantee will provide developmental screening for child participants, including screening tools to be used and plans for referrals and follow up based on identified needs.
        iii. Provide details on materials to be used, including evidence in support of effectiveness, cultural and linguistic appropriateness, and other characteristics.

c. *Core competencies for workforce*
    i. Describe how the staff training and supervision will support implementation of core competencies for the HS workforce, including CHW, nurses, social workers, and other staff. Include description of team approaches or tiered (or triage) case management approaches to be used.
    ii. Define how grantee will provide testing and remediation to assure the HS workforce achieves core competencies.
    iii. Describe how the grantee will work with the Supporting Healthy Start Performance Project to identify technical assistance with the core competencies.

d. *Standardized curriculum and interventions*
    i. Describe how the standardized HS curricula will be used in local context.
    ii. Identify and justify other evidence-based models and approaches proposed for use (e.g., Centering Pregnancy, MIECHV evidence-based home visiting models, Bright Futures for Children).

3. **Strengthen Family Resilience**

a. *Address toxic stress and support delivery of trauma-informed care*.
    i. Describe how lifecourse theory will be integrated into program activities to enhance protective factors.
    ii. Discuss how the grantee intends to assess and document risks related to toxic stress as part of case management approach.
    iii. Provide details on plans for staff training and development in the area of trauma-informed care.

b. *Support mental and behavioral health*
    i. Describe how the project will conduct perinatal depression screening services for women participants, including the tool to be used and intervals for screening, as well as specific case management approaches to assure completion of referrals and follow up.
    ii. Describe how the project will conduct social-emotional development screening services for child participants including the tool to be used and intervals for screening, as well as specific case management approaches to assure completion of referrals and follow up.
    iii. Identify and justify other tools for mental and behavioral health screening.
    iv. Describe linkages and service coordination activities with mental and behavioral health providers intended to increase access to such services.

c. *Promote father involvement*
    i. Discuss how the grantee intends to engage fathers and encourage paternal involvement in supporting the well-being of women, children, and families.
    ii. Identify and justify tools to be used for assessment and health promotion among males/fathers.
    iii. Describe specific activities intended to improve the health, mental health, and resilience of fathers.

d. Improve parenting

i. Describe how parenting education will be delivered, including timing, standardized curricula, tools, staff, and materials proposed for use.

ii. Provide details on plans for staff training and development in the area of parent education and training.

iii. Identify and justify other evidence-based models and approaches proposed for use (e.g., Strengthening Families, The Incredible Years, Triple P – Positive Parenting Program, Parents as Teachers, Systematic Training for Effective Parenting – STEP, STAR Parenting, The Nurturing Parent Programs, Effective Black Parenting Program, Touchpoints, Legacy for Children).

4. Achieve Collective Impact

a. Develop and use Community Action Network (CAN)

i. Provide details on how the applicant will identify/select members of the 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 (SG or LG), program participant (PP), community participant (CP), community-based organizations (CBO), community health centers (CHC), private agencies or organizations (not community-based), or other service providers.

iii. Describe plan for engaging and retaining program participants in CAN activities such as strategic planning, budget development, oversight of proposed activities, and sustainability planning. Provide information on how HS grantees will participate in existing CANs in their community.

b. *Contribute to collective impact efforts*.

i. Describe grantee role in other community coalitions, collaboratives, and activities intended to achieve collective impact.

ii. Describe how the grantee will develop and maintain relationships with coalitions, collaboratives, key leaders, etc. necessary for effective collective impact. Level 1 programs must serve no less than 500 program participants per year. At least 50% of program participants should be pregnant women. Program participants must be case managed and the program must be able to collect data on all program participants.

5. **Increase Accountability through Quality Improvement, Performance Monitoring, and Evaluation**

a. Use quality improvement

i. Describe how ongoing quality improvement process will be used to make changes in the project including a process for submitting to MCHB an annual quality improvement plan. The plan must include: overall management approach, specific aims and measures, process and activities, measurement plan, and analysis. Provide details on how the

grantee will engage key leaders using rapid cycles of change and identifying benchmarks using real time.

ii. Provide details on results of past quality improvement activities.

b. Conduct performance monitoring

i. Describe the system for acquiring or collecting client/participant-level data and monitoring individual and participant group outcomes, including reports to MCHB.

ii. Provide details on the applicant's data collection system, including case management, process, and outcome data.

iii. Describe how the grantee will measure progress towards achieving the MHCB benchmarks.

c. Conduct evaluation

i. Describe the process and plan for program monitoring activities which includes process and outcome measurements. Include in this description process and outcome measurements, who will be conducting the local evaluation, and how efforts will be monitored.

ii. Provide details on past evaluation efforts and how the findings were operationalized into program planning and implementation.

iii. Describe how the grantee will collect and report data for national evaluation

HRSA-14-120: Level 2: Enhanced Services Healthy Start. In addition to providing the essential HS program activities listed under Level 1, applicants applying for Level 2 funding will engage in additional activities, and be accountable to reach the entire community, thereby driving collective impact and supporting community change. Level 2 is responsible for community level effect.

Funding for this level of activities will support the implementation of essential HS program activities needed to achieve five approaches: 1) improve women's health, 2) promote quality services, 3) strengthen family resilience, 4) achieve collective impact, and 5) increase accountability through quality improvement, performance monitoring, and evaluation. Grantees will be responsible for the Level 1 functions described above but also for additional services and supports. In addition to providing community-based Level 1 services and supports, HS applicants applying for Level 2 must <u>also</u> provide details on how the applicant will:

1. Improve Women's Health

a. Outreach and enrollment in health coverage

i. Describe if the grantee will connect individuals with Navigators (Federally-facilitated Marketplace) or Non-Navigator Assistance Personnel (State based Marketplace or State Partnership Marketplace).

ii. Provide details on whether or not the grantees will apply to become a designated CAC organization. (If the applicant will not apply to be a designated CAC organization, evidence must be presented that the community will be served by another CAC organization and a plan must be submitted on how the Healthy Start grantee will link/collaborate with the CAC organization.)

iii. Describe how the grantee will increase community-wide knowledge and awareness of affordable coverage options, including Medicaid, exchange plans, CHIP, or other state-specific plans.

b. *Coordination and facilitation of access to health care services*
   i. Explain how HS assessment and case management information will be used to improve care effectiveness and service coordination (e.g., communication and linkages with primary care providers).

c. *Support for prevention, including clinical preventive services, interconception health, and health promotion; and assistance with reproductive life planning*
   i. Describe how the grantee will augment community-wide health education and promotion in the required areas for woman and their male partners.
   ii. Describe how the grantee will increase provider awareness of best practices in preconception, prenatal care, birth, postpartum, interconception, well-woman care, and reproductive life planning.

2. Promote Quality

a. Service coordination and systems integration, with a medical home for every family
   i. Provide details on proposed activities to increase the availability of primary health care services and medical homes for every HS participant.
   ii. Provide details on proposed activities to increase service coordination and systems integration through the CAN and other place-based initiative approaches.
   iii. Describe how the grantee will support activities to build a ladder of opportunity for all children and families. HS will be the first step in the ladder by focusing on service coordination and systems integration.

b. Focus on prevention and health promotion
   i. Describe how the grantee will augment community-wide health education and promotion in the required areas for woman, infant, and family (described above), as well as any additional areas proposed.

c. Core competencies for workforce
   i. Describe how the grantee will collaborate with other community organizations using case management or in-home services to increase staff competencies across programs (e.g., home visiting, Early Head Start, infant mental health).
   ii. Provide details on how the grantee will use a universal intake form to document training for staff competencies

3. Strengthen Family Resilience

a. *Address toxic stress and support delivery of trauma-informed care*
   i. Describe how the grantee will augment community-wide knowledge and awareness of toxic stress, ACE, and trauma-informed care.
   ii. Discuss how the grantee will use partnerships, linkages, and system coordination to increase access to trauma-informed care.

b. *Support mental and behavioral health*
   i. Provide details on proposed activities to increase the availability of mental and behavioral health care services for HS participants.

ii. Discuss how the grantee will increase community activities to support these services.

c. Promote father involvement

i. Discuss how the grantee intends to engage community partners in strategies to encourage paternal involvement in supporting the well-being of women, children, and families.

ii. Describe specific community-based activities intended to improve the health, mental health, and resilience of fathers.

d. Improve parenting

i. Describe how the grantee will collaborate and integrate with other community organizations providing parenting education (e.g., home visiting, Early Head Start, Strengthening Families).

4. Achieve Collective Impact

a. Develop common agenda

i. Describe how the grantee will identify collaborative partners to develop a common agenda with shared outcomes.

ii. Provide details on how the grantee will revise, update, and monitor activities included in the common agenda.

b. Contribute to shared measurement system

i. Collect community-level data for selected HS perinatal outcome measures.

ii. Describe how the grantee will contribute to collection of community-wide data and measurement targets.

c. Conduct mutually reinforcing activities

i. Provide the data system infrastructure required for collective impact community-wide efforts.

ii. Convene and lead the process for determining shared measures for collective impact.

iii. Collect, analyze, and report on data that supports indicator measures of collective impact.

d. Provide continuous communication

i. Describe how the grantee will convene and facilitate a collaborative partnership required to fulfill the goals and objectives of HS.

ii. Describe how the grantee will engage partners who can contribute to shared outcomes.

e. Support backbone organization

i. Describe how the grantee will serve as the backbone organization providing leadership and structure for collective impact, including overall strategic direction, dedicated staff, coordination of communication and outreach, data collection and analysis, and mobilization of funding and other resources.

ii. Provide details on past performance that demonstrate capacity to serve as a backbone organization for achieving collective impact. <u>Level 2 programs must serve no less than 800 program participants per year. At least 50% of program participants should be pregnant women. Program participants must be case managed and the program must be able to collect data on all program participants.</u>

5. **Increase Accountability through Quality Improvement, Performance Monitoring, and Evaluation**
    a. *Use quality improvement.*
        i. Provide details on any collaborative quality improvement activities to be undertaken with community partners or other service providers. Include information on potential topics, the methodology to be used, and measuring progress through analysis.
    b. *Conduct performance measurement.*
        i. Describe how the grantee will collect community level data.
        ii. Discuss the proposed process for assessing community resources, capacities, and risks (i.e., mapping).
        iii. Conduct community-level, reproductive risk monitoring.
            1. Fetal Infant Mortality Review (FIMR): Applicants must provide details on how the grantee will either be involved in an existing FIMR project in their community OR describe the steps to be taken to develop a project in their community (i.e., 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).
            2. Maternal Morbidity and Mortality Review (MMMR): Applicants must provide details on how the grantee will either be involved in an existing MMMR project in their community OR describe the steps to be taken to develop a project in their community.
            3. Perinatal Periods of Risk (PPOR): Applicants must provide details on how the grantee 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.
    c. *Conduct evaluation (same as Level 1).*

HRSA-14-122: Level 3: Leadership and Mentoring Healthy Start. This level supports the provision of expanded maternal and women's health services and will support the development of a place-based initiative that will serve as the backbone or hub organization for achieving collective impact. Level 3 grantees will work in alignment with other place-based initiatives, such as initiatives in communities of concentrated poverty that provide universal access to services, an integrated platform of care, and enhanced services to children and families. Grantees should develop and work towards implementing plans to make HS services universally available for eligible women (given greater funding amounts) and should develop a working place for integrating these services with other early childhood programs in a universal manner.

In addition to providing community-based (Level 1) and enhanced (Level 2) HS program activities, applicants applying for Level 3 must also provide details on how the applicant will:

- Serve as a resource site for state, regional, and national action in support of other HS grantees and organizations working to improve perinatal outcomes. This might include providing technical assistance, peer-to-peer mentoring, consultation, and advice to local, state, regional and national programs.
- Serve as leaders and participate in the development of state/ regional/ national programs and policies, such as Promise Zones and Best Babies Zones. Supporting place-based demonstration projects targeting specific high-risk communities allows HS to improve health outcomes for young children and coordinate with other HHS partners on early learning and other relevant services for those living in communities with highly concentrated poverty.
- Participate with other Level 3 Leadership and Mentoring HS grantees, and the Supporting Healthy Start Performance Project[25], in the development and implementation of a HS Collaborative and Innovation Improvement Network (HS CoIIN). The HS CoIIN would develop plans to reduce infant mortality by using common priorities in a collaborative way using evidence-based strategies and facilitate collaborative learning and adoption of quality improvement (QI) principles and practices across participating HS sites to reduce infant mortality and improve birth outcomes. Level 3 programs must serve no less than 1,000 program participants per year. At least 50% of program participants should be pregnant women. Program participants must be case managed and the program must be able to collect data on all program participants.

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

  Describe the activities or steps that will be used to achieve each of the strategies proposed during the entire four years and nine months project period in the Methodology section. Each activity or step must be linked to the approaches of the HS Model according to the program funding level selected by the applicant. Use a timeline that includes each activity and that identifies staff person(s) who is responsible for leading and implementing each activity. Identify meaningful support and collaboration with key stakeholders in planning, designing and implementing all activities, including development of the application and, further, the extent to which these contributors reflect the cultural, racial, linguistic and geographic diversity of the populations and communities served. Include which activities will lead to a change in the collective impact, and how these activities will be spread/implemented beyond Healthy Start.

[25] **Supporting Healthy Start Performance Project:** MCHB is developing the **Supporting Healthy Start Performance Project** (SHSPP) to support all HS community health workers. SHSPP will promote the uniform implementation of HS by skilled, well qualified workers at all levels of the program by identifying and better defining effective services and interventions. The SHSPP will also offer mentoring, education, and training to staff delivering these interventions and services. SHSPP will assist successful applicants to identify curriculum, tools, and resources appropriate for the target population. Healthy Start grantees will work/collaborate with the SHSPP as directed by MCHB/DHSPS. In addition, MCHB has developed a resource list to assist applicants in developing their project plan (Appendix C). Some links are to non-Federal websites. HRSA does not necessarily endorse other information on the website or other work conducted by the agency/organization.

In this section, identify measurable, realistic, time-framed project objectives which are responsive to the goals of this program and the identified need(s) and strengths/resources of the target population. Each objective should be clearly stated, outcome-oriented, and realistic for the resources available. Each project period objective must have associated calendar year objectives for each year of requested HS funding. The goals and objectives must be linked to the benchmarks.

Both project period and calendar period objectives should relate to the needs assessment presented in the previous section of the application. Based upon benchmarks, objective statements should 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 data source including year**. See Appendix A for benchmark descriptions and numerator and denominator information.

The initial proposed calendar year objective should include baseline data (utilizing the most current data source available prior to implementation of services using HS funds) which will be used as a basis for comparison with data from subsequent measurements (as the project period progresses) of the specific health problem(s) to determine whether or not the project is having its intended impact. When utilizing baseline data, applicants must document the data source for both the baseline and the current status. If data sources are older than 2009, please explain why more current data are unavailable – and the plan to collect and use more recent data. If percentages are used, the relevant numerator and denominator must be cited. Each project period objective should have a performance indicator which is the statistical or quantitative value that expresses the result of the objective.

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

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

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

Discuss challenges that are likely to be encountered in designing and implementing the activities described in the Work Plan, and approaches that will be used to resolve such challenges.

Applicants must address:

- Program participant barriers such as enrollment and retention in the Healthy Start 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
- Buy-in to QI plan and changes that are being recommended/implemented; spread of change and other barriers that might be QI related.

- ***EVALUATION AND TECHNICAL SUPPORT CAPACITY -- Corresponds to Section V's Review Criterion 3***

The applicant must submit proposed approaches and plans for quality improvement, performance monitoring, and evaluation to address the requirements in this funding announcement. The plans must be very specific in demonstrating how project quality improvement, performance monitoring, and evaluation activities will be conducted throughout the period of performance. . These activities are to support and help better understand challenges, effectiveness, efficiency and impact of the HS grantee project, as well as the HS program overall.

Applicants must describe the plan for the program evaluation that will 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.

Applicants must describe the systems and processes that will support the organization's effective tracking of HRSA required HS performance measures, including a description of how the organization will collect and manage data (e.g., assigned skilled staff, data management software) in a way that allows for accurate and timely reporting of performance data. Describe past success in collecting and reporting similar data. Include current experience, skills, and knowledge, including individuals on staff, materials published, and previous work of a similar nature. Describe the data collection strategy to collect, analyze and track data to measure process and impact/outcomes, with different cultural groups (e.g., race, ethnicity, language). Applicants must describe any potential obstacles for implementing the program performance monitoring and how those obstacles will be addressed.

The quality improvement, performance monitoring, and evaluation initiatives are critical to strengthening HS in the following areas:

Quality Improvement

1. Identify opportunities for quality improvement (i.e., to close the gap between knowledge and practice) in each grantee's activities, services, and supports, as well as for the program as a whole.
2. An assessment of overall project implementation, including lessons learned and best practices, as well as an assessment of quality.

Performance Monitoring

1. Describe the different health services and program models in the community (service delivery systems implemented internally and externally by Healthy Start).
2. How have funds been expended and/or leveraged to improve the awardee and organizational processes, or relationships with partner organizations' capacity to more effectively address the health needs of the specified target population?
3. Identify the community factors which have contributed to strengthening the capacity of the grantee to provide effective services.

Evaluation

1. Determine the impact of the HS grantees in improving women's health before, during, and after pregnancy. As a corollary, the local evaluation can look at how the project increases community capacity to improve perinatal outcomes.
2. Document the baseline and follow-up data and characteristics of clients/participants served in the HS projects (i.e., demographics, health, drug use and treatment history, mental health and risk factors, race/ethnicity, geographic location, co-morbidity and co-existing medical disorders, co-occurring disorders, etc.), providers, and programs to inform future study and policy concerning the development and implementation of HS service programs within a community organizational settings (e.g., MIECHV, Early Head Start, Thrive Neighborhoods).
3. An assessment of outcomes of HS participants.

All Healthy Start grantees will participate in any MCHB/DHSPS-sponsored national evaluation.

- ***ORGANIZATIONAL INFORMATION -- Corresponds to Section V's Review Criteria 5 and 7***

Describe your (applicant) agency, its history, past experiences, and current capacities in MCH, especially in leading community-based initiatives. Please include relative quantitative and qualitative data as they relate to accomplishing project objectives, performance measures, and utilization of services.

Provide an organizational chart of the agency, including how the administration and the fiscal management of the proposed HS project will be integrated into the current administration. 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 (including evaluation/QI staff), contractors, and the CAN.

Briefly describe the current capacity and potential of the applicant agency, providers, and any other entities that will assume/sustain the provision of any part(s) of the project once the funding period is ended.

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.

Identify which activities and services the applicant agency will conduct in-house and those activities and services that will be accomplished through contracts.

Describe your applicant organization's history of management and oversight involving other grant or contractual funds. If deficiencies have been noted in the most recent internal/external audit, reviews, or reports on the applicant organization's financial management system and management capacity or its implementation of these systems, policies and procedures, identify the corrective action taken to remedy the deficiency. **Please note: Once approved for funding, Healthy Start grantees may be required to submit copies of their annual audits with each application for continued funding.**

Briefly describe methodologies that will be used for monitoring utilization and quality assurance (including program participant satisfaction) of all activities and services and contractors. Include information on the organization's experience with quality improvement and the staffing plan for these activities.

Briefly describe the current capacity and potential of the applicant agency and providers and any other entities to assume the provision of any part(s) of the project once the funding period is ended.

iii. Budget and Budget Justification Narrative

In addition to the instructions in Section 4.1.iv and v. of HRSA's *SF-424 Application Guide* the *Healthy Start Initiative: Eliminating Disparities in Perinatal Health* program requires the following:

Provide a narrative that explains the amounts requested for each line in the budget. The budget justification should specifically describe how each item will support the achievement of proposed objectives. The initial budget period is for nine months. However, the applicant must submit one-year budgets for each of the subsequent project period year's total of four years and nine months project period at the time of application. Five separate and complete budgets must be submitted with this application. For year 5, please submit a copy of Sections A and B of the SF-424A as Attachment 8.

The budget justification must clearly describe each cost element and explain how each cost contributes to meeting the project's objectives/goals. Be very careful, thorough, and specific about showing how each item in the "other" category is justified. The budget justification MUST be concise. Do NOT use the justification to expound on the project narrative.

Budget for Multi-Year Grant

This announcement is inviting applications for four years and nine months project period.. Awards, on a competitive basis, will be for an initial period of nine months (September 1, 2014 to May 31, 2015). Applications for one-year continuation grants funded under these awards beyond the initial nine months budget period but within the four years and nine months project

period will be entertained in subsequent years on a noncompetitive basis, subject to availability of funds, satisfactory progress of the grantee, and a determination that continued funding would be in the best interest of the Government. However, again, five (5) separate and complete budgets must be submitted with this application.

Include the following in the Budget Justification narrative:

Personnel Costs: Personnel costs should be explained by listing each staff member who will be supported from funds, name (if possible), position title, percent full time equivalency, and annual salary.

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

Fringe Benefits: List the components that comprise the fringe benefit rate (e.g., health insurance, taxes, unemployment insurance, life insurance, retirement plan, and tuition reimbursement). The fringe benefits should be directly proportional to that portion of personnel costs that are allocated for the project.

Travel: List travel costs according to local and long distance travel. For local travel, the mileage rate, number of miles, reason for travel and staff member/consumers completing the travel should be outlined. The budget should also reflect the travel expenses associated with participating in meetings and other proposed trainings or workshops. All non-local travel must be pre-approved by MCHB/DHSPS.

Equipment: List equipment costs and provide justification for the need of the equipment to carry out the program's goals. Extensive justification and a detailed status of current equipment must be provided when requesting funds for the purchase of computers and furniture items that meet the definition of equipment (a unit cost of $5000 and a useful life of one or more years).

Supplies: List the items that the project will use. In this category, separate office supplies from medical and educational purchases. Office supplies could include paper, pencils, and the like; medical supplies are syringes, blood tubes, plastic gloves, etc., and educational supplies may be pamphlets and educational videotapes. Remember, each item type must be listed and accounted for separately.

Subcontracts: All subcontract budgets and justifications should be standardized, and should be presented by using the same object class categories contained in the SF-424A. Provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. Please submit budgets for the initial nine months and for each of the following four years of the project period, and include as Attachment 9-15.

Other: Put all costs that do not fit into any other category into this category and provide an explanation of each cost in this category. (In some cases, grantee rent, utilities and insurance fall under this category if they are not included in an approved indirect cost rate.)

Evaluation: The cost for evaluation should be included under the contractual line item, if it is contractual. Otherwise the cost should be placed in the other line item. Larger amounts of funds are feasible for the first year of the project to cover start-up activities/training and equipment/data system purchases.

Personnel Allocation: Please provide a list of all personnel. For each, include name, title, annual salary, number of months budgeted, % of time to project (FTE) and amount of funding requested for this position. Provide a total of all salaries and the fringe benefit rate.

Contractor Status Report: Provide the name(s) of each contractor; proposed time period of contract (start/end date), date contract will be/was or will be signed; service to be provided; date service began and contract amount.

Staffing Plan and Personnel Requirement: Applicants must present a staffing plan and provide a justification for the plan that includes education and experience qualifications and rationale for the amount of time being requested for each staff position. Position descriptions that include the roles, responsibilities, and qualifications of proposed project staff must be included in **Attachment 3**. Copies of biographical sketches for any key employed personnel that will be assigned to work on the proposed project must be included in **Attachment 4**. All key personnel must receive prior approval by MCHB/DHSPS. Changes to key personnel throughout the project period must also receive prior approval by MCHB/DHSPS.

For FY 2014, the Consolidated Appropriations Act, 2014, Division H, § 203, Pub. L. 113-76 signed into law on January 17, 2014 includes a provision that states, "None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II" Please see Section **4.1.iv Budget – Salary Limitation** of HRSA's *SF-424 Application Guide* for additional information.

iv. Program-Specific Forms

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

The Health Resources and Services Administration (HRSA) has modified its reporting requirements for SPRANS projects, CISS projects, and other grant programs administered by the Maternal and Child Health Bureau (MCHB) to include national performance measures that were developed in accordance with the requirements of the Government Performance and Results Act (GPRA) of 1993 (Public Law 103-62). This Act requires the establishment of measurable goals for Federal programs that can be reported as part of the budgetary process, thus linking funding decisions with performance. Performance measures for States have also been established under the Block Grant provisions of Title V of the Social Security Act, the MCHB's authorizing legislation. Performance measures for other MCHB-funded grant

programs have been approved by the Office of Management and Budget and are primarily based on existing or administrative data that projects should easily be able to access or collect. An electronic system for reporting these data elements has been developed and is now available.

2) Performance Measures for the ***Healthy Start Initiative: Eliminating Disparities in Perinatal Health*** *and Submission of Administrative Data*

To prepare successful applicants for their reporting requirements, the listing of MCHB administrative forms and performance measures for this program can be found at: https://perf-data.hrsa.gov/mchb/DgisApp/FormAssignmentList/H49_2.HTML

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

v. Attachments

Please provide the following items in the order specified below to complete the content of the application. Please note that these are supplementary in nature, and are not intended to be a continuation of the project narrative. Unless otherwise noted, attachments count toward the application page limit. **Each attachment must be clearly labeled, have a page number, and be listed in the Table of Contents**.

Attachment 1: Transmittal Letter

Attach the transmittal letter for the project that includes all information detailed in Section III. i. Eligible Applicants.

Attachment 2: Work Plan

Attach the Work Plan for the project that includes all information detailed in Section IV. i. Project Narrative including the project implementation plan worksheet and required logic model in this attachment.

Attachment 3: Staffing Plan and Job Descriptions for Key Personnel (see section 4.1. of the HRSA's *SF-424 Application Guide)*

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

Attachment 4: Biographical Sketches of Key Personnel

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

Attachment 5: Letters of Agreement and/or Description(s) of Proposed/Existing Contracts (project specific)

Provide any documents that describe working relationships between the applicant organization and other entities and programs cited in the proposal. Documents that

confirm actual or pending contractual agreements should clearly describe the roles of the contractors and any deliverable. Letters of agreement must be dated. The quality and strength of the relationship between the applicant organization and other entities and programs cited in the proposal should be addressed in this letter and will be a critical element in determining the applicant's collaboration and networking.

Attachment 6: Project Organizational Chart

Provide a one-page figure that depicts the organizational structure of the grantee organization, including subcontractors and other significant collaborators. Include where Healthy Start fits within the larger organization.

Attachment 7: Tables, Charts, etc.

To give further details about the proposal (e.g., Gantt or PERT charts, flow charts, etc.).

Attachment 8: For Multi-Year Budgets--Fifth Year Budget, if applicable

After using columns (1) through (4) of the SF-424A Section B for a four year and nine month project period. The applicant will need to submit the budgets for year 5 as an attachment. They should use the SF-424A Section B.

Attachments 9-15: Other Relevant Documents

Include here any other documents that are relevant to the application, including letters of support. Letters of support must be dated and specifically indicate a commitment to the project/program (in-kind services, dollars, staff, space, equipment, etc.) List all other support letters on one page. The letter of support should address the quality and strength of the relationship between the applicant organization and the letter writer.

3. Submission Dates and Times

Notification of Intent to Apply

A pre-application letter of intent is requested from applicants. Although the letter of intent is optional, it is a useful tool for HRSA planning. An applicant is eligible to apply even if no letter of intent is submitted.

The letter should identify the applicant organization and its intent to apply, the Level (1, 2 or 3) to which the organization wishes to apply, and briefly describe the proposal to be submitted. The letter of intent should also include eligible project area identification (urban, rural, or border) and anticipated level of funding.

Receipt of Letters of Intent will ***not*** be acknowledged.

This letter should be sent via email by *March 3, 2014* to:

Director, Division of Independent Review
HRSA Digital Services Operation (DSO)
Please use HRSA opportunity number as email subject (HRSA-14-121, HRSA-14-120 or HRSA-14-122)
HRSADSO@hrsa.gov

Application Due Date
The due date for applications under this funding opportunity announcement is *March 31, 2014 at 11:59 P.M. Eastern Time*.

4. Intergovernmental Review

Healthy Start Initiative: Eliminating Disparities in Perinatal Health is a program subject to the provisions of Executive Order 12372, as implemented by 45 CFR 100. See Executive Order 12372 in the HHS Grants Policy Statement.

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

5. Funding Restrictions

Applicants responding to this announcement may request funding for a project period of up to four years and nine months, at no more than the chosen funding Level 1, 2, or 3 per year (as listed in the Summary of Funding section). 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.

Funds awarded under this announcement may not be used for the following purposes:

Shared Staffing: Applicants proposing to utilize the same director or contractual staff across multiple grants/programs (e.g., CISS, SPRANS, HS, State Title V block grant, WIC) should assure that the combined funding for each position does not exceed 100% FTE. If such an irregularity is found, HS funding will be reduced accordingly.

Shared Equipment: Applicants proposing to purchase equipment which will be used across multiple grants/programs (e.g., CISS, SPRANS, HS, State Title V block grant, WIC) should pro-rate the costs of the equipment across programs and show the calculation of this pro-ration in their justification. If an irregularity is found where HS equipment is being used by other programs without reimbursement, HS funding will be reduced accordingly.

Cash Stipends/Incentives: Funds cannot be utilized for cash stipends/monetary incentives given to clients to enroll in project services. However, funds can be used to facilitate participation in project activities (e.g. day care/transportation costs/tokens to attend prenatal/ well child clinic visits), as well as for services rendered to the project (e.g., adolescent peer mentors).

Purchase of Vehicles: Projects should not allocate funds to buy vehicles for the transportation of clients, but rather lease vehicles or contract for these services.

The General Provisions in Division F, Title V of the Consolidated Appropriations Act, 2012 (P.L. 112-74) and continued through the Consolidated and Further Continuing Appropriations Act, 2013 (P. L. 113-6), and the Continuing Appropriations Act, 2014 (P.L. 113-46), apply to this program. Please see Section 4.1 of HRSA's *SF-424 Application Guide* for additional information.

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

V. Application Review Information

1. Review Criteria

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

Applicants should pay strict attention to addressing all these criteria, as they are the basis upon which the reviewers will evaluate their application.

Review Criteria are used to review and rank applications. Applicants will be scored by points assigned to review criteria. The number of points assigned to each criterion depends on the applicant level of funding (**HRSA-14-121:** Level 1: Community-based Healthy Start, **HRSA-14-120:** Level 2: Enhanced Services Healthy Start, or **HRSA-14-122:** Level 3: Leadership and Mentoring Healthy Start). The number of points may differ for review criteria by level depending on the importance of that criterion for that particular level. The *Healthy Start Initiative: Eliminating Disparities in Perinatal Health has* seven (7) review criteria:

Criterion 1: NEED – Corresponds to Section IV's Introduction and Needs Assessment

Level 1: 20 points
Level 2: 10 points
Level 3: 10 points

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

1. The extent to which the proposed plan defines problems in relationship to the needs to: 1) improve women's health, 2) promote quality services, 3) strengthen family resilience, 4) achieve collective impact, 5) increase accountability through quality improvement, performance monitoring, and evaluation.

2. The extent to which the demonstrated need(s) of the target population to be served are adequately described and supported in the needs assessment and summarized in the problem statement.

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

4. 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 consumers.

Criterion 2: RESPONSE – Corresponds to Section IV's Methodology, Workplan, and Resolution of Challenges

Level 1: 20 points
Level 2: 15 points
Level 3: 10 points

The extent to which the proposed project responds to the "Purpose" 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.

1. 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.

2. The extent to which the workplan activities proposed for each approach (improve women's health, promote quality services, strengthen family resilience, achieve collective impact, and conduct quality improvement, performance monitoring, and evaluation) appear feasible and likely to contribute to the achievement of the project's objectives within each budget period.

3. The extent to which the applicant has identified challenges and proposed feasible responses to resolve challenges.

4. The extent to which the CAN includes/or will include the appropriate representation of target area consumers, providers, and other key stake holders and leaders.

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

Criterion 3: EVALUATIVE MEASURES (10 points for all levels) – Corresponds to Section IV's Evaluation and Technical Support Capacity

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

1. The extent to which the proposed evaluation plan is designed to measure program performance, and is well organized, adequately described, and utilizes sound evaluation methodologies.

2. The extent to which each proposed methodology within the local evaluation is either congruent to or linked with the scopes of the approaches required of all HS grantees to: improve women's health, promote quality services, strengthen family resilience, achieve collective impact, and conduct quality improvement, performance monitoring, and evaluation.

3. The extent to which the proposed methodology includes a feasible and valid plan for data collection and reporting for both local and national evaluation.

Criterion 4: IMPACT – Corresponds to Section IV's Methodology

Level 1: 10 points
Level 2: 15 points
Level 3: 20 points

The feasibility and effectiveness of plans for dissemination of project results, the extent to which project results may help to achieve collective impact, the degree to which the project activities are replicable, and the sustainability of the program beyond the Federal funding.

1. The extent to which the proposed plan describes sustainable and/or replicable activities in the areas of: improving women's health, promoting quality services, and strengthening family resilience.

2. The extent to which the community action plan proposes to work with other programs and activities serving the MCH population to drive community change and collective impact, as appropriate to the proposed level.

3. The extent to which the applicant demonstrates understanding of the concept of collective impact and describes roles in achieving collective impact, including carrying out or supporting the functions of a backbone organizations.

4. The extent to which the applicant proposes to sustain the project through new or existing sources and/or to acquire additional resources.

Criterion 5: RESOURCES/CAPABILITIES – Corresponds to Section IV's Organizational Information

Level 1: 15 points
Level 2: 20 points
Level 3: 20 points

The extent to which 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.

1. 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.

2. The extent to which the applicant has demonstrated the successful ability to maximize and coordinate existing resources, monitors contracts, and acquire additional resources.

3. The extent to which the applicant's fiscal and programmatic contract monitoring system demonstrates their successful ability to implement and monitor their program.

4. The extent to which the applicant has demonstrated experience in quality improvement or how the applicant plans to acquire that expertise.

Criterion 6: SUPPORT REQUESTED (10 points for all levels) – Corresponds to Section IV's Budget and Budget Justification

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

1. The extent to which costs, as outlined in the budget and required resources sections, are reasonable given the scope of work.

2. The extent to which key personnel have adequate time devoted to the project to achieve project objectives.

Criterion 7: COMMUNITY READINESS – Corresponds to Section IV's Organizational Information

Level 1: 15 points
Level 2: 20 points
Level 3: 20 points

Applicants must have significant demonstrated experience with implementing strategies/activities targeted to improving perinatal outcomes and reducing racial/ethnic disparities using community-based approaches. A successful applicant must have significant demonstrated experience in addressing social determinants of health as a method for reducing infant mortality in targeted communities. Life course theory must be well integrated into successful applications to demonstrate interventions aimed at addressing the critical and sensitive periods of development (i.e., preconception, prenatal, interconception, infancy, etc.).

1. [All levels] The extent to which the project is linked to an existing perinatal system of care that enhances the community's perinatal health programs already in operation in the target area.

2. [All levels] The capacity, expertise and past experience of the applicant agency to carry out, and manage a maternal and child health promotion, case management and service coordination approach supporting the proposed activities within the proposed target area directed at the proposed target population.

3. [Levels 2 and 3] The capacity, expertise and past 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.

4. [Levels 2 and 3] The extent of demonstrated support from local and state leadership (e.g., elected officials, hospital systems and local universities, etc.).

5. [All levels] The capacity of the applicant agency to support enrollment and implementation of health insurance coverage, appropriate to level.

6. [All levels] The extent to which the applicant demonstrates strong, meaningful, and ongoing collaboration with other community organizations and MCH programs such as Title V block grant, Maternal, Infant, and Early Childhood Home Visiting (MIECHV) programs, Title X family planning, and ACF Early Head Start, but does not duplicate services.

7. [Level 3] The extent to which the applicant demonstrates and documents the capacity to serve as a resource, training, mentor, and consultant to other HS grantees and perinatal projects.

2. Review and Selection Process

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

3. Anticipated Announcement and Award Dates

It is anticipated that awards will be announced prior to the start date of September 1, 2014.

VI. Award Administration Information

1. Award Notices

The Notice of Award will be sent prior to the start date of September 1, 2014. See Section 5.4 of HRSA's *SF-424 Application Guide* for additional information.

2. Administrative and National Policy Requirements

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

Human Subjects Protection:
Federal regulations (45 CFR 46) require that applications and proposals involving human subjects must be evaluated with reference to the risks to the subjects, the adequacy of protection against these risks, the potential benefits of the research to the subjects and others, and the importance of the knowledge gained or to be gained. If research involving human subjects is anticipated, grantees must meet the requirements of the HHS regulations to protect human subjects from research risks as specified in the Code of Federal Regulations, Title 45 –

Public Welfare, Part 46 – Protection of Human Subjects (45 CFR 46), available online at http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.html.

3. Reporting

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

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

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

1. Performance Measures and Program Data
To prepare successful applicants for their reporting requirements, the listing of MCHB administrative forms and performance measures for this program can be found at: https://perf-data.hrsa.gov/mchb/DgisApp/FormAssignmentList/H49_2.HTML.

2. Performance Reporting
Successful applicants receiving grant funds will be required, within 120 days of the Notice of Award (NoA), to register in HRSA's Electronic Handbooks (EHBs) and electronically complete the program specific data forms that appear for this program at: https://perf-data.hrsa.gov/mchb/DgisApp/FormAssignmentList/H49_2.HTML. This requirement entails the provision of budget breakdowns in the financial forms based on the grant award amount, the project abstract and other grant summary data as well as providing objectives for the performance measures.

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

3. Project Period End Performance Reporting

Successful applicants receiving grant funding will be required, within 90 days from the end of the four years and nine months project period, to electronically complete the program specific data forms that appear for this program at: https://perf-data.hrsa.gov/mchb/DgisApp/FormAssignmentList/H49_2.HTML. The requirement includes providing expenditure data for the final year of the project period, the project abstract and grant summary data as well as final indicators/scores for the performance measures.

VII. Agency Contacts

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

Tonya Randall
Grants Management Specialist
Health Resources and Services Administration (HRSA), OFAM
Division of Grants Management Operations
Maternal Child and Health Systems Branch (MCHSB)
Parklawn Building, Room 11A-02
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 594-4259
Fax: (301) 443-6343
Email: TRandall@hrsa.gov

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

Beverly Wright or Benita Baker
Branch Chiefs, Healthy Start
Division of Healthy Start and Perinatal Services
Attn: Healthy Start Initiative: Eliminating Disparities in Perinatal Health
Maternal and Child Health Bureau, HRSA
Parklawn Building, Room 13-91
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 443-8283
Fax: (301) 594-0186
Email: bwright@hrsa.gov or bbaker@hrsa.gov

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

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

Successful applicants/awardees 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 Call Center, Monday-Friday, 9:00 a.m. to 5:30 p.m. ET:

HRSA Contact Center
Telephone: (877) 464-4772
TTY: (877) 897-9910
E-mail: CallCenter@HRSA.GOV

VIII. Other Information

Technical Assistance Webcast:

MCHB will also host a technical assistance webcast on **Friday, February 21, 2014 from 2:00 – 4:00 pm EST** to review the FOA and answers applicants' questions. Applicants can access the webcast at : **https://hrsa.connectsolutions.com/healthystart_ta/**. Click "Enter as a Guest" and type in name. If an applicant is unable to attend the live webcast, a recording of the webcast will be available on http://www.hrsa.gov/grants/apply/assistance/healthystart/ after February 24, 2014.

Logic Models:

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

Although there are similarities, a logic model is not a work plan. A work plan is an "action" guide with a timeline used during program implementation; the work plan provides the "how to" steps. Information on how to distinguish between a logic model and work plan can be found at the following website: http://www.cdc.gov/healthyyouth/evaluation/pdf/brief5.pdf.

IX. Tips for Writing a Strong Application

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

APPENDIX A: Benchmarks

MCHB has developed benchmarks to assist HS grantees in identifying targets for the end of the project period. It is expected that successful applicants will develop project plans to meet, maintain, or exceed the identified benchmarks by the end of the four years and nine months project period. There are two categories of benchmarks based on Healthy People 2020 objectives and HS Project objectives. The benchmarks are listed below. More information and guidance will be provided on the collection and reporting of the Benchmarks upon receipt of funding.

Improve Women's Health: Four areas of women's health-related activity are key for HS grantee efforts to improve the health of women before, during, and after pregnancy: a) outreach and enrollment in health coverage, b) coordination and facilitation of access to health care services; c) support for prevention, including clinical preventive services, interconception health, and health promotion; and d) assistance with reproductive life planning.

- Increase the proportion of HS participants with health insurance to 90%.
- Increase the proportion of HS participants who have a documented reproductive life plan to 90%.
- Increase the proportion of HS participants who receive a postpartum visit to 80%.
- Increase the proportion of women, infants, and children participating in HS who have a medical home to 80%.
- Increase proportion of well women visits among HS participants to 80%.

Promote Quality: Four areas of quality improvement-related activity are required for HS grantees. These activities will: a) improve service coordination and systems integration, b) focus on prevention and health promotion (e.g. breastfeeding, immunization, safe sleep, family planning, smoking cessation, FASD), c) apply core competencies for the HS workforce, and d) use standardized curricula and interventions.

- Increase the proportion of HS participants who engage in safe sleep behaviors to 80%.
- Increase the proportion of HS infants who are ever breastfed to 82%.
- Increase the proportion of HS infants who breastfed at 6 months to 61%.
- Increase abstinence from cigarette smoking among HS pregnant women to 90%.
- Reduce the proportion of HS pregnancies conceived within 18 months of a previous birth to 30%.
- Increase proportion of well child visits (including immunization) for HS participants' children between ages 0-24 months to 90%.
- Reduce the proportion of HS participants with elective delivery before 39 weeks to 10%.

Strengthen Family Resilience: Four areas of resilience-related activity are required for HS grantees. These are activities to: a) address toxic stress and support trauma-informed care, b) support mental and behavioral health, c) promote father involvement, and d) improve parenting.

- Increase the proportion of HS participants who receive perinatal depression screening and referral to 100%.

- Increase the proportion of HS participants who receive follow up services for perinatal depression to 90%.
- Increase the proportion of HS participants who receive intimate partner violence (IPV) screening to 100%.
- Increase the proportion of HS grantees that demonstrate father and/or partner involvement (e.g., attend appointments, classes, infant/child care) during pregnancy to 90%.
- Increase the proportion of HS grantees that demonstrate father and/or partner involvement (e.g., attend appointments, classes, infant/child care) with child 0-24 months to 80%.
- Increase the proportion of HS participants that read daily to a HS child between the ages of 0-24 months to 50%.

Achieve Collective Impact: Two areas of collective impact-related activity are a) develop a CAN and b) contribute to collective impact.

- Increase the proportion of HS grantees with a fully implemented CAN to 100%.
- Increase the proportion of HS grantees with at least 25% HS participant membership on their CAN membership to 100%.

Increase Accountability through Quality Improvement, Performance Monitoring, and Evaluation: Three areas of accountability-related activity are required for HS grantees. These are activities to: a) use continuous quality improvement, b) conduct performance monitoring, and c) conduct local evaluation.

- Increase the proportion of HS grantees who establish a quality improvement and performance monitoring process to 100%.
- For Level 3, increase the proportion of HS grantees that have a fully implemented CoIIN process to 90%.

Benchmarks	Descriptions	Numerator/ Denominator
Improve Women's Health:		
Increase the proportion of HS participants with health insurance to 90%.	Healthy Start (HS) Participants should enroll in health insurance to receive medical and/or health care services.	Number of HS participants with health insurance / **(divided by)** Number of total HS Participants
Increase the proportion of HS participants who have a documented reproductive life plan to 90%.	HS participants will have a comprehensive reproductive life plan to determine if or when they plan to have children in the future, and identify family planning methods to help them fulfill their plan.	Number of HS participants with reproductive life plans / **(divided by)** Number of total HS Participants of childbearing age
Increase the proportion of HS participants who receive a postpartum visit to 80%.	HS participants will a see a health care provider (typically 6 weeks after childbirth) to determine physical and emotional recovery from delivery and address future preventive needs.	Number of HS postpartum participants who received postpartum visits/ **(divided by)** total number of HS participants who gave birth
Increase the proportion of women, infants, and children participating in HS who have a medical home to 80%.	HS participants should have a medical home. The medical home encompasses five functions and attributes (comprehensive care, patient-centered, coordinated care, accessible services, and quality and safety).	Number of women, infants, and children of HS participants in medical homes/ **(divided by)** number of women, infants, children in the HS program
Increase proportion of well woman visits	HS participants should receive a well woman visit. The well	Number of HS participants

among HS participants to 80%.	woman visits is 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.	who received a well woman visits / **(divided by)** number of total HS female participants
Promote Quality:		
Increase the proportion of HS participants who engage in safe sleep behaviors to 80%.	HS participants should practice safe sleep for their infants. These behaviors include infants sleeping on their backs on clean and firm surfaces, in the absence of smoke, and with no extra bedding (pillows) or toys.	Number of HS participants who engage in safe sleep behaviors for their infants/ **(divided by)** total number of HS participants with infants (0-24 months)
Increase the proportion of HS infants who are ever breastfed to 82 %.	HS participants should breastfeed their infants and/or children. **Breastfeeding** is the feeding of their infants or young children with breast milk directly from female human breasts (i.e., via lactation) rather than using infant formula,	Number of HS participants' infants who were ever breastfed / **(divided by)** total number of HS infants (0-24 months)
Increase the proportion of HS infants who breastfed at 6 months to 61%.	HS Participants should breastfeed their infants at 6 months. **Breastfeeding** is the feeding of their infants at 6 months (i.e. via lactation) rather than using infant formula.	Number of HS participants' infants who were breastfed at 6 months/ **(divided by**) total number of HS infants (0-24 months)
Increase abstinence from cigarette smoking among HS pregnant women to 90 %.	HS pregnant participants who abstain from smoking cigarettes.	Number of HS participants who abstained from smoking cigarettes during pregnancy/

		(divided by) total number of HS pregnant participants
Reduce the proportion of HS pregnancies conceived within 18 months of a previous birth to 30%.	HS participants should space pregnancies at least 18 months apart.	Number HS participants who conceived within 18 months of previous birth/ **(divided by)** total number of HS participants who have conceived with a prior birth
Increase proportion of well child visits (including immunization) for HS participants' children between ages 0-24 months to 90%.	HS participants should ensure their infants and children receive well child visits. The well child visit is a preventive care visit annually for children to obtain the recommended preventive services that are age and developmentally appropriate including immunizations.	Number of HS children (0-24 months) who receive well child visits / **(divided by)** total number of children in the HS program
Reduce the proportion of HS participants with elective delivery before 39 weeks to 10%.	The elimination of non-medically indicated (elective) deliveries before 39 weeks gestational age.	Number of HS participants with elective delivery before 39 weeks / **(divided by)** total number of birth among HS participants (exclude medically indicated deliveries)
Strengthen Family Resilience:		
Increase the proportion of HS participants who receive perinatal depression screening and referral to 100%.	All HS participants should receive a perinatal depression screening using an evidence-based depression tool.	Number of HS participants who receive perinatal depression screening and

		referral / **(divided by)** HS participants were eligible for perinatal depression screening and referrals
Increase the proportion of HS participants who receive follow up services for perinatal depression to 90%.	HS participants should receive the necessary follow-up services after the completion of the perinatal depression screening.	Number of HS participants who received follow up services for perinatal depression screening/ **(divided by**) total number of total HS participants identified as needing follow up services
Increase the proportion of HS participants who receive intimate partner violence screening to 100%.	All HS participants will receive the intimate partner violence (IPV) screening. IPV is a pattern of behavior which involves the abuse by one partner against another in an intimate relationship such as marriage, cohabitation, dating or within the family.	Number of HS participants who received intimate partner violence screening / **(divided by**) total number of HS participants
Increase the proportion of HS grantees that demonstrate father and/or partner involvement (e.g., attend appointments, classes, infant/child care) during pregnancy to 90%.	Father and/or partner involvement should consider participation in areas of medical appointments for infants, other children and/or mother, attending HS sponsored classes, prenatal care, care for infant or child during pregnancy.	Number of fathers and/or partners engaged in activities (e.g., attend appointments, classes, infant/child care) with HS participants during pregnancy / **(divided by)** total number of fathers and/ or partners
Increase the proportion of HS grantees that demonstrate father and/or partner	Father and/or partner involvement should consider participation in areas of medical appointments for infants, children and/or mother,	Number of fathers and/or partners engaged in activities

involvement (e.g., attend appointments, classes, infant/child care) with child 0-24 months to 80%.	attending HS sponsored classes, prenatal care, care for infant or child etc.	(e.g., attend appointments, classes, infant/child care) with child 0-24 months HS participants / **(divided by)** number of total fathers and/or partners
Increase the proportion of HS participants that read daily to a HS child between the ages of 0-24 months to 50%.	HS participants (including fathers and partners) should read to infant and/or child.	Number of HS participants involved in reading to their children between ages 0-24 months/ **(divided by)** total number of HS participants with children between ages 0-24 months
Achieve Collective Impact:		
Increase the proportion of HS grantees with a fully implemented CAN to 100%.	CAN is an existing, formally organized partnership, advisory board or coalition of organizations and individuals representing consumers and appropriate agencies 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.	Number of HS grantees with CAN / (**divided by)** total number of HS grantees
Increase the proportion of HS grantees with at least 25% HS participant membership on their CAN membership to 100%.	HS participants must have active membership in CAN.	Number of total HS participants in CAN / **(divided by)** total number of CAN membership

Increase Accountability through Quality Improvement, Performance Monitoring, and Evaluation:		
Increase the proportion of HS grantees who establish a quality improvement and performance monitoring process to 100%.	All HS grantees must have formal quality improvement and performance monitoring process in place within a year of implementation of the grant.	Refer to methodology section of FOA
For Level 3, increase the proportion of HS grantees that have a fully implemented CoIIN process to 90%.	The HS CoIIN would develop plans to reduce infant mortality by using common priorities in a collaborative way using evidence-based strategies and facilitate collaborative learning and adoption of quality improvement (QI) principles and practices across participating HS sites to reduce infant mortality and improve birth outcomes.	Refer to methodology section of FOA

APPENDIX B: 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 Healthy Start 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 the project is progressing towards achieving one of their Project Period objectives.

Below 100 Percent of the Federal Poverty Level: Annual income for the client's family, compared to the Federal Poverty Level. 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). Grantees 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 February 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 Healthy Start projects.

Births with Evidence of Prenatal Exposure to Alcohol: Evidence, at time of delivery, of alcoholic beverages (wine, beer, mixed drinks, e.g., coolers or distilled liquor) consumed during pregnancy.

Births with Evidence of Prenatal Exposure to Drugs: Evidence, at time of delivery, of any drug – other than over the counter or prescription drug – used inappropriately.

Births with Evidence of Prenatal Exposure to HIV/AIDS: Births with exposure to, or presence of, HIV.

Births with Evidence of Prenatal Exposure to STD/STI: Presence, at time of delivery, of Sexually Transmitted Disease/Infection (Syphilis, Gonorrhea, Herpes, Chlamydia, Hepatitis B, etc.).

Border Project Area: Border communities are those communities located within 62 miles/100 kilometers of the U.S./Mexico border. In order to be considered for Border Community funding, the project area and the target population to be served both have to reside within 62 miles/100 kilometers of the U.S./Mexico border.

Budget Period: The interval of time (usually 12 months) into which the project period is divided for budgetary and funding purposes. For the purposes of this FOA, the initial Budget Period is September 1 – May 31 and the remaining budget periods are June 1 – May 31.

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 policy making 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 Services: Provision of services in a coordinated, culturally competent approach through client assessment, referral, monitoring, facilitation, and follow-up on utilization of needed services. Case management is also known as care coordination. For pregnant women, these services include those that assure access and utilization of quality prenatal care, delivery, and postpartum care. For infants up to two years of age, these services assure access and utilization of appropriate quality preventive and primary care services.

Childbirth Education (Number of Participants Who Received): Number of participants who received child-birth information per a pre-designed schedule/curriculum as an ongoing part of their prenatal care or participated in a formal Childbirth Education program. Childbirth education information may have been provided in classes, support groups, or in one-on-one sessions. Information may have been offered either directly or through an outside referral source.

Client Satisfaction: The number of unduplicated MCHB supported projects that report being satisfied with the responsiveness of services provided to them by MCHB in a determined time period as measured by customer satisfaction surveys.

Collaborative Improvement and Innovation Network (CoIIN): A public-private partnership 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 toward shared benchmarks. Team use common priorities in a collaborative way using evidence-based strategies and facilitate collaborative learning and adoption of quality improvement (QI) principles and practices.

Collective Impact: The result of having organizations from different sectors agree to solve a specific social problem using a common agenda, aligning their efforts, and using common measures of success. The five conditions for collective impact are: 1) a common agenda, 2) shared measurement system, 3) mutually reinforcing activities, 4) continuous communication, and 5) backbone organization support.

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 MCHB program/agency. The purpose of these referrals can be either treatment-related or preventive.

Comprehensive System of 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 or coalition 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 must have current approved by-laws, which include policies regarding conflict of interest, to serve the needs as identified by its mission and/or functional 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 Healthy Start Consortium.

Community Participant: is an individual who attends a Healthy Start sponsored event or participates in consortium activities, etc.

CAN Training (Number of Individual Members Trained): Number of individual consortium members participating in formalized Healthy Start funded consortium training.

Contractor: An entity/individual with whom the grantee 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 grantee organization. The scope of one contractor=s proposed services cannot constitute the bulk of services for the proposed Healthy Start project; such sub-granting is not allowed under HRSA.

Cultural Competence: A set of values, behaviors, attitudes, and practices within a system, organization, program or among individuals which enables them to work effective 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 Health Care Services: 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, 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.

Intimate Partner/ Domestic Violence (Number of Participants Served): Number of participants who have received Healthy Start services directed at the prevention or treatment/reduction of domestic violence. This may include formal presentations, support groups, or one-on-one counseling sessions related to domestic violence.

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

Family Planning: Number of participants receiving individualized family planning counseling and/or services with a medical provider or other health provider. The primary purpose is to provide services related to contraception, infertility, or sterilization.

Fetal Alcohol Spectrum Disorder (FASD): 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.

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.

HIV/AIDS Education Only (Number of Participants Who Received): Number of participants who have received individual and/or group education on HIV/AIDS without lab testing. This includes teaching clients on how to get tested, but where the testing was not included in the Healthy Start service.

HIV/AIDS Counseling and Treatment (Number of Participants Served): Number of participants who have received Healthy Start funded individual and/or group counseling which includes (blood) testing, and/or treatment services related to HIV/AIDS, including psycho-social, care giver support, other medical and/or support activities.

Housing Assistance Referrals (Number of Participants Referred): Number of Healthy Start participants who have received assistance and/or a referral pertaining to locating, repairing, or paying for permanent or temporary housing.

Hypertension: Under new, stricter national blood pressure guidelines issued in May 2003, a resting blood pressure reading below 120/80 millimeters of mercury (mm Hg) is normal. Hypertension, or high blood pressure, is defined as a resting blood pressure consistently at 140/90 mm Hg or higher. (Mayo Clinic, 2003)

Immunizations: Number of age-appropriate immunizations provided (e.g., MMR, OPV, DPT, H. influenza, and Hepatitis B) according to AAP/PCIP established standards) during Healthy Start funded activities/services.

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.

Infrastructure Building Services: The base of the MCH pyramid of health services and form its foundation. They are activities directed at improving and maintaining the health status of all women and children by providing 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 include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care.

In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Jobs/Jobs Training (Total Participants Served): Number of Healthy Start participants who have attended programs designed to assist participants in improving, in obtaining and maintaining employment or furthering their formal education including job skills classes, training programs in specific skills, academic mentoring/tutoring programs, GED training, literacy, and English as a Second Language.

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.

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.

Male Support Services (Total Males Served): Number of men who have attended or been involved in the Healthy Start funded fatherhood or male support group activities.

Medical Home (AHQR): The medical home encompasses five functions and attributes:
1. 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.

2. 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.

3. 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.

4. 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.

5. 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.

Mental Health Services (Number of Participants Served): Number of participants in Healthy Start funded mental health activities (i.e., support groups, individual, and group therapy).

Mental Health Services (Number of Participants Referred): Number of Healthy Start participants referred for residential or outpatient mental health services.

Moderate Low Birth Weight: Live births with birth weight greater than or equal to 1500 and less than 2,500 grams (i.e., 1500-2499 grams). This measure is usually reported as a percentage of the total number of live births.

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, care giver from birth to 28 days.

Number of Women Assisted by Case Management: Number of Healthy Start women/program participants who participated in activities which assisted them in gaining and coordinating access to necessary care and services appropriate to their needs. Case management can encompass various types of activities e.g., facilitation/ coordination of services (assessment of family's health and social service needs) development of a care plan; arrangements to assist family in accessing services; follow up on either referrals or no shows; tracking family's changing service needs and/or progress.

Number of Women Assisted through Home Visiting: Number of women/ program participants who were visited in their homes by Healthy Start affiliated health, social, or educational professionals, or by workers with special training including indigenous workers, community perinatal outreach workers, neighborhood health advocates, resource mothers/fathers, etc.

Number of Women Assisted by Outreach: Number of women/ program participants for which there is documentation that they met with a Healthy Start community outreach worker and received services (e.g., Outreach worker logs, assignment sheets, client records).

Number of Pregnant Women/Mothers of Infants Showing Evidence of Alcohol Use: Binge or excessive consumption of alcoholic beverages (wine, beer, mixed drinks, e.g., coolers or distilled liquor).

Number of Pregnant Women/Mothers of Infants Showing Evidence of Behavior Risk Factors: Behavioral risk factors may be documented, and recorded, through 1) self-reporting by the women/ program participants, or 2) other clinical observations.

Number of Mothers of Infants Showing Evidence of Diabetes: Presence by the woman/ program participants of diabetes mellitus (receiving medication to manage blood sugar, insulin dependent) or gestational diabetes.

Number of Pregnant Women/Mothers of Infants Showing Evidence of Intimate Partner/Domestic Violence: Physical, sexual and/or emotional abuse of a woman/ program participants by her partner, companion or another family member.

Number of Mothers of Infants Showing Evidence of Drug Use: Any drug including over the counter or prescription drug used inappropriately.

Number of Mothers of Infants Showing Evidence of Inadequate Housing: Presence of environmental hazards in housing conditions, (i.e., accident hazards, plumbing, electrical, water, heat, ventilation, facilities for cooking, privacy, access barriers).

Number of Pregnant Women/Mothers of Infants Showing Evidence of Lack of Family Support: Family system of the woman/ program participants unable to meet emotional and/or physical needs of participant.

Number of Mothers of Infants Showing Evidence of Problems with Bonding with Infant: Inattention to infant needs, presence of verbalization of negative characteristics of infant, resentment of infant, etc.

Number of Mothers of Infants Showing Evidence of Smoking Use: Presence of tobacco use by the mother.

Number of Mothers Who Received Child Care Services for Their Infant(s): Number of Healthy Start women/ program participants for which intermittent child care has been arranged and/or financed by Healthy Start. Includes care provided either on and/or off clinic sites, and other child care provider sites.

Number of Mothers Who Received Translation Services: Number of women/ program participants who received translation services funded in whole, or in part, by Healthy Start.

Number of Mothers Who Received Transportation Services Includes Tokens, Taxis, Vans: Number of Healthy Start women/ program participants who received transportation services either directly or by a completed referral to a Healthy Start funded transportation provider.

Number of Participants Directly Served: Number of Healthy Start participants who received substance abuse treatment through a residential, outpatient, or other day treatment program funded by Healthy Start.

Number of Participants Referred: Number of Healthy Start participants who have a completed service referral for substance abuse treatment. (i.e., received services from provider to whom s/he was referred by project).

Number of Postpartum Women Influenced By Healthy Start Outreach Activities Prior to Becoming a Participant: Number of clients who enrolled in the Healthy Start program and

received clinical services as a result of a session with or personal contact from a community outreach worker, or a local public education and/or media campaign.

Number of Postpartum Women Participating During Reporting Period: Number of participants who both enrolled and received services after delivery.

Number of Pregnant Participants During Reporting Period: Unduplicated count of all current pregnant participants during reporting period. Participant's age and appropriate age groups should be determined at time of enrollment into any Healthy Start activity.

Number of Pregnant Women Influenced By Healthy Start Outreach Activities Prior to Becoming a Participant: Number of clients who enrolled in the Healthy Start program and received clinical services as a result of a session with or personal contact from a community outreach worker, or a local public education and/or media campaign.

Number of Pregnant Women Showing Evidence Of HIV/AIDS: Presence of HIV

Number of Pregnant Women Showing Evidence Of STDs: Presence of Sexually Transmitted Disease (Syphilis, Gonorrhea, Herpes, Chlamydia, and Hepatitis B)

Number of Pregnant Women Showing Evidence Of Diabetes: Presence of diabetes mellitus (diet controlled receiving medication to manage blood sugar, insulin dependent) or gestational diabetes.

Number of Pregnant Women Showing Evidence Of Hypertension: Presence of a higher blood pressure than is judged to be normal (usually a diastolic pressure of at least 90 mm Hg or a systolic greater than 140 mm Hg or a 15 mm Hg rise in diastolic or at 30 mm Hg in systolic over base line).

Number of Pregnant Women Showing Evidence Of Inadequate Housing: Presence of environmental hazards in housing conditions, (i.e., structural/accident hazards; plumbing, electrical, water, heat, ventilation, facilities for cooking, privacy, access barriers)

Number of Pregnant Women Who Are Medicaid Recipients: Recorded at assessment, updated as necessary.

Number of Pregnant Women Receiving Prenatal Care: Participants who report prenatal care.

Number of Pregnant Women Receiving Adequate Prenatal Care: Number of participants who receive adequate prenatal care as measured by the Kotelchuck Scale, Kessner Index, or similar index.

Number of Pregnant Women Who Enter Prenatal Care During First Trimester: Number of participants with reported first prenatal visit before 13 weeks gestation.

Number of Pregnant Women who Enter Prenatal Care During Second Trimester: Number of participants with reported first prenatal visit between 13 week and 25 week gestation.

Number of Pregnant Women who Enter Prenatal Care During Third Trimester: Number of participants with reported first prenatal visit between 26 week and delivery.

Number of Women Making Postpartum Visit within Eight Weeks of End of Pregnancy: Number of participants within eight weeks of delivery who made at least one visit to a health care provider for a health assessment and/interconception counseling (including postpartum tubal ligation).

Nutrition Education and Counseling including WIC Coordination (Number of Participants Who Received): Number of participating, pregnant women or parents of infants, who have received on a regular or on-going basis, information that is case specific and identifies particular nutritional risks or nutrition related medical conditions that are pertinent to the perinatal period. Services may have been provided and/or coordinated with the local WIC program; or may have been offered by Healthy Start funded professionals.

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 project period objectives through the measurement of their budget period objectives.

Parenting Education (Number of Participants Who Received): Number of participants who attended classes, support groups, or one-on-one education sessions which were provided to parents about infant/child care and development. To qualify as parenting education, these sessions need to be on-going (not sporadic) and have objectives. Parenting tips provided during routine baby exams and sick child care to trips to the emergency room do not constitute parenting education.

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

Perinatal System of Care: 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).

Performance Indicator: A measurable variable developed by the grantee 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: The rate of women in [Target Area] who received early prenatal care in 2002.)

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.

Place-based Initiative: A concept for communities to build capacity through knowledge, skills, relationships, interactions and organizational resources that enable residents, civic leaders, the public and private sectors and local organizations to transform neighborhoods into places of opportunity. Four developmental milestones common to most placed-based initiatives: (1) engaging the community, (2) developing a governance structure, (3) building community capacity for implementation, and (4) learning while doing.

Post-neonatal Mortality: Number of deaths reported by vital records, program records, care giver 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 Clinic Visits: All known medical prenatal care visits made by Healthy Start pregnant clients residing in the project area during the reporting period. The prenatal care visit is made for medical supervision of the pregnancy 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:
A program participant is defined as an individual having direct contact with Healthy Start staff or subcontractors and receiving Healthy Start services on an ongoing systematic basis to improve perinatal and infant health. Specifically, program participants are pregnant women and women of reproductive age and children up to age 2.
Project Area: A geographic area for which improvements have been planned and are being implemented with the Healthy Start 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 Healthy Start funding application process. Healthy Start 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/MCHB.

Project Period: The total time for which Healthy Start funding has been programmatically approved for a project (e.g. four years, two years). A project period may consist of one or more budget periods (defined above). The total project period comprises the original project period and any extensions. For the purpose of this FOA, the four years and nine months project period is September 1, 2014 – May 31, 2019.

Provider Training (Number of Individual Providers Trained): Number of individual providers (professional and paraprofessional workers) participating in Healthy Start funded formalized training activities.

Public Information/Education (Number of Individuals Reached): Number of individuals informed on perinatal issues by Healthy Start media campaigns, health fairs, hotlines, or other Healthy Start funded media activities. Includes persons residing outside the PA who often hear, observe, or respond to Healthy Start media messages via television, radio, bus and/or theater advertisements which by design are directed at the PA community.

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

Race: Racial and ethnic categories reflect Federal Register Announcement "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.

Recommended Number of Well-Child Visits During the First Year of Life: Number of infants at age 12 months or older who received the recommended number of well-child visits for their age.

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

Services Specific to Pregnant Teens: Number of adolescents receiving services from a Healthy Start affiliated program designed for pregnant teens.

Services Specific to Parenting Teens: Number of adolescents receiving services from a Healthy Start affiliated program designed for parenting teens.

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.

Substance Abuse Treatment and Counseling: Number of Healthy Start participants who received substance abuse treatment, counseling and/or referrals. Services may include an array of medical services, including testing and treatment for concurrent HIV/AIDS and/or STD=s,

and psychiatric, psychological or social services which are either provided by a single site or case managed across multiple sites, family and collateral/partner counseling and rehabilitation.

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 MCHB 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 Healthy Start funded project period.

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.

Total # of Deliveries/Births During the Reporting Period: All live births during the reporting period to Healthy Start participants.

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.

Traumatic-Informed Care: An approach that is welcoming and appropriate for trauma survivors (e.g., those with ACE 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 ACE, 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:

- 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.

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 Baby/Pediatric Care Clinic: All ambulatory pediatric care visits made by Healthy Start infant clients residing in the project area, excluding ER visits during the reporting period.

Well Child Visit 2-4 Weeks After Birth: Number of infants whose care giver reports having a well-child visit during this time period.

Well Women 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.

Youth Empowerment/Peer Education/Self-Esteem Mentor Programs: Number of non-pregnant/non-parenting teens who are served by these specified Healthy Start programs. This may include group activities (e.g. Family Life Center activities, Teen Life Center activities, Male Mentoring Programs, Self-Esteem Programs, etc.)

APPENDIX C: RESOURCE LIST

Maternal/Infant Resources:

SUIDS/SIDS Training Toolkit
http://www.mchlibrary.org/suid-sids/trainingtoolkit.html
This toolkit is a collection of resources, curriculum, and programs to reduce SUIDS/SIDS.

Infant Mortality Toolkit: Resources for a Public Health Approach
http://www.mchlibrary.org/toolkits/infant-mortality.html
This toolkit, compiled by the MCH Library and the National SUID/SIDS Resource Center, aims to help the maternal and child health workforce integrate evidenced base practices into infant mortality reduction plans.

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.

Is It Worth It?
http://www.nichd.nih.gov/ncmhep/isitworthit/spreadtheword/Pages/index.aspx#.UbEMEkCR9LJ
This toolkit, developed by the National Institute for Child Health and Human Development, includes a video on the risks of elective early deliveries and materials to accompany the video.

Mother-Baby Dyad Care Implementation Toolkit
http://pcmch.on.ca/initiatives/mother-baby-dyad-care
This toolkit, developed by the Provincial Council for Maternal-Child Health, provides guidance on how to implement mother-baby dyad care.

The Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT) Program
http://www.sophe.org/script.cfm
This smoking cessation program is designed to be implemented as part of a prenatal care provider's health education program.

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.

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.

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

Breastfeeding Resources:

Implementing the Joint Commission Perinatal Care Core Measure on Exclusive Breast Milk Feeding
http://www.usbreastfeeding.org/HealthCareSystem/HospitalMaternityCenterPractices/ToolkitImplementingTJCCoreMeasure/tabid/184/Default.aspx
This toolkit, developed by the United States Breastfeeding Committee, provides information for the Perinatal Core Measure of exclusive breast milk feeding. The toolkit provides guidance on both data collection and adherence to best practices.

The 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.

Loving Support to Glow and Grow in WIC
http://www.nal.usda.gov/wicworks/Learning_Center/BF_training.html
A training to educate WIC staff to promote and support breastfeeding.

Cultural Competence Resources:

The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care
https://www.thinkculturalhealth.hhs.gov/Content/clas.asp
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.

The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice
https://www.thinkculturalhealth.hhs.gov/Content/clas.asp
This implementation guide helps promote and sustain culturally and linguistically appropriate services within an organization by expanding on The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care.

More than Words Toolkit
http://www.hablamosjuntos.org/mtw/default.toolkit.asp
This toolkit provides a series of hands-on tools to clarify the translation process and improve the quality of translated health materials.

Culturally Effective Care Toolkit
http://www.aap.org/en-us/professional-resources/practice-support/Patient-Management/Pages/Culturally-Effective-Care-Toolkit.aspx?nfstatus=401&nftoken=00000000-0000-0000-0000-000000000000&nfstatusdescription=ERROR%3a+No+local+token
This toolkit by the AAP provides resources for providing culturally effective care to patients and their families.

Effective Communication Tools for Healthcare Professionals
http://www.hrsa.gov/publichealth/healthliteracy/index.html?

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

Fatherhood Resources:

Fatherhood E-Learning Modular
http://www.hhs.gov/ash/oah/resources-and-publications/learning/fatherhood/index.html
An online course to educate organizations on the importance of fatherhood involvement

Inside Out 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 24 hours a day, 7 days a week.

Doctor Dad
https://store.fatherhood.org/s-34-doctordad-workshops.aspx
Workshops and curriculum are geared toward first-time or expectant dads and focuses on increasing father knowledge on child health and safety, while increasing fathers' confidence in performing basic parenting skills.

Wise Guys
http://www.wiseguysnc.org/Default.aspx
A curriculum which teaches young men about healthy relationships and making wise sexual decisions.

Common Sense Parenting
http://www.parenting.org/common-sense-parenting
A skill-based parenting program that promotes "healthy family relationships that foster safety and well-being at home, in school and in the community."

Building Blocks for Father Involvement (Head Start/ACF)
http://eclkc.ohs.acf.hhs.gov/hslc/hs/resources/video/Video%20Presentations/BuildBlockstoF
Tools to create a father friendly Head Start program.

Responsible Fatherhood Toolkit: Resources from the Field
http://www.fatherhood.gov/toolkit
A toolkit to create a fatherhood program.

Infant/Child Resources:

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: Safe, Strong, Secure
http://www2.aap.org/connectedkids/
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.

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

AAP: Healthy Child Care America: Building Bridges Project
http://www.healthychildcare.org/BBResources.html
This toolkit by the AAP was developed to promote early brain and child development.

Other Resources:

Social Determinants Toolkit
http://carcweb.musc.edu/sdoh/pledge.html
This toolkit by The Association of Academic Health Centers aims to educate academic health centers and community stakeholders on the importance of the social determinants of health.

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.

Social Media in the States: Tools for Instant Access to Emerging Issues
http://mchlibrary.info/states/social-media.html
This collection of resources, developed by the Maternal Child Health Library at Georgetown University, provides tools for using social media for health information.

Getting the Coverage You Deserve: What to Do If You Are Charged a Co-Payment, Deductible, or Co-Insurance for a Preventive Service
http://www.nwlc.org/resource/getting-coverage-you-deserve-what-do-if-you-are-charged-co-payment-deductible-or-co-insuran
This toolkit provides information on women's preventative health services covered under ACA.

Home Visiting Models
http://mchb.hrsa.gov/programs/homevisiting/models.html
The list of evidence-based home visiting models from HRSA with information on each model.

Community Health Workers Evidence-based Models Toolbox –
http://www.hrsa.gov/ruralhealth/pdf/chwtoolkit.pdf

A toolkit on evidence-based community health worker programs and models by the HRSA Office of Rural Health Policy.

Florida State University Partners for a Healthy Baby
http://www.cpeip.fsu.edu
A home visiting curriculum from prenatal through age 3.

Maternal and Child Health (MCH) Community Activity Checklist

Please check the MCH initiatives and resources available in your proposed project area. Include only programs that have locations/sites or actively provide services within the project area. For example, only check WIC program if there is a physical WIC clinic/office within the project area.

HRSA MCH Programs

- ☐ Healthy Start (previous cycle)
- ☐ Family/Patient Centered Medical Home Program
- ☐ Family-to-Family Health Information Center
- ☐ Maternal, Infant, and Early Childhood Home Visiting Program
- ☐ Early Childhood Program
- ☐ Healthy Tomorrows
- ☐ Other HRSA MCH Program (specify)_____

Other HHS Programs

- ☐ Strong Start (Awardee)
- ☐ Text4baby (Outreach Partners)
- ☐ Women, Infants, and Children (WIC) Program
- ☐ Early Head Start Program
- ☐ Title X Family Planning (specify type below)
    - ☐ Planned Parenthood
    - ☐ Health Department
    - ☐ CHC/FQHC
    - ☐ Other Private Nonprofit
    - ☐ Free-Standing Family Planning Organization
    - ☐ Hospital-based
    - ☐ University-based
    - ☐ Uncategorized
- ☐ Other MCH HHS Program (specify)_____

Collaboratives, Systems, and Networks

- ☐ State Perinatal Quality Collaborative
- ☐ Fetal-Infant Mortality Review Program
- ☐ Other Collaboratives, Systems, Networks (specify)_____