U.S. Department of Health and Human Services

NOTICE OF FUNDING OPPORTUNITY

Fiscal Year 2024

Maternal and Child Health Bureau

Division of Healthy Start and Perinatal Services

Healthy Start Initiative: Eliminating Disparities in Perinatal Health

Funding Opportunity Number: HRSA-24-033

Funding Opportunity Type(s): Competing Continuation, New

Assistance Listing Number: 93.926

Application Due Date: December 15, 2023

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

Issuance Date: September 22, 2023

Mia Morrison, MPH
Supervisory Public Health Analyst, Division of Healthy Start and Perinatal Services
Call: 301-443-2521
Email: MCHBHealthyStart@hrsa.gov

See Section VII for a complete list of agency contacts.

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

508 COMPLIANCE DISCLAIMER

Persons using assistive technology may not be able to fully access information in this file. For assistance, email or call one of the HRSA staff listed in Section VII Agency Contacts.

SUMMARY

Funding Opportunity Title:	Healthy Start Initiative: Eliminating Disparities in Perinatal Health
Funding Opportunity Number:	HRSA-24-033
Assistance Listing Number:	93.926
Due Date for Applications:	December 15, 2023
Purpose:	The purpose of the Healthy Start Initiative: Eliminating Disparities in Perinatal Health (HS) is to improve health outcomes before, during, and after pregnancy and reduce the well-documented racial/ethnic differences in rates of infant death and adverse perinatal outcomes.
Program Objective(s):	Successful HS projects will accomplish the following objectives during the 5-year period of performance: **Direct and Enabling Services for HS Participants** • Increase receipt of case management/care coordination to facilitate access to medical care and community-based resources. • Increase uptake of healthy behaviors before, during, and after pregnancy. • Increase use of healthy and safe infant and toddler care practices.

	Community Consortium Convene diverse, multi-sector state, local, and community level partners, including HS participants and other community members.
Eligible Applicants:	You can apply if your organization is in the United States and is: • Public or private • Community-based • Tribal (governments, organizations) See Section III.1 of this notice of funding opportunity (NOFO) for complete eligibility information.
Anticipated FY 2024 Total Available Funding:	$113,645,000 *We're issuing this notice to ensure that, should funds become available for this purpose, we can process applications and award funds appropriately. You should note that we may cancel this program notice before award if funds are not appropriated.*
Estimated Number and Type of Award(s):	Up to 103 grants
Estimated Annual Award Amount:	Up to $1,100,000 per award, subject to the availability of appropriated funds
Cost Sharing or Matching Required:	No
Period of Performance:	April 1, 2024 through March 31, 2029 (5 years)
Agency Contacts:	**Business, administrative, or fiscal issues:** Tya Renwick Grants Management Specialist Division of Grants Management Operations, OFAM Email: Trenwick@hrsa.gov **Program issues or technical assistance:** Mia Morrison, MPH Supervisory Public Health Analyst

	MCHB Division of Healthy Start and Perinatal Services Email: MCHBHealthyStart@hrsa.gov

Application Guide

You (the applicant organization / agency) are responsible for reading and complying with the instructions included in this NOFO and in *HRSA Application Guide (Application Guide)*. Visit HRSA's How to Prepare Your Application page for more information.

Technical Assistance

We have scheduled the following webinar:

Thursday, October 12, 2023
1 p.m. – 3 p.m. ET

Weblink: https://hrsa-gov.zoomgov.com/j/1615431506?pwd=SnArVTdtTzNFeGVoVWY1MzhjN2loZz09

Attendees without computer access or computer audio can use the following dial-in information:

Call-In Number: 1-833-568-8864
Meeting ID: 161 543 1506
Passcode: 89972057

We will record the webinar.

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I. Program Funding Opportunity Description

1. Purpose

This notice announces the opportunity to apply for funding under the Healthy Start Initiative: Eliminating Disparities in Perinatal Health (Healthy Start or HS) Program. The purpose of HS is to improve health outcomes before, during, and after pregnancy and reduce the well-documented racial/ethnic differences in rates of infant death and adverse perinatal outcomes.[1,2,3] HS is intended to support projects in communities and populations experiencing the greatest disparities in maternal and infant health outcomes.

HS has two focus areas: 1) providing direct and enabling services (for example, screening and referrals, case management and care coordination, health and parenting education, and linkage to clinical care) to enrolled HS participants; and 2) convening Community Consortia (formerly known as Community Action Networks or "CANs") comprised of diverse, multi-sector partners to advise and inform HS activities as well as to develop and implement plans to improve perinatal outcomes within the selected project area. HS continues to have an increased emphasis on addressing social determinants of health, such as access to adequate food, housing, and transportation, to improve disparities in maternal and infant health outcomes. Based on stakeholder feedback, this FY 2024 HS competition also provides recipients with increased flexibility to tailor interventions to the unique needs of their community and/or target population.

The goals of HS are to:

1) Continue reducing infant mortality rates in the United States, and
2) Decrease disparities in infant mortality and poor perinatal health outcomes in areas where those rates are high.

HS projects should be implemented in communities experiencing high rates of maternal and infant mortality and morbidity. Successful HS projects will accomplish the following objectives during the 5-year period of performance:

Direct and Enabling Services for HS Participants

- Increase receipt of case management/care coordination to facilitate access to medical care and community-based resources.
- Increase uptake of healthy behaviors before, during, and after pregnancy.

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[1] https://www.cdc.gov/nchs/data/nvsr/nvsr71/nvsr71-05.pdf
[2] https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/maternal-mortality-rates-2020.htm
[3] https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm

- Increase use of healthy and safe infant and toddler care practices.

Community Consortium

Convene diverse, multi-sector state, local, and community level partners, including HS participants and other community members, that will:

- Advise and inform strategies for providing direct and enabling services to HS participants.
- Develop cross-sector partnerships to ensure access for HS participants to coordinated, comprehensive maternal, child, and family medical care; health and parenting education; and community-based resources within the project area.
- Participate in Communities of Practice with other HS/Healthy Start Initiative - Enhanced (HSE) projects to develop and implement a plan for the community that focuses on at least one social determinant of health (SDOH), such as access to adequate housing, transportation, or food.

For more details, see Program Requirements and Expectations.

2. Background

Authority

The Healthy Start Initiative: Eliminating Disparities in Perinatal Health (Healthy Start or HS) program is authorized by 42 U.S.C. § 254c-8 (Title III, § 330H of the Public Health Service Act).[4]

Infant Mortality, Perinatal Health, and Social Determinants of Health

Approximately four million births occur each year in the U.S.[5] While most women have a safe pregnancy and deliver a healthy infant, there are persistently higher rates of infant mortality and maternal morbidity among some groups, in particular Black and indigenous populations. The highest infant mortality rates in the country are among Black, American Indian/Alaskan Native (AI/AN), and Native Hawaiian/Other Pacific Islander infants (10.38, 7.68, and 7.17 infant deaths per 1,000 live births in 2020, respectively). These rates are significantly higher than that of White infants (4.40 infant deaths per 1,000 live births in 2020).[6] Each year, approximately 3,500 infant deaths occur due to higher mortality rates among non-Hispanic Black and non-Hispanic indigenous, infants.[7] Inequities in access to health promoting resources such as education, employment, and health care contribute to disparities in perinatal health and

[4] 42 USC 254c-8: Healthy start for infants (house.gov)
[5] https://www.cdc.gov/nchs/fastats/births.htm
[6] https://www.cdc.gov/nchs/data/nvsr/nvsr71/nvsr71-05.pdf
[7] https://healthystartepic.org/technical-assistance-activities/catalyst-for-infant-health-equity/

infant death. For example, in many rural tribal communities, pregnant women and families face barriers accessing medical care due to geographic barriers and insufficiencies in the health care infrastructure and workforce.

The Healthy Start Initiative

Since its start as a demonstration project in 1991, the Healthy Start program has provided awards to communities with infant mortality rates at 1.5 times the U.S. national average and high rates of other adverse perinatal outcomes (for example, low birthweight, preterm birth, maternal morbidity, and mortality).[8] The purpose of Healthy Start is to reduce infant mortality rates and improve perinatal outcomes by focusing on project areas with high or above the national average annual rates of infant mortality. Healthy Start uses a community-based approach to delivering direct and enabling services that facilitates access to health care and community services. In alignment with the statute, the program focuses on addressing factors that contribute to infant mortality, such as low birthweight, preterm birth, and social determinants of health in communities with high rates of infant mortality or high rates of other adverse infant health outcomes in specific subpopulations within the community. As such, Healthy Start works to eliminate the disparity in health status in communities.

In the most recent program evaluation, Healthy Start participants were shown to have positive outcomes related to several program goals, including earlier and more frequent prenatal care, greater engagement in infant safe sleep practices, and lower rates of low birthweight infants (all of which are factors associated with improved infant morbidity and mortality outcomes). Healthy Start participants also met or exceeded targets with respect to having a usual source of health care and having been screened for depression. For more information, see: https://mchb.hrsa.gov/programs-impact/healthy-start.

About MCHB and Strategic Plan

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

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

[8] For reference visit https://mchb.hrsa.gov/programs-impact/healthy-start/2019-grantees to see a list of the 101 HRSA-19-049 Healthy Start recipients (project period April 1, 2019 - March 31, 2024). We are including this link for your awareness/background information only. Many of the HRSA-19-049 awardees may re-apply for the same or similar project areas; you may wish to contact them for coordination purposes to avoid overlap in proposed project areas.

***Goal 2**: Achieve health equity for MCH populations*

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

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

This program addresses MCHB's goals to assure access to high quality and equitable health services to optimize health and well-being for all MCH populations. To lean more visit Mission, Vision, and Work | MCHB: https://mchb.hrsa.gov/about-us/mission-vision-work.

II. Award Information

1. Type of Application and Award

Application type(s): Competing Continuation, New

We will fund you via a grant.

2. Summary of Funding

We estimate $113,645,000 will be available each year to fund 103 recipients. You may apply for a ceiling amount of up to $1,100,000 annually (reflecting direct and indirect costs).

The period of performance is April 1, 2024, through March 31, 2029 (5 years).

This program notice depends on the appropriation of funds. If funds are appropriated for this purpose, we will proceed with the application and award process.

Support beyond the first budget year will depend on:

- Appropriation
- Satisfactory progress in meeting the project's objectives
- A decision that continued funding is in the government's best interest

45 CFR part 75 - Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards applies to all HRSA awards.

If you've never received a negotiated indirect cost rate, you may elect to charge a *de minimis* rate of 10 percent of modified total direct costs (MTDC)*. You may use this for the life of the award. If you choose this method, you must use it for all federal awards until you choose to negotiate for a rate. You may apply to do so at any time. See Section 4.1.v. Budget Narrative in the *Application Guide*.

**Note*: One exception is a governmental department or agency unit that receives more than $35 million in direct federal funding.

III. Eligibility Information

1. Eligible Applicants

You can apply if your organization is in the United States and is:

- Public or private
- Community-based
- Tribal (governments, organizations)

Additional Notes:

If you are a recipient of the Healthy Start Initiative – Enhanced (HRSA-23-130) (HSE) you are still eligible to apply for this grant if you are proposing a new project area, that is, an area not currently served by your or an existing HSE award. HSE grant project areas have been settled and it is not HRSA's intent to alter or reset existing HSE project areas. Therefore, if you propose to serve a project area that fully overlaps with your own award or another HSE award, your application will be deemed ineligible and will not be considered. Please see Appendix H for a list of Healthy Start Initiative – Enhanced project areas.

For all other applicants, if your proposed project area is the same as a Healthy Start Initiative – Enhanced (HSE) recipient, your application will be deemed ineligible.

These provisions ensures that new communities with the highest rates of infant mortality and other adverse perinatal health outcomes that do not already have access to Healthy Start services are reached by this program.

2. Cost Sharing or Matching

Cost sharing or matching is not required for this program.

3. Other

We may not consider an application for funding if it contains any of the following non-responsive criteria:

- Exceeds the funding ceiling amount
- Fails to satisfy the deadline requirements referenced in Section IV.4

Multiple Applications

We will only review your **last** validated application before the Grants.gov due date.

IV. Application and Submission Information

1. Address to Request Application Package

We ***require*** you to apply online through Grants.gov. Use the SF-424 workspace application package associated with this notice of funding opportunity (NOFO). Follow these directions: How to Apply for Grants. If you choose to submit using an alternative online method, see Applicant System-to-System.

Note: Grants.gov calls the NOFO "Instructions."

Select "Subscribe" and enter your email address for HRSA-24-033 to receive emails about changes, clarifications, or instances where we republish the NOFO. You will also be notified by email of documents we place in the RELATED DOCUMENTS tab that may affect the NOFO and your application. *You're responsible for reviewing all information that relates to this NOFO.*

2. Content and Form of Application Submission

Application Format Requirements

Submit your information as the *Application Guide* and this program-specific NOFO state. **Do so in English and budget figures expressed in U.S. dollars.** There's an Application Completeness Checklist in the *Application Guide* to help you.

Application Page Limit

The total number of pages that count toward the page limit shall be no more than **60 pages** when we print them. We will not review any pages that exceed the page limit. Using the pages within the page limit, HRSA will determine eligibility using Section III. Eligibility Information of the NOFO.

These items do not count toward the page limit:

- Standard OMB-approved forms you find in the NOFO's workspace application package
- Abstract (standard form (SF) "Project_Abstract Summary")
- Indirect Cost Rate Agreement
- Proof of non-profit status (if it applies)

If there are other items that do not count toward the page limit, we'll make this clear in Section IV.2.v Attachments.

If you use an OMB-approved form that isn't in the HRSA-24-033 workspace application package, it may count toward the page limit.

Applications must be complete and validated by Grants.gov under HRSA-24-033 before the deadline.

Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification

- When you submit your application, you certify that you and your principals[9] (for example, program director, principal investigator) can participate in receiving award funds to carry out a proposed project. That is, no federal department or agency has debarred, suspended, proposed for debarment, claimed you ineligible, or you have voluntarily excluded yourself from participating.
- If you fail to make mandatory disclosures, we may take an action like those in 45 CFR § 75.371. This includes suspending or debarring you.[10]
- If you cannot certify this, you must include an explanation in *Attachment 9-15: Other Relevant Documents*.

(See Section 4.1 viii "Certifications" of the *Application Guide*)

Program Requirements and Expectations

The Program Requirements and Expectations for the FY 2024 Healthy Start Program fall into the following categories:

i. Project Area and Target Population

ii. Direct and Enabling Services for HS Participants.

iii. Community Consortium

iv. Leadership at the Local State and/or Regional Level

v. Performance Monitoring and Evaluation

i. Project Area and Target Population

You are expected to define your project area and target population using the criteria outlined below. Include information requested under "Project Area Proposed to be Funded" and "Factors Demonstrating Need for the Target Population" in Attachment 1. Please note that you are encouraged to use the template located in Appendix F to organize the information requested in Attachment 1.

Project Area Proposed to be Funded

- A project area is defined as a geographic area where the proposed HS services will be implemented. HS project areas are expected to be communities experiencing rates of infant mortality that are 1.5 times the national average or greater.
- Project areas should be distinct and not overlap with another Healthy Start/Healthy Start Initiative - Enhanced project area.

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[9] See definitions at eCFR :: 2 CFR 180.995 -- Principal. and eCFR :: 2 CFR 376.995 -- Principal (HHS supplement to government-wide definition at 2 CFR 180.995).
[10] See also 2 CFR parts 180 and 376, 31 U.S.C. § 3354, and 45 CFR § 75.113.

- Applicants are encouraged to be specific in delineating the boundaries of their proposed project area, including existing or future service agreements.
- Identify your organization as serving an urban[11] or rural[12] project area. Use the Rural Health Grants Eligibility Analyzer to determine whether your project is urban or rural https://data.hrsa.gov/tools/rural-health. Note that this calculation is made based upon the population density of your project area.
- Define your project area by county, Zip Code™, or Census Tract. Include a map of the proposed project area and a list of Zip Codes™ within the project area (Attachment 1). If you are proposing to serve a portion of a county or Zip Code™, you are expected to define the borders of your project area (for example, use street names, Census Tracts or for portions of a Zip Code™ you may use county lines).
    - A project area (that is, your catchment area) might consist of a group of Zip Codes™ or portions of Zip Codes™ if it is an urban project. For a rural project, a project area might be a combination of counties (or portions of counties or Zip Codes™). The counties or Zip Codes™ in your project area do not need to be contiguous and cannot be served by another HS/HSE-funded project.

Overlapping Project Areas

To ensure that communities with the highest rates of infant mortality and other adverse perinatal health outcomes have access to HS services, HRSA intends to fund projects serving distinct project areas that do not overlap with one another.

I. **If two or more applicants propose *the same project area*** and receive fundable scores, HRSA will award the grant to the highest scoring applicant.

II. **If two or more applicants propose *project areas that partially overlap*** and they receive fundable scores, HRSA will notify the applicant(s) of the overlap and request that, within a specified period of time, they establish an agreement outlining amended project areas that do not overlap. The agreement should:
    - describe the need for multiple HS recipients within the project area, including the distinct target population served;
    - provide a map of each project area. Define each applicant's boundaries within the proposed project area using Zip Codes™, street names, and/or or Census

[11] **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.
[12] **Rural** – To determine whether the Census Tract or County for your proposed project area is defined as a rural area, visit the webpage Rural Health Grants Eligibility Analyzer and enter the project area address. Link: https://data.hrsa.gov/tools/rural-health

Tracts, demonstrating the specific population(s) that will be served (HRSA will use this information to check for potential overlaps);

- outline partnership responsibilities for outreach, recruitment, and referrals demonstrating that there will be no overlap in populations served;
- include the number of births in the target population within the project area in order to demonstrate that both/all applicants will each be able to serve 700 participants annually.

Please note: Your revised project area will not be approved if it overlaps with other fundable applicants or Healthy Start Initiative – Enhanced (HSE) recipients.

III. **If one or more applicant(s) inadvertently propose *project areas that partially overlap with an existing Healthy Start Initiative – Enhanced (HRSA-23-130) grantee's project area*[13]** and are in the fundable range, it is incumbent upon the applicant(s) to amend their project area, removing the overlap, while continuing to meet the program requirements described in the NOFO. HRSA will contact you before awards are made, ask you to revise your project area and submit the following information:

- Revised project area including a list of counties, Zip Codes™ and/or Census Tracts and an updated map.
- Number of births in the target population for the revised project area.

IV. ***Tribes, Tribal Organizations and Health Organizations Serving Tribes*** – Because many tribes and tribal populations access health care services and other social supports through the Indian Health Service and other organizations that are specific to tribal nations, rather than through Medicaid or private health insurance programs, overlaps in project area with applicants proposing to serve non-tribal populations generally does not imply a duplication of services. Therefore, two applicants in the fundable range may propose to serve the same project area if one, but not both of the applicants is a tribe, tribal organization or health organization serving tribes. HRSA will notify you before an award is made and will ask you to develop an agreement with the other applicant(s) to either:

- amend your project area(s); and/or
- define your unique target populations within the same project area;

[13] Please note: you are highly encouraged to review Appendix H to confirm that your proposed project area has no overlap with an HSE recipient's project area. There is no expectation that HSE recipients will revise their project areas. It is the responsibility of the applicant to revise their project area and ensure there is not overlap. Your revised project area will not be approved if it overlaps with other fundable applicants or other HSE recipients.

- establish that both applicants are able to meet all program requirements and expectations, including serving 700 participants annually.[14]

The following applies to all scenarios involving project area overlap described above:

- Program activities implemented in amended project areas are expected to continue to meet the program requirements.
- If HRSA determines that the changes to your project area potentially impact the information provided under "Factors Demonstrating Need for the Target Population" (below), you will be asked to provide revised data for IMR, low birthweight and preterm births for the target population in the project area. HRSA may also ask for other documentation including a revised budget and work plan. HRSA will evaluate the information to ensure the proposed activities in the revised project area continue to meet the Program Requirements and Expectations of this NOFO.
- If an agreement is submitted by the deadline and approved by HRSA, you will be required to develop a formal Memorandum of Agreement (MOA)/Memorandum of Understanding (MOU) with the other recipient(s) after the award is made.
- If an agreement cannot be reached in the specified period of time or HRSA determines that the information provided was incomplete or insufficiently demonstrates your ability to meet all of the Program Requirements and Expectations outlined in this NOFO, HRSA intends to fund only the highest scoring applicant.

Factors Demonstrating Need for the Target Population

The target population is the population that you will serve within your project area. **It should be the population with the highest rate of infant deaths, low birthweight, or preterm birth.**

Your target population within your proposed project area should meet the following criteria using verifiable, vital statistics data:[15,16]

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[14] Please Note: If two applicants propose services in the same project area, with the same primary target population, for example, they propose to serve the same tribe, then only the highest scoring application will be considered.

[15] Vital statistics include records of births, deaths and fetal deaths. They also record information about the cause of death, or details of the birth. There are 57 vital registration jurisdictions in the U.S.: 50 states, 5 territories (Puerto Rico, U.S. Virgin Islands, Guam, American Samoa, Northern Mariana Islands), the District of Columbia, and New York City.

[16] Do not use the Maternal and Infant Health Mapping Tool for need-based eligibility criteria. IMR, low birth weight, and preterm birth data are not available for the period requested (2019-2021) and the number of events is not provided.

1. If the combined 2019 through 2021 number of infant deaths in the target population are 30 or more, the 2019 through 2021 combined 3-year IMR in the target population should be equal to or more than 8.2 deaths per 1,000 live births (1.5 times the national average).[17]
2. If the combined 2019 through 2021 number of infant deaths in the target population are less than (<)30**, one of the following should be met:**[18]
    a. The 2019 through 2021 3-year low birthweight rate in the target population is equal to or more than 12.5 percent (1.5 times the national average) **AND** there should be 90 or more low birth weight births in the target population during the 3-year period, 2019 through 2021.

    OR

    b. The 2019 through 2021 preterm birth rate in the target population is equal to or more than 15.4 percent (1.5 times the national average) **AND** there should be 90 or more preterm births in the target population during the 3-year period, 2019 through 2021.

ii. Direct and Enabling Services for HS Participants

HS projects are expected to have the necessary partnerships, curricula, evidence-based/evidence-informed, and/or scientific information to implement high quality direct and enabling services.

HS staff (at all levels of the program) should be reflective of the communities they serve and have the training and supervision necessary to address the unique needs of individuals in their target populations. HS projects are also expected to have processes in place to support staff retention (for example, adequate supervision, competitive salaries, manageable caseloads). Please see Strengthening the Maternal Infant Early Childhood Home Visiting Workforce: A Checklist for Staff Recruitment and Staff Retention as a resource.

HS direct and enabling services should be customized to meet the needs of the project area. These services should focus on your target population (which is the group with the highest IMR within the project area or, if there were less than 30 infant deaths from 2019 through 2021, then the group with the highest rate of low birthweight or preterm birth) and the geographic area(s) as described above. Strategies should be culturally responsive and linguistically appropriate.

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[17] For project areas that include whole counties, CDC Wonder may be used to obtain infant mortality statistics (250,000+ population only): https://wonder.cdc.gov/lbd.html. Otherwise, please contact your state or local vital statistics department.

[18] For project areas that include whole counties, CDC Wonder may be used to obtain preterm birth/low birthweight statistics (100,000+ population only): https://wonder.cdc.gov/natality.html. Otherwise, please contact your state or local vital statistics department.

HS recipients are expected to provide two broad categories of services: case management[19]/care coordination[20] and group-based health and parenting education. HS projects will be expected to enroll participants in case management/care coordination and/or group-based health and parenting education depending on each participant's interest and which types of services meet their needs. A HS participant may participate in both types of services. For example, a participant enrolled in case management/care coordination can also attend, and should be encouraged to attend, group-based education sessions, and vice-versa.

Further expectations for direct and enabling services fall into the following categories:

- Numbers Served Through Direct and Enabling Services
- Case Management/Care Coordination Services
- Provide Group-based Prenatal/Postpartum and Parenting Education
- Numbers Served through Group-Based Health and Parenting Education
- Conduct Outreach, Recruitment, and Retention Efforts for HS Participants
- Implement a Continuum of Services That Meet the Unique Needs of HS Participants
- Ensure HS Participants Have Access to Preventive Health Services, Behavioral Health Care, and Other Specialty Services
- Health Promotion

Numbers Served Through Direct and Enabling Services

HS projects are expected to serve 700 unduplicated participants annually through direct and enabling services within the following categories:

- At least 450 participants through case management/care coordination.[21]
- At least 250 participants through group-based health and parenting education.[22]

Out of the 700 participants served, a minimum of 50 percent should be from the target population (group with the highest IMR in your project area or, if there were less than 30

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[19] Case management is a process of developing and executing a plan for an individual to access medical care, community-resources and education by advocating, guiding and coordinating services and supports.

[20] Care coordination organizes and aligns participant care by sharing information and individual family preferences to eliminate duplication and increase efficiency and effectiveness.

[21] For additional details on numbers served through case management/care coordination please see "Case Management/Care Coordination Services for Women of Reproductive Age and Fathers/Partners."

[22] For additional details on numbers served through group-based health and parenting education please see "Group-based Health and Parenting Education"

infant deaths in your target population from 2019 through 2021, the group with the highest low birthweight rate or preterm birth rate).

The above targets are based on expectations of, numbers served by, and overall performance of Healthy Start recipients through previous Healthy Start Initiative programs.

Case Management/Care Coordination Services

HS projects should provide family-centered, strengths-based case management/care coordination, which is a method of case management/care coordination that focuses on an individual's strengths, rather than on their challenges and deficits, for enrolled participants. It is expected that participants enrolled in case management/care coordination receive both health and parenting education (either one-on-one or in a group setting) and information on community-based resources. Information will be delivered through multiple modalities to best meet the unique needs of participants and families. These modalities may include meeting with participants in their homes, at the HS site, and/or virtually.

HS projects should encourage participants enrolled in case management/care coordination to attend group-based health education sessions (discussed below).

For additional guidance on the essential components of case management/care coordination, please review the Healthy Start Case Management/Care Coordination guidance available online.

- Numbers Served Though Case Management/Care Coordination:
    - HS projects are expected to provide case management/care coordination to a minimum of 450 participants annually. You should plan to serve:
    - A minimum of 250 pregnant women;
    - A minimum of 25 fathers/partners who have an infant or child from newborn to 18 months of age and/or are the current or former partner of an enrolled participant.
    - The remaining 175 participants may be any combination of the following five categories:
        - Pregnant women;
        - Preconception women;
        - Interconception women of reproductive age;
        - Infants/children from birth to 18 months of age;

- Fathers/partners with a pregnant partner or who have an infant or child younger than 18 months of age and/or are the current or former partner of an enrolled participant.

Provide Group-based Prenatal/Postpartum and Parenting Education

- HS projects are expected to provide group-based health and parenting education which includes prenatal health, parenting, and child development education. HS projects can provide group-based education through a Group Prenatal Care model or a Community-based Group Prenatal and Parenting Education model. The group education sessions are expected to provide participants with a forum to: 1) learn and obtain information about critical health promotion and education topics, the knowledge of which can lead to positive perinatal outcomes; and 2) form connections and receive support from other pregnant women/parents in their community, which has also been found to lead to positive perinatal outcomes. Tailor models and strategies to meet the needs of the target population.

  HS projects are expected to:

- Implement group-based health and parenting education in groups or cohorts so that participants are able to form supportive connections with other group members.
- Implement group-based health and parenting education programs to ensure learning and robust interaction among participants over time in accordance with the design of the group educational model.
- Implement strategies that reduce participants' barriers to attending group-based health and parenting education sessions, such as providing transportation, meals, child care, etc.

  For a list of suggested health promotion and parenting education topics for group-based health and parenting education please see Appendix B. Please note activities such as health fairs do not constitute group-based education.

Numbers Served through Group-Based Health and Parenting Education

As noted above, participants receiving group-based education may be enrolled in case management/care coordination. However, it is expected that HS projects provide group-based education to a minimum of 250 unduplicated participants who are not also enrolled in case management/care coordination (for example, mothers/women of reproductive age and/or fathers/partners) annually.

Conduct Outreach, Recruitment, and Retention Efforts for HS Participants

Outreach and recruitment efforts to engage and retain residents of the project area in services that focus on identifying and providing HS services to mothers/women[23] of reproductive age, fathers/partners[24], and families experiencing the highest rates of infant mortality and other adverse maternal and infant health outcomes within the project area. It is expected that you will use varied outreach and recruitment strategies such as developing referral partnerships with other community-based organizations, hospitals and clinics and conducting direct community-based outreach within the project area.

HS projects are also expected to implement strategies and activities to retain enrolled participants for up to 18 months postpartum. This can include using incentives (for example, diapers, gift cards, etc.).

Implement a Continuum of Services That Meet the Unique Needs of HS Participants

It is expected that HS projects have processes for identifying which services and intensity of support best meet the needs and interests of participants. At a minimum, all HS sites should offer the following types of services:

- Health promotion and education
- Preventive screening services and prenatal care. This may include:
    - Providing and/or contracting for well women visits, prenatal/postpartum care and screening for maternal depression, intimate partner violence, sexually transmitted infections, diabetes, hypertension, etc.

Referrals and linkages to clinical care and support services addressing social determinants of health (SDOH) using high touch support, which is support that delivers care through high frequency patient/participant-provider encounters to deliver preventative services, and warm hand-offs, which are transfers of care between members of a care team that occur in front of the participant and/or family.

    - Navigation support to retain participants in clinical care and to maintain connection to services addressing SDOH (which can include case management and/or care coordination).

It is essential that HS sites develop and maintain a robust network of referral partnerships. These partnerships should include, but are not limited to: Title V programs, Maternal Infant Early Childhood Home Visiting (MIECHV) funded home visiting programs, health care providers, mental health services, doulas, Special

[23] For the purposes of brevity this NOFO will primarily use the term women to describe preconception, pregnant, and interconception HS program participants.
[24] Partners who are caregivers to infants and children up to 18 months old.

Supplemental Nutrition Program for Women, Infants and Children (WIC), Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance to Needy Families (TANF), Ryan White HIV/AIDS Program Part D, education, and vocational training programs and organizations addressing housing and food insecurity.

Ensure HS Participants Have Access to Preventive Health Services, Behavioral Health Care, and Other Specialty Services[25]

HS projects are expected to deliver prenatal care and other preventive health services and/or have partnerships and referral procedures for ensuring participants receive clinical and behavioral health services from other entities within the project area. If services are unavailable within the project area, HS recipients should have plans for transportation and other supports to ensure services are delivered. Prenatal and preventive health services should be operational within 90 days of award.

It is expected that all recipients provide clinical services to HS participants.[26] Successful applicants will be expected to dedicate 10 percent of their award to support nurse practitioners, certified nurse midwives, physician assistants, behavioral health specialists, and other maternal-child advanced practice health professionals dedicated to HS projects. As part of the 10 percent, funds may also be used to support health educators by having clinical staff conduct trainings on associated topics, such as Urgent Maternal Early Warning Signs.

HRSA understands the vital role doulas play in reducing disparities in infant mortality, maternal mortality, and other adverse perinatal outcomes. You are strongly encouraged to consider community-based doulas as members of HS participant care teams and to connect participants to doula services during pregnancy, birth, and for at least 3 months post-partum.[27]

Health Promotion

It is expected that HS projects have a protocol in place for providing health education to all HS participants receiving case management/care coordination and group-based education. Information should be from a scientific or evidence-based curriculum. Projects should address the following health promotion topics: preventive health services, behavioral health and wellness, infant care and parenting, and access to community-based resources and benefits. More details on these four topics and what should be covered can be found in Appendix C.

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[25] Examples of preventive health services, behavioral health care and other specialty services include: well-woman health visits, prenatal/postpartum care, primary care, nutrition counseling, mental health services and tobacco cessation.
[26] From FY 2019 – FY 2024, Congressional Report language accompanying Fiscal Year appropriations indicated that approximately $15 million of Healthy Start funding should be used to support access to clinical services. HRSA expects recipients of funds under this NOFO to support clinical services within HS projects for consistency with this language.
[27] Note that doulas should not be included in the 10 percent of funds used to support clinical services.

HS projects should customize education to meet the unique needs of program participants by partnering with participants and a multi-disciplinary team of knowledgeable HS staff to develop an individualized approach to delivering health education.

Note: Each HS project is expected to submit an annual Health Education Plan (in your Non-Competing Continuation Report) identifying the curriculum, topics and methods of delivery for health promotion topics that will be offered by the program. The plan should also include continuing education for HS staff and a list of the community partners and contractors who you will partner with to provide education to HS participants. Please note that recipients will have 30 days after award to submit their Health Education Plan for the first year of the program.

Community Consortium

Community Consortia are intended to bring together various representatives across the community to address pressing issues and needs that may lead to poor perinatal health outcomes. Community Consortia are expected to implement plans aimed at reducing disparities in perinatal health outcomes by improving the quality of and access to clinical, support, and education services within the project area. Community Consortia may provide training and serve as a forum for organizational updates if and when those activities align with the community-driven approach to implement the plan.

Successful applicants will demonstrate how they meet the following expectations for their community consortium:

- **Convene your Community Consortium within 90 days of the start of the HS period of performance.**
    - Post-award, it is expected that a minimum of 25 percent of Community Consortium members are enrolled HS participants and women of reproductive age, mothers, fathers, or partners, and other people with lived experience living in the project area. It is expected that the Community Consortium have representation from Title V, public health departments, hospitals, health centers under section 254b,[28] State substance abuse agencies, and other significant sources of health care services. Other categories of partners can include community leaders; representatives from service agencies; community-based organizations; state/non-profit organizations/faith-based organizations addressing housing, employment, education, transportation, and health care. The HS project is expected to

[28] "Health centers under section 254b" is a reference to health centers receiving funding or designation under 42 U.S.C. 254b (section 330 of the Public Health Service Act), and which include an entity that serves a population that is medically underserved, or a special medically underserved population comprised of migratory and seasonal agricultural workers, people experiencing homelessness, and residents of public housing, by providing primary care and other resources and supports under this authority.

build meaningful, sustainable partnerships with Community Consortium partners and establish and work towards goals that are reflective of the priorities of the target population.

- The HS project is expected, as possible, to hire or contract with a Community Consortium Coordinator from, and representative of, the community being served. The Community Consortium Coordinator will oversee the development and implementation of the plan (described below).
- As a best practice, the Community Consortium chair or co-chair should preferably be a current or former HS participant.

- **The Community Consortium will advise and inform the planning and implementation of HS direct and enabling services**.
- **Finalize your Community Consortium plan to address SDOH by obtaining community buy-in/approval by October 30, 2024.**
  - Plans should:
    - Be based upon results of a community needs assessment and environmental scan that identifies and prioritizes SDOH causes of disparities in perinatal outcomes in the project area.
    - Be community-driven and address the factors and conditions beyond clinical care that contribute to disparities in perinatal outcomes.
    - Describe strategic partnerships and strategies to address the "upstream factors" and unique SDOH contributing to disparities in perinatal outcomes within the project area.

  Include a minimum of five performance measures corresponding to plan activities. Examples of performance measures include: increase access to nutritious foods by ensuring X percent of eligible residents of the project area are enrolled in WIC; increase access to prenatal care by coordinating X group prenatal care[29] offerings within less than a X minute walk from public transportation; and, increase access to employment opportunities for participants by increasing the completion rate of job training programs in the project area by X percent.
  - HS projects are expected to collaborate with their Community Consortium members, HRSA, and the Supporting Healthy Start Performance Project to revise and finalize their plans within 7 months of the project start date.

[29] Group prenatal care is an approach to care that is designed to bring together groups of perinatal patients for routine prenatal care, learning, and social support while maintaining the risk screening and physical assessment of individual prenatal visits.

- The Community Consortium should regularly report out/disseminate information to community members and partners on the implementation of the HS project overall, the plan and progress made towards achieving goals/objectives of the plan.

NOTE: No appropriated funds may be expended by the recipient of a federal contract, award, loan, or cooperative agreement to support activities intended to influence, or to pay any person for influencing or attempting to influence, an officer or employee of any federal, state, or local agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress. This includes influencing or attempting to influence any federal, state, or local agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal award, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, award, loan, or cooperative agreement.

- **Begin implementation of the Community Consortium plan to address SDOH by November 1, 2024.**
- **Participate in HS Community Consortium Community of Practice activities through the Supporting Healthy Start Performance Project.**
  - HS Community Consortium Coordinators are expected to participate in the Community of Practices and other technical assistance opportunities. These activities may focus on peer support across HS projects, sharing of best practices in partnership engagement, plan implementation, and creation of new knowledge. The Community Consortium Coordinator may invite community partners to engage in select Community of Practice activities.
  - An example of a performance metric for HS projects participating in these learning communities includes the number of promising practices implemented addressing SDOH topics within the project area.

iii. Leadership at the Local, State, and/or Regional Levels

In addition to leading Community Consortium activities, HS projects are expected to take on a leadership role at the local, state, or regional level by participating in committees, projects or initiatives aimed at improving maternal, infant, and child health outcomes. Recipients are encouraged to participate in Fetal Infant Mortality Reviews, Maternal Morbidity and Mortality Reviews, or Perinatal Periods of Risk analysis.

iv. Performance Monitoring and Evaluation

Data Collection and Performance Monitoring of Direct and Enabling Services

- Healthy Start Benchmarks
    - Recipients will report annually on progress toward achieving the 10 HS benchmark goals (please see Appendix D for the complete list of HS benchmarks). Failure to ensure compliance with reporting requirements once an award is made may result in further actions or conditions during post-award monitoring (see 45 CFR § 75.371 Remedies for noncompliance).
- Objectives and Performance Measures
    - The application should include baselines for all HS benchmarks in the work plan. When utilizing baseline data, you should document the date of the source. If baseline data sources are older than 2020, please explain why more current estimates are not available. If percentages are used, provide the relevant numerator and denominator.
- Standardized Healthy Start Data Collection Forms
    - Your program is expected to use the standardized HS data collection forms for collection of universal participant-level data elements. Your program should ensure organizational approvals are in place (for example, Institutional Review Board) to be ready and able to report on data collected through the forms on a quarterly basis via the Healthy Start Monitoring and Evaluation Data System (HSMED). HS projects are expected to complete HS data collection forms and collect benchmark data for HS participants enrolled in case management/care coordination.
- Quality Improvement
    - Your program is expected to engage in quality improvement (QI) efforts informed by participant-level, program-level, and community-level data. QI is a process of systematic and continuous actions that lead to measurable improvement, particularly around health care services and the health status of the targeted population.
    - You are encouraged to access technical assistance, which is targeted, knowledge-based support to build organizational capacity or address a programmatic need or problem, on QI from the Supporting Healthy Start Performance Project. It is expected that your program will identify opportunities for QI related to your activities, services, and supports, as well as for the overall program. After your program reports its first year of HS benchmark data, you are expected to work with HRSA staff and the Supporting Healthy Start Performance Project to develop a QI plan to improve

performance on specific HS benchmarks and/or address data collection challenges.

Evaluation

- Program Evaluation
    - The recipient should monitor impact, ongoing processes, and the progress towards the goals and objectives of the project. Your HS program should continue to refer to the community needs assessment and environmental scan findings throughout the period of performance and monitor progress to identify opportunities for QI. A final program evaluation and performance monitoring plan will be required 12 months after the award is made. A description of progress to implement the program evaluation and performance monitoring plan will be due annually, when submitting your annual non-competing progress report.

National Evaluation

- Acceptance of award funding reflects agreement on the part of the recipient, if selected, to participate fully in the national evaluation of the program.

Program-Specific Instructions

Include application requirements and instructions from Section 4 of the *Application Guide* (budget, budget narrative, staffing plan and personnel requirements, assurances, certifications, and abstract). Also include the following:

i. *Project Abstract*

Use the Standard OMB-approved Project Abstract Summary Form that you'll find in the workspace application package. Do not upload the abstract as an attachment or it may count toward the page limit. For information you must include in the Project Abstract Summary Form, see Section 4.1.ix of the *Application Guide.*

NARRATIVE GUIDANCE

The following table provides a crosswalk between the narrative language and where each section falls within the review criteria. Make sure you've addressed everything. We may consider any forms or attachments you reference in a narrative section during the merit review.

Narrative Section	**Review Criteria**
Introduction	*Criterion 1: NEED*
Organizational Information	*Criterion 5: RESOURCES/CAPABILITIES*

Narrative Section	Review Criteria
Need	*Criterion 1: NEED*
Approach	*Criterion 2: RESPONSE* *Criterion 4: IMPACT*
Work Plan	*Criterion 2: RESPONSE* *Criterion 4: IMPACT*
Resolution of Challenges	*Criterion 2: RESPONSE*
Evaluation and Technical Support Capacity	*Criterion 3: EVALUATIVE MEASURES*
Budget and Budget Narrative	*Criterion 6: SUPPORT REQUESTED*

ii. *Project Narrative*

This section must describe all aspects of the proposed project. Make it brief and clear.

Provide the following information in the following order. Please use the section headers. This ensures reviewers can understand your proposed project.

- *Introduction – Corresponds to Section V's Review Criterion 1 NEED*

  In the narrative, briefly describe the purpose of the proposed HS project and your project area (that is, geographic area where the proposed HS services will be implemented). Indicate whether you are serving an urban[11] or rural[12] project area. Use the Rural Health Grants Eligibility Analyzer to determine whether your project is urban or rural https://data.hrsa.gov/tools/rural-health. Note that this calculation is made based upon the population density of your project area.

  Provide the following information in Attachment 1 (you are encouraged to use the template in Appendix F to organize your information):

  - A map of the proposed project area and a list of counties and Zip Codes™ within the project area. If you are proposing to serve a portion of a county or Zip Code™, you must define the borders of your project area using street names or Census Tracts. If you are proposing to serve a portion of a Zip Code™ you may define the border of your project area using the county line or some other standard demarcation.
  - State clearly whether you intend to serve an entire county or a portion of a county.

- Copies of service area agreements demonstrating that there will not be overlap with another Healthy Start-Enhanced or proposed Healthy Start project area, if known.
- A statement indicating if you are serving a rural or urban project area.

▪ *Organizational Information – Corresponds to Section V's Review Criterion 5 RESOURCES/CAPABILITIES*

Succinctly describe your organization's current mission, structure, and scope of current activities. Include an organizational chart in Attachment 6. Describe any current collaboration efforts or partnerships that will contribute to the organization's ability to implement the HS program requirements and meet program expectations.

Describe your organization's capacity and experience in:

- Providing direct and enabling services as described in the Program Requirements and Expectations section of this NOFO; and
- Convening and facilitating a diverse, multi-sector consortium focused on implementing systems changes and improvements that address SDOH.

Include a staffing plan in Attachment 3. Describe the key personnel responsible for the project and the amount of time each will devote to the project. Describe current experience, relevant expertise, skills, and knowledge of staff, contractors, and partners. Include biographical sketches for each key personnel in Attachment 4. Note that the Community Consortium Coordinator, should be from, and representative of, the community being served.

For recipients of HRSA-19-049:

Provide evidence of the impact your program has had on decreasing the IMR and other adverse perinatal health outcomes within your project area. Use both quantitative and qualitative data to document your project's impact. Note: this will be evaluated by meeting 10 out of 19 of the Healthy Start Benchmarks for Calendar Year 2022.

For applicants who were not recipients of HRSA-19-049:

Describe your organization's capacity to decrease the IMR and other adverse perinatal health outcomes (such as reducing rates of low birthweight and preterm birth) within your proposed project area. Include a discussion of the organizational profile, collaborative partners, key staff, budget, data systems and other resources. You may include examples of other projects your organization has implemented with similar objectives around improving maternal and infant health outcomes and corresponding data if available.

- *Need – Corresponds to Section V's Review Criterion 1 NEED*

  In the narrative, describe the target population that you will serve within the project area (it should be the population with the highest IMR).

  Provide a clear description of the current perinatal system serving your project area (that is, health systems and social supports). Include socio-demographics such as education level, employment and income level, and health statistics to demonstrate current prevalent disparities in the target population. Provide a brief overview of the target population within the project area including key health indicators such as insurance status, rate of Sudden Unexpected Infant Deaths, births to teenagers 18 years and younger, trimester of initiation of prenatal care, and adequacy of prenatal care. Highlight other current trends in family health and wellness and maternal and infant morbidity and mortality, as appropriate (for example, rates of birth defects, sexually transmitted infections, intimate partner violence etc.)

  Describe the SDOH that contribute to adverse perinatal outcomes for the target population in the project area. Describe barriers/challenges to equity in perinatal health for the target population. Also describe strengths/assets, such as state, tribal (if applicable), local/community resources and services, collaborations/partnerships, and systems change interventions intended to address disparities in perinatal health.

  Use and cite demographic data whenever possible to support the information provided above. Use of story-telling or qualitative data is permitted (as an addition to, but not replacement of, the quantitative data).

  Include the following information in Attachment 1 (you are encouraged to use the template in Appendix F to organize the information requested within this section):

  The following information is required, and accounts for 15 points under the need section. If data are not provided or not provided accurately, 0 points will be awarded for this portion of the Need criterion.

- For the target population within your proposed project area,[30] provide the following data using verifiable, vital statistics data, typically a group of Zip Codes™ for urban projects and a combination of counties (or portions of counties or Zip Codes™) for rural projects:

  a. the number of births over the 3-year period (2019-2021);

  b. the number of infant deaths over the 3-year period (2019–2021) and the combined 3-year IMR (infant deaths per 1,000 live births);

  c. the number of preterm births over the 3-year period (2019-2021) and the preterm birth rate (preterm births per 100 live births); and

  d. the number of low birthweight births over the 3-year period (2019-2021) and low birthweight rate (low birthweight births per 100 live births).

- *Approach – Corresponds to Section V's Review Criteria 2 RESPONSE and 4 IMPACT*

Direct and Enabling Services for HS Participants

Describe methods for implementation of direct and enabling services that the project will provide to participants, as described in the Program Requirements and Expectations section of this NOFO, ensuring services are culturally responsive and linguistically appropriate.

Describe in detail the type and/or model of group-based health and parenting education you plan to implement including proposed topics.

Discuss in detail the strategies and activities you will use to address the main drivers of infant mortality in the community (for example, preterm birth, low birthweight, Sudden Infant Death Syndrome, and accidental injuries), and promote optimal maternal, infant, child, and family health and wellness.

Community Consortium

Describe your proposed methods for meeting all required project activities and expectations listed under the Community Consortium in the Program Requirements and Expectations section of the NOFO.

Describe the composition and structure of the proposed Community Consortium.

- Include a tentative roster that includes names and affiliations of proposed members, including identifying individuals with lived experience with adverse maternal or infant health outcomes.

[30] To protect confidentiality, please indicate if there are fewer than 10 events and do not provide an exact number or calculate a rate.

- Include any Letters of Agreement, Memorandum of Understanding/ Proposed/Existing Contracts (project specific) in Attachment 5.
- Include any letters of support in Attachments 9–15: Other Relevant Documents.

Describe your proposed approach/methodology for conducting a community needs assessment and an environmental scan. Describe how it will identify and prioritize root causes of disparities in perinatal outcomes in your project area to inform your plan. If using a community needs assessment and environmental scan that was already conducted, describe the approach and how it identified and prioritized the root causes of disparities in the proposed project area.

Briefly describe the steps you will take to obtain community buy-in/approval of the plan. Describe how you will disseminate the plan and regularly report out information to community members and partners on the plan's progress and impact.

Describe how you will conduct regular and ongoing measurement of your plan's implementation and progress. Describe how you will collect data on the following process measures:

- Number of systems-level changes/actions developed and implemented to address SDOH and reduce disparities in adverse perinatal outcomes within the project area. Examples include: partners develop green space in community to promote physical activity; providers integrate behavioral health services into primary care locations; and pregnant tenants receive education on eviction prevention and access to pro-bono eviction prevention resources.
- Number and type of partners, including HS participants and community members engaged in development and implementation of the plan to address the SDOH that contribute to perinatal disparities in the project area.

Describe plans for ongoing facilitation, support, and assistance to the Community Consortium. State whether community members and/or HS participants on the Community Consortium will be compensated for services provided.

HRSA encourages recipients to sustain key elements of their projects. These may include strategies and interventions shown to be effective in improving practices and outcomes for the priority population. A sustainability plan will be required in the final year of the award.

- *Work Plan – Corresponds to Section V's Review Criteria RESPONSE and #4 IMPACT*

Develop a work plan for the entire period of performance that details the activities and steps you will use to achieve each of the two focus areas outlined in the Purpose. Include the work plan in Attachment 2.

Include a timeline with dates for completing key tasks in the work plan and identify responsible personnel/staff or other parties. The application should include baselines for all HS benchmarks in the work plan. The work plan should demonstrate that your organization possesses the capacity to implement and carry out the proposed project successfully within the period of performance.

In this section of the Project Narrative, describe the key activities and steps that you will use to achieve each of the required objectives and major milestones of your proposed work plan. If you will make subawards or expend funds on contracts, describe how your organization will ensure proper documentation and oversight of funds, including compliance with award requirements.

- *Resolution of Challenges – Corresponds to Section V's Review Criterion 2 RESPONSE*

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

- *Evaluation and Technical Support Capacity – Corresponds to Section V's Review Criterion 3 EVALUATIVE MEASURES*

Describe the plan for performance monitoring. Performance monitoring should track processes and progress towards the goals and objectives of the project and contribute to continuous quality improvement.

Describe the systems and processes that will support your organization's performance management requirements. Describe:

- How you will effectively track performance outcomes.
- How the organization will collect and manage data (for example, assigned skilled staff, data management software) in a way that allows for accurate and timely reporting of HS benchmarks and performance measures for Community Consortium activities. See Appendix D for a list of HS benchmarks associated with the HS program.

Describe your plan for program evaluation**.** The program evaluation should monitor ongoing processes and the progress towards the goals and objectives of the project. Include descriptions of the inputs (for example, organizational profile, collaborative partners, key staff, budget, and other resources), key processes, and expected outcomes of the funded activities.

iii. *Budget*

The *Application Guide* directions may differ from those on Grants.gov.

Follow the instructions in Section 4.1.iv Budget of the *Application Guide* and any specific instructions listed in this section. Your budget should show a well-organized plan.

Reminder: The total project or program costs are all allowable (direct and indirect) costs used for the HRSA activity or project. This includes costs charged to the award and non-federal funds used to satisfy a matching or cost-sharing requirement (which may include MOE, if applicable).

Program Income

You must use any program income you generate from awarded funds for approved project-related activities. Use program income under the addition alternative (45 CFR § 75.307(e)(2)). Find post-award requirements for program income at 45 CFR § 75.307.

As required by the Consolidated Appropriations Act, 2023 (P.L. 117-328), Division H, § 202, "None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II." Effective January 2023, the salary rate limitation is $212,100. As required by law, salary rate limitations may apply in future years and will be updated.

iv. *Budget Narrative*

See Section 4.1.v. of the *Application Guide.*

v. *Attachments*

Provide the following attachments in the order we list them.

Most attachments count toward the application page limit. Indirect cost rate agreement and proof of non-profit status (if it applies) are the only exceptions. They will not count toward the page limit.

Clearly label each attachment. Upload attachments into the application. Reviewers will not open any attachments you link to.

*Attachment 1: Project Area, Map of Proposed Project Area, List of Counties and Zip Codes™ within the Proposed Project Area, and Target Population. (*Note that Attachment 1 does not count toward the application page limit).

> Please see Appendix E for a checklist of information to include in Attachment 1. Note: you are encouraged to use the template in Appendix F to organize the information in this attachment.

Attachment 2: Work Plan

> The work plan for the project that includes all information detailed in Section IV.2.ii. Project Narrative.

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

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

Attachment 4: Biographical Sketches of Key Personnel ***(Do not count towards the page limit)***

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

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

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

Attachment 6: Project Organizational Chart

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

Attachment 7: Tables, Charts, etc.

This attachment should give more details about the proposal (for example, Gantt or PERT charts, flow charts), if needed.

Attachment 8: Budget for Year 5 ***(Does not count towards the page limit)***

Provide the 5th year budget as an attachment.

Attachments 9 – 15: Other Relevant Documents (15 is the maximum number of attachments allowed)

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

3. Unique Entity Identifier (UEI) and System for Award Management (SAM)

A UEI is required to apply for this funding. You must register in the SAM.gov to receive your UEI.

You cannot use a DUNS number to apply. For more details, visit the following webpage: General Service Administration's UEI Update

After you register with SAM, maintain it. Keep your information updated when you have: an active federal award, application, or plan that an agency is considering.[31]

When you register, you must submit a notarized letter naming the authorized Entity Administrator.

We will not make an award until you comply with all relevant SAM requirements. If you have not met the requirements by the time we're ready to make an award, we will deem you unqualified and award another applicant.

If you already registered on Grants.gov, confirm that the registration is active and that the Authorized Organization Representative (AOR) has been approved.

To register in Grants.gov, submit information in two systems:

- System for Award Management (SAM) (SAM Knowledge Base)
- Grants.gov

Effective March 3, 2023, individuals assigned a SAM.gov Entity Administrator role must be an employee, officer, or board member, and cannot be a non-employee. This change is to ensure entities are in control of who has permission to control roles within their entity.

Here's what this means:

- Entity Administrators assigning roles to non-employees will only be able to assign a Data Entry role or lower.
- Any entities assigning Entity Administrator roles using an Entity Administrator Role Request Letter (formerly called "notarized letter") will no longer be able to assign the Entity Administrator role to a non-employee.
- Entity Administrator roles assigned to non-employees will be converted to Data Entry roles. With a Data Entry role, non-employees can still create and manage entity registration data entry but cannot manage roles.

If you are an entity using a non-employee or if you are a non-employee working with an entity to manage registrations, please read (and share) more about this change on the BUY.GSA.gov blog to know what to expect.

For more details, see Section 3.1 of the *Application Guide.*

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[31] Unless 2 CFR § 25.110(b) or (c) exempts you from those requirements or the agency approved an exemption for you under 2 CFR § 25.110(d)).

Note: Allow enough time to register with SAM and Grants.gov. We do not grant application extensions or waivers if you fail to register in time.

4. Submission Dates and Times

Application Due Date

Your application is due on *December 15, 2023, at 11:59 p.m. ET*. We suggest you submit your application to Grants.gov at least 3 calendar days before the deadline to allow for any unexpected events. See the *Application Guide's* Section 8.2.5 – Summary of emails from Grants.gov.

5. Intergovernmental Review

Healthy Start Initiative must follow the terms of Executive Order 12372 in 45 CFR part 100.

See Section 4.1 ii of the *Application Guide* for more information.

6. Funding Restrictions

The General Provisions in Division H of the Consolidated Appropriations Act, 2023 (P.L. 117-328) apply to this program. See Section 4.1 of the *Application Guide* for information. Note that these and other restrictions will apply in fiscal years that follow, as the law requires.

Program-specific Restrictions

Except for the nominal incentives to retain enrolled participants (for example, diapers, gift cards, etc.), funds awarded under HRSA-24-033- Healthy Start, cannot be used to provide in-kind benefits or cash payments (for example, rental assistance payments, housing vouchers, income supplements, etc.).

You must have policies, procedures, and financial controls in place. Anyone who receives federal funding must comply with legal requirements and restrictions, including those that limit specific uses of funding.

- Follow the list of statutory restrictions on the use of funds in Section 4.1 (**Funding Restrictions**) of the *Application Guide.* We may audit the effectiveness of these policies, procedures, and controls.
- 2 CFR § 200.216 prohibits certain telecommunications and video surveillance services or equipment. For details, see the HRSA Grants Policy Bulletin Number: 2021-01E.

If funded, for-profit organizations are prohibited from earning profit from the federal award (45 CFR § 75.216(b)).

V. Application Review Information

1. Review Criteria

We review your application on its technical merit. We have measures for each review criterion to help you present information and to help reviewers evaluate the applications.

We use six review criteria to review and rank HS applications. There is a maximum score of 100 total points. Reviewers will evaluate and score the merit of your application based upon the review criteria. Reviewers will score **up to 85 points** of the 100 total points.

The remaining 15 points will be based on infant mortality, preterm birth, and low birthweight data and will be assigned by HRSA, as outlined in the Review Criteria below. If your application meets the specified IMR and number of infant deaths, number of preterm births and the preterm birth rate or number of low birthweight infants and the low birthweight rate[32] outlined in Factors Demonstrating Need for the Target Population, HRSA will apply 15 points to your application. If your application fails to meet those indicators, you will receive 0 points out of the 15 points assigned by HRSA.

Here are descriptions of the review criteria and their scoring points.

Criterion 1: NEED (5 points determined by reviewers and 15 points determined by HRSA = 20 points TOTAL) – Corresponds to Section IV's Introduction and Need

Overview of Key Health Indicators – Reviewers Will Assess (5 points):

- The need for the project based on the extent to which the application clearly and effectively describes the current perinatal system (that is, health systems and social supports), socio-demographics such as education level, employment and income level, and health statistics demonstrating current prevalent disparities in the target population.
- The need for the project based upon key health indicators such as insurance status, rate of Sudden Unexpected Infant Deaths, births to teenagers 18 years and younger, trimester of initiation of prenatal care and adequacy of prenatal care for the target population.
- The need for the project based upon other current trends in family health and wellness and maternal and infant morbidity and mortality (for example, rates of birth defects, sexually transmitted infections, intimate partner violence etc.)
- The need for the project based upon the SDOH contributing to adverse perinatal outcomes for the target population in the project area. The extent to which there

[32] IMR, preterm birth and low birth weight are all critical health determinants used to assess which target populations are at highest risk for adverse maternal and infant health outcomes.

are barriers/challenges that result in disparities in parental health for the target population.

IMR, Preterm Birth and Low Birthweight – HRSA Will Assess (15 points):

The following information is required, and accounts for 15 points under the Need section. If data are not provided or not provided accurately, 0 points will be awarded for this section of the Need criterion.

The need for the project based on the extent to which the application clearly and effectively:

- Describes the needs of the target population and the adverse perinatal health outcomes they experience. These include the number of births, IMR, number of infant deaths, number of preterm births, preterm birth rate, number of low birthweight infants, and the low birthweight rate (using data from 2019–2021).
- Describes and defines the project area and includes a list of counties and Zip Codes™ (for example, rural/urban, size demographic characteristics).
- For the target population within the proposed project area provide the following information:
    1. If the combined 2019 through 2021 number of infant deaths in the target population are 30 or more, the 2019 through 2021 combined 3-year IMR[33] should be equal to or more than 8.2 deaths per 1,000 live births (1.5 times the national average).
    2. If the combined 2019 through 2021 number of infant deaths in the target population are less than (<)30, do not use the IMR. One of the following must be met:
        a. The 2019 through 2021 3-year low birthweight rate is equal to or more than 12.5 percent (1.5 times the national average) AND there must be 90 or more low birthweight births in the target population during the 3-year period, 2019 through 2021.

        OR

        b. The 2019 through 2021 preterm birth rate is equal to or more than 15.4 percent (1.5 times the national average) **AND** there must be 90 or more preterm births in the target population during the 3-year period, 2019 through 2021.

[33] Infant deaths per 1,000 live births over 3 years

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

Approach (15 points)

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

- The application demonstrates knowledge and awareness of the health status of individuals in the project area.
- The application demonstrates knowledge and awareness of the SDOH contributing to adverse perinatal outcomes for the target population.
- The application demonstrates an understanding of the existing barriers/challenges and strengths/assets, such as state, Tribal (if applicable), local/community resources and services, collaborations/partnerships, and systems change interventions intended to address disparities in perinatal health.
- The activities described in the application can address the problem and meet the objectives of both Direct and Enabling Services for HS Participants and Community Consortium.
- The application comprehensively describes methods/proposed plans to carry out the multiple components of Direct and Enabling Services for HS Participants and Community Consortium.
- The application comprehensively describes an approach and/or model for providing group-based health and parenting education.
- The application demonstrates an actionable plan for staffing and ensuring the timely delivery of preventive care, required clinical services, case management, care coordination, and community/social service supports to the target population in the project area.
- The application has a well-defined and achievable approach to conducting high quality health promotion and education activities at an appropriate frequency to reach the target population and influence health behaviors.
- The application describes a feasible and appropriate approach by the Community Consortium to develop and begin implementation of a plan in the first year of the project with cross-sector Tribal (if applicable), state, and local partners (including the State Title V Maternal and Child Health Block Grant Program); community members; and individuals with lived experience.
- The application describes an effective and feasible approach or process for the Community Consortium to regularly report out/disseminate information to community members and partners on the plan's progress and impact.

Work Plan (10 points)

- The work plan activities proposed for each HS focus area appear feasible and likely to contribute to the achievement of the project's objectives within each budget period.
- The work plan successfully demonstrates that the applicant can stand up prenatal and other clinical services within 90 days; provide care coordination and group-based education to a minimum of 700 participants per year; build a robust referral network for community-based social services.

Resolution of Challenges (5 points)

- The application identifies challenges to implementing the activities described in the work plan and proposes feasible responses to resolve challenges.

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

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

- Demonstrates a feasible and appropriate approach for monitoring and tracking overall performance and progress on the project's activities and objectives.
- Demonstrates a feasible and appropriate approach for evaluating outcomes.

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

The application will be assessed based on the extent to which it demonstrates that:

- Activities described in the application are likely to reduce infant mortality rates in the target population. The overall project will result in outcomes (for example, decreases in disparities in infant mortality and adverse perinatal outcomes [such as low birthweight and preterm birth] and disparities; systems changes and improvements); and
- The project's outcomes will have a positive impact on the target population in the proposed project area.

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

The application will be assessed based on the degree to which it demonstrates the applicant organization (including contractors/consultants, partners, and key personnel/project staff) has the needed experience – including lived experience, knowledge, capacity, time/level of effort, infrastructure, and resources – to:

- Address program requirements and expectations for both Direct and Enabling Services for HS Participants and Community Consortium.

- Conduct program requirements and expectations in other areas successfully.
- Implement and carry out the proposed project successfully within the period of performance.

For recipients of HRSA-19-049:

The application must indicate your status as a HRSA-19-049 recipient and provide evidence of the applicant organization's impact on improving perinatal health outcomes within the project area. This will be evaluated by meeting 10 out of 19 of the Healthy Start Benchmarks for Calendar Year 2022.

For applicants who were not recipients of HRSA-19-049:

Your application must demonstrate the organization's capacity to decrease the IMR and improve other adverse perinatal health outcomes (such as reducing rates of low birthweight and preterm birth) within the proposed project area. This will be evaluated through assessment of an overview of the organizational profile, collaborative partners, key staff, budget, data systems and other resources. You may include examples of other successful projects that you have implemented with similar objectives around improving maternal and infant health outcomes and corresponding data if available.

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

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

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

2. Review and Selection Process

Subject matter experts provide an impartial evaluation of your application. Then, they pass along the evaluations to us, and we decide who receives awards. See Section 5.3 of the *Application Guide* for details. When we make award decisions, we consider the following when selecting applications for award:

- How high your application ranks
- Funding availability
- Risk assessments
- Other pre-award activities, as described in Section V.3 of this NOFO

For this program, HRSA may fund out of rank order to ensure an appropriate distribution of projects to address the objectives of the NOFO, as described below, in selecting applications for award.

- HRSA will award no more than 6 HS awards per state (that is, recipients of HRSA-23-130 and HRSA-24-033 projects combined).
- HRSA intends to award at least 10 percent of grants to organizations serving a rural project area. To determine whether the Census Tract or County for your proposed project area is defined as a rural area, visit the Rural Health Grants Eligibility Analyzer and enter the project area address https://data.hrsa.gov/tools/rural-health.
- As outlined in Program Requirements and Expectations, in most instances, an application will not be funded if a higher scoring application is received that proposes to serve the same or overlapping project area. As noted in the Program Requirements and Expectations, HRSA would consider funding two applicants with overlapping project areas if:
    - One but not both of the applicants is a tribe, tribal organization or health organization serving tribes.
    - Part of your project area overlaps with a project area proposed by one or more applicant(s) of HRSA-24-033[34] and HRSA approves your agreement to modify project areas as described in "Overlapping Project Areas" on pages 8-10 of this NOFO.

Priority Point(s)

This program includes a funding priority. A funding priority is the favorable adjustment of combined review scores of individually approved applications when applications meet specified criteria. HRSA staff adjusts the score by a set, pre-determined number of points. The HS program has two funding priorities:

Note: If an application meets one or both criteria listed below, HRSA will award a ***total* maximum of 2 additional points.** If you meet both criteria below, **2 points** is the maximum additional points you can receive. HRSA will crosscheck data provided with a verified data source.

Priority 1: Infant Deaths for the Target Population (2 Points)

You will be granted a funding priority if:

- You propose to serve a project area which falls within one or more counties with 60 or more infant deaths for your target population over three years. Use 2019-2021 verifiable, vital statistics data.[35]

[34] HRSA will use, counties, Zip Codes™, street names, and/or Census Tracts provided by the applicant to determine project area overlaps.
[35] CDC Wonder may be used to obtain infant mortality statistics (for counties with a 250,000+ population only): https://wonder.cdc.gov/lbd.html. Otherwise, please contact your state or local vital statistics department.

Priority 2: Other Perinatal Indicators for the Total Pregnant Population (2 Points)

You will be granted a funding priority if:

- Your proposed project area is located within at least one county that meets at least three of the criteria below. A list of counties eligible for priority points can be found in Appendix G.
    - Percentage of pregnant women with pre-pregnancy or gestational diabetes is in the top quintile of counties (9.0 percent or more);
    - Percentage of pregnant women with pre-pregnancy or gestational hypertension is in the top quintile of counties (12.3 percent or more);
    - Percentage of pregnant women with pre-pregnancy obesity is in the top quintile of counties (35.7 percent or more);
    - Percentage of pregnant women entering prenatal care in the first trimester is in the bottom quintile of counties (71.1 percent or less).

3. Assessment of Risk

If you have management or financial instability that directly relates to your ability to carry out statutory, regulatory, or other requirements, we may decide not to fund your high-risk application (45 CFR § 75.205).

First, your application must get a favorable merit review. Then we:

- Review past performance (if it applies)
- Analyze the cost of the project/program budget
- Assess your management systems
- Ensure you continue to be eligible
- Make sure you comply with any public policies.

We may ask you to submit additional information (for example, an updated budget) or to begin activities (for example, negotiating an indirect cost rate) as you prepare for an award.

However, even at this point, we do not guarantee that you'll receive an award. After a full review we'll decide whether to make an award, and if so, if special conditions are required, and what level of funding is appropriate.

Award decisions are discretionary and final. You cannot appeal them to any HRSA or HHS official or board.

We review information about your organization in the Federal Awardee Performance and Integrity Information System (FAPIIS). You may comment on anything that a federal awarding agency previously entered about your organization. We'll consider your comments, and other information in FAPIIS. We'll use this to judge your organization's integrity, business ethics, and record of performance under federal awards when we

complete the review of risk. We'll report to FAPIIS if we decide not to make an award because we have determined you do not meet the minimum qualification standards for an award (45 CFR § 75.212).

VI. Award Administration Information

1. Award Notices

The Notice of Award (NOA) is issued on or around the start date listed in the NOFO. See Section 5.4 of the *Application Guide* for more information.

2. Administrative and National Policy Requirements

See Section 2.1 of the *Application Guide*.

If you receive an NOA and accept the award, you agree to conduct the award activities in compliance/accordance with:

- All provisions of 45 CFR part 75, currently in effect or started during the award period, with the exception of the termination provisions, which have been superseded by 2 CFR § 200.340(a)(1)-(4), effective on or after August 13, 2020.
- 2 CFR § 200.340(a)(1)-(4) apply to this award. No other termination provisions apply.
- Other federal regulations and HHS policies in effect at the time of the award or started during the award period. In particular, the following provision of 2 CFR part 200, which became effective on or after August 13, 2020, is incorporated into this NOFO: 2 CFR § 200.301 Performance measurement.
- Any statutory provisions that apply

Accessibility Provisions and Non-Discrimination Requirements

If you receive an award, you must follow all applicable nondiscrimination laws. You agree to this when you register in SAM.gov. You must also submit an Assurance of Compliance (HHS-690). To learn more, see the HHS Office for Civil Rights website.

Please contact the HHS Office for Civil Rights for more information about obligations and prohibitions under federal civil rights laws or call 1-800-368-1019 or TDD 1-800-537-7697.

The HRSA Office of Civil Rights, Diversity, and Inclusion (OCRDI) offers technical assistance, individual consultations, trainings, and plain language materials to supplement OCR guidance and assist HRSA recipients in meeting their civil rights obligations. Visit OCRDI's website to learn more about how federal civil rights laws and

accessibility requirements apply to your programs, or contact OCRDI directly at HRSACivilRights@hrsa.gov.

Executive Order on Worker Organizing and Empowerment

Executive Order on Worker Organizing and Empowerment (E.O. 14025) encourages you to support worker organizing and collective bargaining. Bargaining power should be equal between employers and employees.

This may include developing policies and practices that you could use to promote worker power. Describe your plans and activities to promote this in the application narrative.

Subaward Requirements

If you receive an award, you must follow the terms and conditions in the NOA. You'll also be responsible for how the project, program, or activity performs; how you and others spend award funds; and all other duties.

In general, subrecipients must comply with the award requirements (including public policy requirements) that apply to you. You must make sure your subrecipients comply with these requirements. 45 CFR § 75.101 Applicability gives details.

Data Rights

All publications you develop or purchase with award funds must meet program requirements.

You may copyright any work that's subject to copyright and was developed, or for which ownership was acquired, under an award.

However, we reserve a royalty-free, nonexclusive, and irrevocable right to your copyright-protected work. We can reproduce, publish, or otherwise use the work for federal purposes and allow others to do so. We can obtain, reproduce, publish, or otherwise use any data you produce under the award and allow others to do so for federal purposes. These rights also apply to works that a subrecipient develops.

If it applies, the NOA will address HRSA's rights regarding your award.

Health Information Technology (IT) Interoperability Requirements

Successful applicants under this NOFO agree that:

Where award funding involves:	Recipients and subrecipients are required to:
Implementing, acquiring, or upgrading health IT for activities by any funded entity	Use health IT that meets standards and implementation specifications adopted in 45 CFR part 170, Subpart B, if such standards and implementation specifications can support the activity. Visit https://www.ecfr.gov/current/title-

Where award funding involves:	Recipients and subrecipients are required to:
	45/subtitle-A/subchapter-D/part-170/subpart-B to learn more.
Implementing, acquiring, or upgrading health IT for activities by eligible clinicians in ambulatory settings, or hospitals, eligible under Sections 4101, 4102, and 4201 of the HITECH Act	Use health IT certified under the ONC Health IT Certification Program, if certified technology can support the activity. Visit https://www.healthit.gov/topic/certification-ehrs/certification-health-it to learn more.

If standards and implementation specifications adopted in 45 CFR part 170, Subpart B cannot support the activity, recipients, and subrecipients are encouraged to utilize health IT that meets non-proprietary standards and implementation specifications developed by consensus-based standards development organizations. This may include standards identified in the ONC Interoperability Standards Advisory, available at https://www.healthit.gov/isa/.

3. Reporting

Award recipients must comply with Section 6 of the *Application Guide* **and** the following reporting and review activities:

1) **Federal Financial Report**. The Federal Financial Report (SF-425) is required. The report is an accounting of expenditures under the project that year. Financial reports must be submitted electronically. Visit Reporting Requirements | HRSA. More specific information will be included in the NOA

2) **Progress Report**(s). The recipient must submit a progress report to us annually. The NOA will provide details.

3) **DGIS Performance Reports.** Available through the Electronic Handbooks (EHBs), the Discretionary Grant Information System (DGIS) is where recipients will report annual performance data to HRSA. Award recipients are required to submit a DGIS Performance Report annually, by the specified deadline. To prepare successful applicants for their reporting requirements, the listing of administrative forms and performance measures for this program are available at https://grants4.hrsa.gov/DGISReview/programmanual?NOFO=HRSA-24-033&ActivityCode=H49. The type of report required is determined by the project year of the award's period of performance. The full OMB-approved reporting package is accessible at https://mchb.hrsa.gov/data-research-epidemiology/discretionary-grant-data-collection (OMB Number: 0915-0298 | Expiration Date: 08/31/2025).

Type of Report	Reporting Period	Available Date	Report Due Date
a) New Competing Performance Report	4/01/2024 – 3/31/2029 *(administrative data and performance measure projections, as applicable)*	Period of performance start date	120 days from the available date
b) Non-Competing Performance Report	4/01/2024 – 3/31/2025 4/01/2025 – 3/31/2026 4/01/2026 – 3/31/2027 4/01/2027 – 3/31/2028	Beginning of each budget period (Years 2–5, as applicable)	90 days from the available date
c) Project Period End Performance Report	4/01/2028 – 3/31/2029	Period of performance end date	90 days from the available date

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

- Benchmarks, Performance Measures, and Program Data
    - The Healthy Start Program established benchmarks and goals for performance. Achievement of benchmarks will be evaluated using the data submitted for the HS performance measures. Your HS program is required to collect data and demonstrate progress towards meeting program goals. Your program will collect and report data to HRSA in two ways. You are expected to:
        1. Use the Healthy Start data collection forms to collect individual client-level data for HS participants receiving CM/CC services and report the client-level data elements to HRSA quarterly using the Healthy Start Monitoring and Evaluation Data System (HSMED) within the HRSA Electronic Handbooks (EHBs).
        2. Collect data to report indicators for the HS performance measures in the Discretionary Grants Information System (DGIS) within the HRSA Electronic Handbooks (EHBs).

HRSA strongly encourages recipients to consider using the CAREWare database for their data collection, management, and reporting needs. CAREWare provides recipients with a client-level data collection system at no cost to them with reporting and case management features; customization capabilities; dedicated technical assistance; a

quick-start option for new and inexperienced recipient; and an adaptable system that is directly informed by/linked to Healthy Start's data reporting requirements.

Note that the OMB revisions to Guidance for Grants and Agreements termination provisions located at 2 CFR § 200.340 – Termination apply to all federal awards effective August 13, 2020. No additional termination provisions apply unless otherwise noted.

VII. Agency Contacts

Business, administrative, or fiscal issues:

Tya Renwick
Grants Management Specialist
Division of Grants Management Operations, OFAM
Health Resources and Services Administration
Call: 301-594-0227
Email: Trenwick@hrsa.gov

Program issues or technical assistance:

Mia Morrison, MPH
Supervisory Public Health Analyst
Division of Healthy Start and Perinatal Services
Attn: Healthy Start Initiative: Eliminating Disparities in Perinatal Health
Maternal and Child Health Bureau
Health Resources and Services Administration
Call: 301-443-2521
Email: MCHBHealthyStart@hrsa.gov

You may need help applying through Grants.gov. Always get a case number when you call.

Grants.gov Contact Center (24 hours a day, 7 days a week, excluding federal holidays)
Call: 1-800-518-4726 (International callers: 606-545-5035)
Email: support@grants.gov
Search the Grants.gov Knowledge Base

Once you apply or become an award recipient, you may need help submitting information and reports through HRSA's Electronic Handbooks (EHBs). Always get a case number when you call.

HRSA Contact Center (Monday – Friday, 7 a.m. – 8 p.m. ET, excluding federal holidays)
Call: 877-464-4772 / 877-Go4-HRSA
TTY: 877-897-9910

Electronic Handbooks Contact Center

The EHBs login process changed on May 26, 2023, for applicants, recipients, service providers, consultants, and technical analysts. To enhance EHBs' security, the EHBs now uses **Login.gov** and **two-factor authentication**. Applicants, recipients, service providers, consultants, and technical analysts must have a Login.gov account for the new login process. For step-by-step instructions on creating a Login.gov account refer to the EHBs Wiki Help page.

VIII. Other Information

Technical Assistance

See TA details in Summary.

Tips for Writing a Strong Application

See Section 4.7 of the *Application Guide*.

Appendix A: Page Limit Worksheet

The purpose of this worksheet is to give you a tool to ensure the number of pages uploaded into your application is within the specified page limit. (Do not submit this worksheet as part of your application.)

The Standard Forms listed in column 1 do not count against the page limit; however, attachments to the Standard Forms listed in column 2 do count toward the page limit. For example, the Budget Narrative Attachment Form does not count, however the attachment uploaded in that form does count against the page limit.

Standard Form Name ***(Forms themselves do not count against the page limit)***	**Attachment File Name** ***(Unless otherwise noted, attachments count against the page limit)***	**# of Pages** *Applicant Instruction – enter the number of pages of the attachment to the Standard Form*
Application for Federal Assistance (SF-424 – Box 14)	Attachment 1: Project Area, Map of the Proposed Project Area, List of Counties and Zip Codes™, and Target Population (*Do not count toward the application page limit.)*	*My attachment pages* =__
Application for Federal Assistance (SF-424 – Box 16)	Attachment 2: Work Plan	*My attachment* = ___ *pages*
Application for Federal Assistance (SF-424 – Box 20)	Attachment 3: Staffing Plan and Job Descriptions for Key Personnel	*My attachment* = ___ *pages*
Attachments Form	Attachment 4: Biographical Sketches of Key Personnel (Do not count toward the application page limit.)	*My attachment* = ___ *pages*
Attachments Form	Attachement 5 : Letters of Agreement, Memoranda of Understanding, and/or Description(s) of Proposed/Existing Contracts (project-specific)	*My attachment* = ___ *pages*
Attachments Form	Attachment 6: Project Organizational Chart	*My attachment* = ___ *pages*

Standard Form Name ***(Forms themselves do not count against the page limit)***	**Attachment File Name** ***(Unless otherwise noted, attachments count against the page limit)***	**# of Pages** *Applicant Instruction – enter the number of pages of the attachment to the Standard Form*
Attachments Form	Attachment 7: Tables, Charts, etc.	*My attachment* = ___ *pages*
Attachments Form	Attachment 8 : Budget for Year 5	*My attachment* = ___ *pages*
Attachments Form	Attachment 9 – 15: Other Relevant Documents (15 is the maximum number of attachments allowed)	*My attachment* = ___ *pages*
Project/Performance Site Location Form	Additional Performance Site Location(s)	*My attachment* = ___ *pages*
Project Narrative Attachment Form	Project Narrative	*My attachment* = ___ *pages*
Budget Narrative Attachment Form	Budget Narrative	*My attachment* = ___ *pages*
# of Pages Attached to Standard Forms		Applicant Instruction: Total the number of pages in the boxes above.
Page Limit for HRSA-24-033 is 60 pages		**My total = ____ pages**

Appendix B: Glossary

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

Case Management\Care Coordination Services (CM/CC) – Helps participants to access medical care, community resources and health/parenting information by encouraging, guiding, and coordinating services and supports. It is a family-centered, strength-based partnership between the HS/HSE participant, HS/HSE staff/team and other affiliated providers. Services are flexible, culturally responsive, and linguistically appropriate. CM/CC can include the following components:

- Screening and intake using Healthy Start enrollment forms;
- Comprehensive assessment and identification of each participant's/family's unique needs;
- Partnering with participants to develop a shared plan of care:
    - This includes identification of participant strengths, goals, and support needs (for example, health/parenting information, linkage or referral to medical care and other community-based resources).
    - Monitoring and discussing progress on the shared plan of care.
    - Updating the shared plan of care to reflect participant accomplishments and changes in participant priorities.

Community Consortium – A formally organized partnership, advisory board or coalition of organizations and individuals representing program participants such as appropriate agencies at the State, Tribal, and local government levels; public and private providers, faith-based organizations, and local civic groups; and local businesses which identify with the project's target area. The Community Consortium works collaboratively to develop and implement a plan focused on SDOH with activities that result in systems changes and improvements to accelerate reducing disparities in perinatal outcomes.

Community-Based Doulas – Community-based Doulas are members of the communities they serve who provide culturally appropriate emotional, physical, and informational support to their clients before, during, and after childbirth. Community-based doulas typically provide more visits than standard doula models and refer to a wide network of community-based services as needed.[36]

Community of Practice – A community of practice (CoP) is a group of people who share a common concern, a set of problems, or an interest in a topic and who come

[36] Attanasio LB, DaCosta M, Kleppel R, Govantes T, Sankey HZ, Goff SL. Community Perspectives on the Creation of a Hospital-Based Doula Program. Health Equity. 2021 Sep 3;5(1):545-553. doi: 10.1089/heq.2020.0096. PMID: 34909521; PMCID: PMC8665817. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8665817/

together to fulfill both individual and group goals by sharing expertise, ideas, strategies, and best practices.

Direct Services – Direct services are preventive, primary, or specialty clinical services to pregnant women, infants, and children where funds are used to reimburse or fund providers for these services through a formal process similar to paying a medical billing claim or managed care contracts.

Doulas – Doulas provide continuous emotional, physical, and informational support to their clients before, during, and after childbirth. They are trained, non-clinical partners to pregnant and postpartum individuals, often supplementing care from doctors, midwives, and nurses. Continuous doula support during labor is a potential means of reducing disparities in perinatal outcomes. A meta-analysis of 26 randomized controlled trials from 17 countries found that continuous labor support significantly reduced cesarean deliveries, improved APGAR scores among newborns, and increased satisfaction with the birth experience.[37]

Downstream Interventions – Involves individual-level behavioral approaches for prevention or health management.[38]

Enabling Services – Enabling services are non-clinical services (that is, not included as direct or public health services) that enable individuals to access health care and improve health outcomes. Enabling services include, but are not limited to, case management, care coordination, referrals, translation/interpretation, transportation, eligibility assistance, health education for individuals or families, environmental health risk reduction, health literacy, and outreach.

Group-Based Prenatal & Parenting Education – A structured and highly collaborative form of learning aimed at improving prenatal health and wellness while providing critical social support for women and increasing empowerment and resiliency. Researchers believe the effectiveness of group prenatal education in improving perinatal outcomes is due to the following:

- Social support provided to pregnant women who attend the education sessions from other pregnant women and mothers in their communities. Social support has been found to reduces chronic and toxic stress and to reduces isolation.
- Additional time provided for health education and skills building- with learning done in small groups through a collaborative, interactive, and engaging environment.
- Building health knowledge and skills empowers women to make positive changes in their health habits.

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[37] Bohren MA, Hofmeyr GJ, Sakala C, Fukuzawa RK, Cuthbert A. Continuous support for women during childbirth. Cochrane Database Syst Rev. 2017;7(7):CD003766. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD003766.pub6/full

[38] https://www.cdc.gov/pcd/issues/2010/jul/09_0249.htm

Please note activities such as health fairs do not constitute group-based education.

Group Prenatal Care – An approach to care that is designed to bring together groups of perinatal patients for routine prenatal care, learning and social support while maintaining the risk screening and physical assessment of individual prenatal care.[39]

High Touch Support – Support that delivers care through high frequency patient/participant-provider encounters to deliver preventative services (including case management/care coordination and health promotion).

Interconception – Between pregnancies. Interconception care (or interpregnancy care) is the care provided to women of childbearing age who are between pregnancies to improve their health outcomes and the health outcomes of their infant.

Infant Mortality – Infant mortality is the death of an infant before their first birthday.[40]

Low Birthweight – Defined as an infant born weighing 2,500 grams or less. This measure is usually reported as a percentage of total live births.

Performance Measure – A narrative statement that describes a specific maternal and child health need or requirement that, when successfully addressed, will lead to or assist in leading to a specific health outcome within a community or project area and generally within a specific time frame. (Example: Percentage of HS women participants that receive a well-woman/preventive visit.)

Preconception – Before pregnancy. Preconception health care is the medical care a person receives from their doctor or other health professionals that focuses on the parts of health that have been shown to increase the chance of having a healthy baby.[41]

Preterm Births – Live births that occur before 37 weeks of gestation.[42]

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

Social Determinants of Health – The conditions in which people are born, grow, live, work and age as well as the complex, interrelated social structures and economic systems that shape these conditions. Social determinants of health include aspects of

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[39] The American College of Obstetrics and Gynecologists. Group Prenatal Care. Committee Opinion Number 731. March 2018. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/03/group-prenatal-care

[40] https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm

[41] https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm

[42] https://www.cdc.gov/preconception/overview.html#:~:text=Preconception%20health%20care%20is%20the,depending%20on%20their%20unique%20needshttps://www.cdc.gov/preconception/overview.html#:~:text=Preconception%20health%20care%20is%20the,depending%20on%20their%20unique%20needshttps://www.cdc.gov/preconception/overview.html#:~:text=Preconception%20health%20care%20is%20the,depending%20on%20their%20unique%20needshttps://www.cdc.gov/preconception/overview.html#:~:text=Preconception%20health%20care%20is%20the,depending%20on%20their%20unique%20needs

the social environment (for example, discrimination, income, education level, marital status), the physical environment (for example, place of residence, crowding conditions, built environment [that is, buildings, spaces, transportation systems, and products that are created or modified by people]), and health services (for example, access to and quality of care, insurance status).[43]

Strengths-Based / Strengths-Based Approach – A strengths-based approach is a method of case management/care coordination that focuses on an individual's strengths, rather than on their challenges and deficits. It aims to build on participants' resources, skills, and goals to overcome challenges and achieve their desired outcomes.

Systems Change – An intentional process designed to change the root causes of an issue. As opposed to an individual-level behavioral change, which only addresses indicators**.**

Technical Assistance – The process of providing targeted, knowledge-based support to build organizational capacity or address a programmatic need or problem.

Upstream Interventions – Strategies that impact the conditions that affect an individual's future acute health or other needs or potential challenges. Examples of upstream interventions include:

- Identify opportunities to address food deserts or environmental hazards (e.g. exposure to excessive pollution or irritants that could negatively impact infant health) in HS project area.
- In collaboration with local housing authorities and other stakeholders, promote information-sharing and best practices to improve housing stability/security among pregnant and postpartum women.
- Ensure all eligible HS participants are connected to the Volunteer Income Tax Assistance program so they can access appropriate tax credits such as the Earned Income Tax Credit, which researchers suggest can improve perinatal outcomes such as low birth weight.
- Implement medical-legal partnership in the HS program and through the legal services provided to HS participants, identify systemic barriers to fair housing practices, medical or insurance benefits, etc.

Warm Handoffs – Warm handoffs are transfers of care between members of a care team that occur in front of the patient and family. This transparent handoff of care allows patients and families to hear what is said and engages patients and families in communication, giving them the opportunity to clarify or correct information or ask questions about their care.

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[43] https://www.cdc.gov/socialdeterminants/index.htm
https://health.gov/healthypeople/objectives-and-data/social-determinants-health

Appendix C: Health Promotion Topics

HS projects may use strategies including screening and referral, individual or group-based education, support navigating resources (for example, CM/CC) and linkage to clinical care to address the following health promotion topics.

1. **Preventive Health Services**
   - Entry into prenatal care in the first trimester and adherence to the recommended American College of Obstetrics and Gynecologists prenatal and postpartum visit schedule.
   - Healthy birth spacing and sexual and reproductive health during the preconception, interconception, prenatal, and postpartum periods**.** These efforts include engaging participants in reproductive life planning and education on prevention of sexually transmitted infections (for example, syphilis).
   - Having a usual source of medical care (for example, medical home) and attending recommended preventive health care visits**.**

2. **Behavioral Health and Wellness**
   - Healthy interpersonal relationships (for example, screening and referral for interpersonal violence).
   - Optimal mental health and wellness (for example, screening and referrals for maternal depression).
   - Tobacco cessation and reduction of alcohol and substance misuse.

3. **Infant Care and Parenting**
   - Breastfeeding and feeding infants with expressed breast milk.
   - Prevention of SIDS and accidental injuries.
   - Infant care and parenting practices that support optimal infant and child development.
   - Developmental milestones.
   - Father/partner involvement.

4. **Community-Based Resources and Benefits**
   - HS projects may work to ensure participants have access to:
   - Health insurance (for example, Medicaid), Supplemental Nutrition Assistance Program, Special Supplemental Nutrition Program for Women, Infants, and Children, Temporary Assistance for Needy Families, Social Security Income, housing assistance and other state and federal benefit programs.
   - Material and educational resources to reduce the impact of negative SDOH on perinatal outcomes.

Appendix D: Healthy Start Benchmarks

1. Increase the proportion of HS women and child participants with health insurance to 90 percent (reduce uninsured to less than 10 percent).
2. Increase the proportion of pregnant HS participants who receive prenatal care in the first trimester to 80 percent.
3. Increase the proportion of HS women participants who receive a postpartum visit to 80 percent.
4. Increase the proportion of HS women participants who receive a well-woman/preventive visit in the past year to 80 percent.
5. Increase the proportion of HS infants placed to sleep following safe sleep practices to 80 percent.
6. Increase the proportion of HS infant participants who were:
   A. ever breastfed or fed breast milk to 82 percent.
   B. breastfed or fed pumped breast milk at 6 months to 50 percent.
7. Increase the proportion of pregnant HS participants that abstain from cigarette smoking, or using any tobacco products, to 90 percent.
8. Increase the proportion of HS child participants who receive the last age-appropriate recommended well-child visit based on the AAP schedule to 90 percent.
9. Increase the proportion of HS women participants who receive depression screening to 90 percent; of those who screen positive for depression, increase the proportion who receive referral to 95 percent.
10. Increase the proportion of HS women participants who receive interpersonal violence (IPV) screening to 90 percent; of those who screen positive for IPV, increase the proportion who receive referral to 95 percent.

Appendix E: Attachment 1 Checklist

Please include all the information listed in the checklist below in Attachment 1. Note that you are encouraged to use the suggested template provided in Attachment F to organize your information.

☐Provide the number of births in your proposed project area (2019-2021).

☐Provide all information requested under "Project Area Proposed to be Funded" in the Program Requirements and Expectations section of this NOFO. Indicate if you are serving a rural or urban project area.

☐Provide a map of the proposed project area and a list of Zip Codes™ within the project area. If you are proposing to serve a portion of a county or Zip Codes™, define the borders of your project area using street names or Census Tracts.

☐Provide all the information requested under "Factors Demonstrating Need for the Target Population" in the Program Requirements and Expectations section of this NOFO.

Provide the following information for each county in your project area:

☐Number of infant deaths for your target population over three years (2019-2021);[44,45]
☐Percentage of pregnant women with pre-pregnancy or gestational diabetes (Check Appendix G);
☐Percentage of pregnant women with pre-pregnancy or gestational hypertension (Check Appendix G);
☐Percentage of pregnant women with pre-pregnancy obesity (Check Appendix G); [33]
☐Percentage of pregnant women entering prenatal care in the first trimester (Check Appendix G);

[44] Use verifiable vital statistics data.
[45] CDC Wonder may be used to obtain infant mortality statistics (for counties with a 250,000+ population only): https://wonder.cdc.gov/lbd.html. Otherwise, please contact your state or local vital statistics department.

Appendix F: Sample Template for Attachment 1

Provide all information requested under Program Requirements and Expectations.

You are expected to include information requested under "Project Area Proposed to be Funded" and "Factors Demonstrating Need for the Target Population" in Attachment 1 – (Project Area, Map of the Project Area with a List of Zip Codes™, and Target Population)

Note: Listed below are examples of how to capture requested project area and target population information within your NOFO application.

Project Area Proposed to be Funded:

A. Define Project Area

A project area (that is, your catchment area) is defined as the geographic area where the proposed Healthy Start (HS) services will be implemented; HS project areas may be defined by Zip Code™, county, or Census Tract. For urban projects, a project area might consist of a group of Zip Codes™. For rural projects, a project area might be a combination of counties or portions of counties and Zip Codes™. The areas served in your project area do not need to be contiguous.

Identify whether the project area is defined by Counties, Zip Codes™, or Census Tracts. Clearly state if you intend to serve an entire county or a portion of a county.

Project area is defined by: □ County □ Zip Code™ □ Census Tract

Enter all of the counties that contain all or part of the project area separated by commas:

Enter all of the Zip Codes™ in the project area separated by commas:

For project areas defined by Census Tracts, enter all of the Census Tracts in the project area separated by commas:

B. Project Area Map

Provide a map of the proposed project area. If you are proposing to serve a portion of a county/counties or Zip Code(s)™, you are expected to define the borders of your project area

using street names, Census Tracts. For portions of a Zip Code™ you may also indicate the border of your project area using the county line.

Urban/Rural Classification

Identify whether the proposed project area will serve an urban or rural project area. Use the Rural Health Grants Eligibility Analyzer to determine whether your project is urban or rural: https://data.hrsa.gov/tools/rural-health. Note that this calculation is made based upon the population density of your project area.

Based on the results of the Rural Health Grants Eligibility Analyzer, is your project area classified as rural? ☐ Yes ☐ No

Factors Demonstrating Need for the Target Population:

Your target population within your proposed project area should meet the following criteria:

If the combined 2019 through 2021 number of infant deaths in the target population are 30 or more, the 2019 through 2021 combined 3-year IMR should be equal to or more than 8.2 deaths per 1,000 live births (1.5 times the national average).

If the 2019 through 2021 combined 3-year number of infant deaths is less than (<)30, do not use the IMR. To be eligible, one of the following should be met:

a. The combined 2019 through 2021 low birthweight (LBW) rate is equal to or more than 12.5 percent (1.5 times the national average) **AND** there should be 90 or more LBW births in the target population during the 3-year period, 2019 through 2021.

OR

b. The combined 2019 through 2021 preterm birth (PTB) rate is equal to or more than 15.4 percent (1.5 times the national average) **AND** there should be 90 or more PTB births in the target population during the 3-year period, 2019 through 2021.

Sample Table I – Factors Demonstrating Need for the Target Population

Directions: Complete the rows below for the target population in your project area..							
2019–2021 Data for your target population in the project area	**# of Live Births**	**# of Infant Deaths**	**3-year IMR**	**# of LBW Births**	**3-year LBW Rate**	**# of Preterm Births**	**3-year PTB Rate**
[Target Population]							
Total							

Funding Priorities

HRSA will award **a maximum of 2 additional points** total if an application meets one or both of the criteria listed below. In other words, even if you meet both criteria below, 2 points is the maximum additional points you can receive. HRSA will crosscheck data provided with a verified data source.

Note: Use verifiable, vital statistics data to obtain the number of infant deaths for your target population over three years (2019-2021).

Note: A list of counties eligible for priority points under Other Perinatal Indicators can be found in Appendix G.

Priority 1: Infant Deaths for the Target Population (2 Points)
You will be granted a funding priority if:

- You propose to serve a project area which falls within one or more counties with 60 or more infant deaths for your target population over three years (use 2019-2021 data).

Priority 2: Other Perinatal Indicators for the Total Pregnant Population (2 Points)

You will be granted a funding priority if:

Your proposed project area is located within at least one county that meets at least three of the criteria below (A list of counties eligible for priority points can be found in Appendix G).

- Percentage of pregnant women with pre-pregnancy or gestational diabetes is 9.0 percent or more;
- Percentage of pregnant women with pre-pregnancy or gestational hypertension is 12.3 percent or more;
- Percentage of pregnant women with pre-pregnancy obesity is 35.7 percent or more;
- Percentage of pregnant women entering prenatal care in the first trimester is 71.1 percent or less.

Based on the criteria above, is your project area eligible for priority points?

☐Yes ☐ No

Sample Table II – Priority Points for Infant Deaths and Other Perinatal Indicators

Directions

- For Infant Deaths use verifiable, vital statistics data.
- For Other Perinatal Indicators refer to the priority points table in Appendix G to determine whether any of the counties in your project area are eligible for priority points.
- If eligible for priority points, please include the county eligible, and 3 perinatal indicators and\or the number of infant deaths.

	(Check Appendix G)				**2019-2021 DATA**
	% of Pregnant Women with:				Number of Infant Deaths for Target Population (>=60 deaths)
Data for Project Area Counties	Pre-pregnancy or gestational diabetes (> = 9.0%)	Pre-pregnancy or gestational hypertension (>=12.3%)	Pre-pregnancy obesity (>=35.7%)	Entering prenatal care in 1st trimester (<=71.1%)	
Enter "X" if met criteria; *enter county name here:* _____					

Appendix G: Counties Eligible for Priority Points for Other Perinatal Indicators

State	County	Diabetes Pre-pregnancy or Gestational	Hypertension Pre-pregnancy or Gestational	Obesity Pre-pregnancy	Prenatal Care First Trimester
AL	Barbour County	6.1	14.0	41.2	67.4
AL	Coffee County	6.1	12.7	37.5	69.3
AL	Colbert County	6.9	13.5	35.9	69.5
AL	Dale County	5.8	13.7	39.5	70.0
AL	Etowah County	6.4	14.3	36.6	65.5
AL	Greene County	5.5	13.0	38.0	50.3
AL	Hale County	5.8	12.4	40.1	58.9
AL	Marengo County	5.5	14.5	38.6	66.0
AL	Perry County	6.7	12.5	42.6	61.3
AL	Pickens County	5.3	16.5	36.6	61.1
AL	Randolph County	5.6	14.2	36.7	67.7
AL	Wilcox County	5.4	14.9	44.6	66.6
AK	Aleutians East Borough	18.0	20.4	31.1	67.6
AK	Aleutians West Census Area	25.2	19.6	39.8	66.4
AK	Bethel Census Area	13.7	23.7	24.8	65.6
AK	Bristol Bay Borough	18.6	16.1	39.2	70.2
AK	Dillingham Census Area	21.1	20.6	29.2	67.0
AK	Kusilvak Census Area	11.1	22.8	26.5	53.9
AK	Lake and Peninsula Borough	16.1	13.9	37.9	75.4
AK	North Slope Borough	19.7	15.4	39.1	69.4
AZ	Apache County	15.6	14.6	39.2	66.6
AZ	Navajo County	15.0	13.7	36.4	68.3
AR	Ashley County	6.1	15.5	40.2	69.1
AR	Ouachita County	5.3	12.3	42.5	68.9
GA	Clay County	5.9	13.2	43.1	70.7
GA	Colquitt County	8.9	14.6	39.6	66.4
GA	Grady County	10.7	10.2	36.8	63.5
GA	Hancock County	7.1	15.0	41.9	70.6
GA	Troup County	5.6	12.5	37.1	65.2
IL	Bond County	9.4	12.7	36.5	81.1
IL	Christian County	12.4	16.5	36.3	83.3
IL	Lawrence County	9.6	13.9	36.3	81.3
IL	Logan County	10.8	13.9	36.1	85.0
IL	Macoupin County	10.5	13.9	35.7	81.8
IL	Montgomery County	10.2	14.4	36.2	85.3
IL	Vermilion County	7.4	13.4	36.7	69.0

State	County	Diabetes Pre-pregnancy or Gestational	Hypertension Pre-pregnancy or Gestational	Obesity Pre-pregnancy	Prenatal Care First Trimester
IN	Clay County	9.8	13.3	37.2	77.4
IN	LaPorte County	9.5	10.4	36.2	65.5
IA	Montgomery County	9.7	13.3	40.8	81.5
KY	Breathitt County	12.6	14.5	39.5	73.4
KY	Clay County	9.3	12.6	36.1	79.9
KY	Elliott County	10.5	18.0	36.3	81.1
KY	Floyd County	10.6	13.8	41.3	81.8
KY	Garrard County	9.7	14.1	35.9	81.3
KY	Grant County	9.9	17.6	35.7	76.7
KY	Johnson County	11.1	16.4	39.3	80.5
KY	Knott County	11.2	12.9	42.0	78.8
KY	Lawrence County	10.0	17.0	35.9	82.1
KY	Leslie County	12.8	15.2	39.5	73.5
KY	Magoffin County	11.5	15.2	39.7	79.0
KY	Martin County	9.8	14.3	38.7	80.0
KY	Mercer County	9.4	12.9	37.4	83.0
KY	Morgan County	10.4	16.3	36.5	80.8
KY	Perry County	14.1	13.5	41.9	73.2
KY	Rockcastle County	9.3	13.2	39.1	81.4
KY	Taylor County	9.2	12.8	36.8	78.4
KY	Wolfe County	9.6	15.1	36.2	76.6
LA	Claiborne Parish	5.6	16.5	40.3	65.8
LA	East Carroll Parish	5.5	21.6	40.5	62.6
LA	Franklin Parish	7.2	20.1	40.8	68.8
LA	Iberville Parish	8.7	16.9	39.5	69.7
LA	Jackson Parish	7.8	18.0	40.6	69.6
LA	Lincoln Parish	6.6	16.8	36.6	66.0
LA	Madison Parish	6.0	18.2	40.7	66.7
LA	Morehouse Parish	7.5	20.0	39.8	69.6
LA	Ouachita Parish	7.6	21.1	39.6	69.9
LA	Richland Parish	7.6	21.9	39.7	69.9
LA	St. Helena Parish	7.6	14.7	36.3	68.2
LA	St. James Parish	9.0	18.0	37.9	76.8
LA	Tensas Parish	4.9	12.7	43.0	65.3
LA	Union Parish	7.1	19.6	41.2	66.0
LA	West Carroll Parish	6.7	21.6	39.7	68.9
MS	Holmes County	3.3	13.3	44.1	68.1
MS	Issaquena County	4.1	14.5	38.2	69.7
MS	Leflore County	3.1	13.8	43.0	69.4
MS	Sharkey County	2.8	13.2	42.5	70.5
MS	Tate County	5.6	12.7	37.8	70.3
MO	Schuyler County	6.1	12.4	36.7	68.3

State	County	Diabetes Pre-pregnancy or Gestational	Hypertension Pre-pregnancy or Gestational	Obesity Pre-pregnancy	Prenatal Care First Trimester
NJ	Cumberland County	13.6	12.5	36.5	68.7
NM	McKinley County	19.1	12.2	41.8	62.2
NM	San Juan County	11.9	7.6	36.1	69.4
NY	Washington County	10.6	12.7	37.3	87.5
NC	Bladen County	8.1	12.5	39.5	66.7
NC	Duplin County	10.4	13.5	35.6	71.0
NC	Edgecombe County	6.8	13.5	41.0	69.0
NC	McDowell County	10.8	16.0	35.7	84.5
ND	Benson County	8.3	12.5	36.5	43.2
OH	Clark County	8.5	15.5	36.6	69.8
SC	Williamsburg County	8.0	13.1	40.6	68.3
TX	Bee County	10.2	10.3	36.0	65.8
TX	Brooks County	10.2	9.7	37.6	60.9
TX	Duval County	11.1	5.5	37.2	60.8
TX	Gonzales County	10.3	13.9	36.3	63.9
TX	Hidalgo County	10.0	9.3	35.9	66.2
TX	Jim Wells County	10.6	9.8	36.7	54.4
TX	Karnes County	9.4	11.1	36.1	70.4
TX	Kenedy County	10.0	9.2	36.0	66.5
TX	Live Oak County	9.3	10.3	36.6	62.0
TX	McMullen County	11.2	9.0	37.2	70.8
TX	Starr County	9.3	10.8	37.4	58.9
WA	Grays Harbor County	11.0	12.5	36.4	71.3
WA	Mason County	9.8	12.7	34.9	69.4

Appendix H: Healthy Start – Enhanced (HSE) Project Site Counties and Zip Codes™

Grantee Organization	State	County/Counties	Zip Codes
Care Ring, Inc.	NC	Mecklenburg County	28031 28203 28210 28217 28270 28036 28204 28211 28223 28273 28078 28205 28212 28226 28274 28104 28206 28213 28227 28277 28105 28207 28214 28244 28278 28134 28208 28215 28262 28280 28202 28209 28216 28269 28282
Family Tree Information Education & Counseling Center	LA	Rapides Parish, Avoyelles Parish, Grant Parish, Catahoula Parish, Concordia Parish, LaSalle Parish, Vernon Parish, Winn Parish	71360 71485 71351 71467 71343 71328 70634 71457 71303 71424 71322 71417 71340 71334 71446 71483 71301 71359 71327 71423 71326 71342 71459 71465 71302 71472 71350 71454 71331 71373 70656 71463 71466 71355 71404 71363 71371 71438 71422 71455 71362 71407 71368 71354 71480 71439 71409 71427 71341 71432 71425 71316 71479 71461 71405 71448 71369 71401 71377 71441 70639 71031 71433 71306 71474 71410 71346 71307 71333 70659 71473 71430 71315 71323 71443 71440 71330 71348 71356 71475 71471 71447 71361 71339 71496 71365 71320 71325 71431 71329 71309 71477
Global Communities, Inc.	CA	San Bernardino	91701 91708 91709 91710 91729 91730 91737 91739 91743 91758 91759 91761 91762 91763 91764 91784 91785 91786 91798 92242 92252 92256 92267 92268 92277 92278 92280 92284 92285 92286 92301 92304 92305 92307 92308 92309 92310 92311 92312 92313 92314 92315 92316 92317 92318 92321 92322 92323 92324 92325 92326 92327 92329 92331 92332 92333 92334 92335 92336 92337 92338 92339 92340 92341 92342 92344 92345 92346 92347 92350 92352 92354 92356 92357 92358 92359 92363 92364 92365 92366 92368 92369 92371 92372 92373 92374 92375 92376 92377 92378 92382 92385 92386 92391 92392 92393 92394 92395 92397 92398 92399 92401 92402 92403 92404 92405 92406 92407 92408 92410 92411 92412 92413 92414

			92415 92418 92423 92424 92427 93558 93562
Maricopa, County of	AZ	Maricopa County	85022 85023 85029 85037 85051 85281 85283 85302 85323 85326 85335 85339 85345 85353 85392
MedStar Health Research Institute Inc.	MD	Prince George's County	20601 20607 20608 20613 20623 20705 20706 20707 20708 20722 20747 20748 20762 20769 20770 20771 20772 20774 20781 20912 20710 20712 20715 20716 20721 20782 20783 20784 20720 20904 20735 20737 20740 20742 20743 20744 20745 20746 20785 20903
Mississippi State Department of Health	MS	Chickasaw County, Clay County, Lee County, Lowndes County, Monroe County, Prentiss County	38850 38851 39751 38860 39756 38868 38878 39766 39741 39750 39755 39773 39776 38824 38826 38828 38843 38849 38857 38858 38862 38866 38801 38804 38879 39736 39740 39701 39702 39705 39743 39759 39730 38821 38844 38848 39746 38870 38829 38833 38856 38859 38865 38873
Mobile County Board of Health	AL	Mobile County	36522 36560 36521 36587 36613 36572 36608 36688 36618 36612 36611 36610 36617 36607 36604 36602 36603 36606 36695 36609 36615 36693 36619 3660536544 36505 36509 36523 36525 36528 36541 36571 36575 36582
Prisma Health-Midlands	SC	Anderson County, Cherokee County, Greenville County, Greenwood County, Laurens County, Lexington County	29006 29033 29036 29053 29054 29063 29070 29072 29073 29075 29112 29123 29138 29160 29169 29170 29172 29178 29210 29212 29325 29332 29335 29340 29341 29351 29355 29356 29360 29370 29372 29384 29388 29601 29605 29607 29609 29611 29613 29614 29615 29617 29621 29624 29625 29626 29627 29630 29635 29638 29642 29643 29644 29645 29646 29649 29650 29651 29653 29654 29655 29657 29661 29662 29666 29669 29670 29673 29680 29681 29683 29684 29687 29689 29690 29692 29702 29819 29848
Southern Nevada Health District	NV	Clarke County	89109 89110 89115 89121 89122 89128 89130 89131 89142 89145 89146 89156 89169 89179 89005 89030 89031 89032 89081 89084 89085 89086 89101 89102 89104 89106 89108
State of North Carolina Department of Health &	NC	Cumberland County, Hoke County	28318 28334 28342 28301 28303 28304 28305 28306 28311 28312 28314 28307 28310 28344 28348 28356 28371 28308 28382 28384 28390 28391 28395 28315 28357 28364 28376 28377 28386

Human Services			