Due Date for Applications: November 27, 2018
Period of Performance: April 1, 2019-March 31, 2024 (5 years, pending availability of funds)
Eligible Applicants: Eligible applicants include any domestic public or private entity.
Domestic faith-based and community-based organizations, tribes, and tribal organizations are also eligible to apply

SUMMARY OF FUNDING (page 3 of NOFO)

1) Will grantees be reimbursed for time and expenses related to mentoring, TA, and serving on the HS CoIIN?

ANSWER: The TA contractor (competed separately) will be responsible for the HS CoIIN process.

2) Is there any opportunity for supplemental funding to assist successful projects in maintaining systemic/structural capacity (clinic partnership for chronic health conditions & postpartum care) and/or implementing proposed community disparity activities (community-wide maternal mortality messaging, Fatherhood branding, etc.)?

ANSWER: At this time, based on current level of appropriated funds, there are no plans to provide additional funding.

3) If no other funding is available, can we use Healthy Start funding to pay for us to start an Evidence Based Home Visiting Model (Healthy Families) as part of our full Healthy Start program?

ANSWER: An applicant can propose to include an evidence-based home visiting model as part of their HS program as long as each component of the program addresses the four HS approaches, and the evidence-based model allows for the HS program to collect the data included in the HS screening tools. That is, the requirements of any curriculum or model chosen do not supersede the requirements of Healthy Start.
4) If you have a State Home Visiting Program are you still eligible to apply for the Healthy Initiatives funding?

**ANSWER:** Yes, although any state with a home visiting program is eligible to apply for HS funding. You will need to describe how you would ensure non-duplication of services or supplantation of funds?

5) With the phrase "up to 25" rural projects will be funded, does that mean no more than 25, or that HRSA is targeting to reach 25, and if more than 25 reach the top rated applications then they will be considered for funding?

**ANSWER:** HRSA anticipates funding no more than 25 programs serving rural project areas.

6) Are you going to issue two separate Notice of Awards if the funding is approved for both funding sources: $950K and $120K?

**ANSWER:** Only one Notice of Award will be issued and the $120K would be supplemental funding to provide clinical services with a separate term.

**ELIGIBILITY INFORMATION (Page 4 of NOFO)**

**Eligible Project Area**

You must identify your organization as serving an urban, rural, or other project area. A project area is defined as a geographic community in which the proposed services are to be implemented. A project area must represent a reasonable and logical catchment area, but the defined areas do not have to be contiguous. A map of the proposed project area and a list of zip codes must be included in the application. (Pg.4 of NOFO)

7) Define Project Area

**ANSWER:** A geographic area for which improvements have been planned and are being implemented with the HS principles of: innovation, community commitment and involvement, increased access, service integration, and personal responsibility. A project area must represent a reasonable and logical catchment area.

8) Our project area spans two counties. One county is officially defined as Rural, the other county just moved into the Urban Category. Do we apply for the grant as Rural, Urban or Other? When a county is listed as partially rural, is it defined as rural or urban, or other?

**ANSWER:** Applicants must self-identify their proposed project area as urban, rural, or other. HRSA will not make that decision for an applicant. However, the applicant should make this determination based on where the majority of the proposed project area is located, and provide the corresponding eligibility information to support this decision.
9) Is a proposed project area required to be only rural, urban or other, can it be a blend of both?

**ANSWER:** A proposed project area can be a blend of urban and rural. But the applicant must classify their application as urban OR rural OR other.

10) HS is using the definitions of urban/rural through HPSAs designations. There are three categories in their definition: rural, partially rural, and Non-rural. They are determined by "discipline", mental health, dental health, primary care, etc. So a certain county might be designated rural for dental care but partially rural or non-rural for primary care. How this would be applied for our eligibility determinations.

**ANSWER:** The NOFO provides a link to determine rural project areas and this is what HRSA will use for verification. Please use the rural health analyzer by address or state/county to determine if your proposed project area is designated as eligible as a rural grant.

11) If an entire county meets the eligibility requirements for infant mortality, etc., could an agency propose to focus services on neighborhoods in the highest need ZIP codes within the county as long as we show those areas also meet or exceed eligibility requirements?

**ANSWER:** You will need to define your target area based on those zip codes -- and that target area must meet the eligibility criteria.

12) We are a current HRSA Healthy Start grantee applying for funding under this grant. However, we have revised our geographic area in order to meet eligibility requirements. Would such a project with a revised geographic area be considered a new application or a competing continuation?

**ANSWER:** The applicant would be considered a Competing Continuation.

13) Is the project area for the 3-year average data for calendar years 2013-2015 the entire city or the census tracts that we plan to target? Or is the project area the zip code from which the census tract reside?

**ANSWER:** It is up to the applicant to decide their target area. A project area must represent a reasonable and logical catchment area, but the defined areas do not have to be contiguous. A map of the proposed project area and a list of zip codes must be included in the application.

14) Is the funding eligibility criteria 3. "Other" required for all applicants or only for those who don’t meet the IMR requirement (1.5 the national average)?

**ANSWER:** The “Other” criteria is not for all applicants; it is intended for applicants who do not fit the Urban or Rural definition and meet at least three of indicators listed in the NOFO under “Other” criteria.
15) What is the criteria for applying in the "Other" Category”? Does HRSA have a goal of how many "Other" grants it hopes to award?

ANSWER: The criteria is listed in the NOFO. HRSA does not have a goal for awards that apply under “other” criteria.

16) If a Healthy Start Program serves only African American Population, will HRSA check Eligibility data for all Races or just African Americans?

ANSWER: An applicant can use either the IMR for their proposed project area OR the IMR for their target population to determine eligibility. While you can serve everyone within your proposed project area, the target population should be the population with the highest IMR (for Urban or Rural) and whom the majority of services are targeted, or meet at least three of the indicators (Other project area). HRSA will verify the data provided by the applicant. An applicant must clearly define both their proposed project area and proposed target population.

17) Does Frontier count as “other”?

ANSWER: Yes

18) We had begun preparing an application under the “other” criteria because we serve a tribal population at both rural and urban sites. However the recent change requiring a minimum of 1,000 births in 1 year (2016) instead of 1,000 births over 3 years (2013-2015) appears to make us ineligible. Is this correct that we would no longer be eligible to apply for Healthy Start if our population meets 3 of the required “other” criteria but does not have 1,000 births in a single year?

ANSWER: If your proposed project area fits the urban or rural definition in the NOFO, then you should be applying using the urban or rural eligibility criteria. You would designate your project as urban or rural based on where the majority of your area is located. The “other” criteria is only to be used by those programs that do not fit the urban or rural definitions. In addition, the programs applying using the “other” criteria must meet the three indicators AND the 1,000 births in 2016 in order to be eligible.

19) If eligibility area is “other”, but IMR rates do make area eligible, are you required to include criteria from “other” in addition to the qualifying IMR?

ANSWER: The “other” criteria is only to be used for programs that do not fit the urban or rural definitions in the NOFO. If your proposed project area has IMR data then you may not fit the “other” criteria. However, if your proposed project area does fit the “other” criteria, then you are only required to meet the three indicators and the 1,000 births in 2016 as stated for the “other” criteria in the NOFO.
Eligible Target Population

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

Target Population

20) Define Target Population

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

21) The NOFO requires serving 300 infants/children, ICC and PC women combined. Does an ICC woman and her child count as 2 project participants or 1?

ANSWER: Each program participant is counted separately as an individual. Therefore, Mother and Child count as two program participants.

25) The NOFO states that the IMR must be at least 8.8 deaths per 1,000 live births. If a certain racial/ethnic group of the population has an IMR far greater than 8.8, is it appropriate to focus solely on serving that subset of the population?

ANSWER: Yes, while you may serve all populations in the project area, the target population (population that you will direct the majority of services to) should be the population with the highest IMR (Urban or Rural) or meet at least three of the indicators (Other project area). An applicant must clearly define both their proposed project area and proposed target population.

26) The guidance states that “your program cannot deny services to any eligible member of the community.” How is eligibility defined in this context? Does it mean that all individuals within our project area are eligible, and that our “target population” is a subset of the population served?

ANSWER: Yes, while you may serve all populations in the project area, the target population (population that you will direct the majority of services to) should be the population with the highest IMR (Urban or Rural) or meet at least three of the indicators (Other project area).
27) The NOFO emphasizes serving the “target population” as the population exhibiting disparities in birth outcomes in the project area, and explicitly identifies race. However, the application guide reminds us that we must offer equal access to programs without regard to race, color, disability, etc. How should we reconcile these directives?

ANSWER: You may serve all populations in the project area, the target population (population that you will direct the majority of services to) should be the population with the highest IMR (Urban or Rural) or meet at least three of the indicators (Other area).

28) Are we required to serve preconception women or is it merely an option?

ANSWER: Although Healthy Start has a focus on women before, during, and after/in-between pregnancies, it is not required to serve preconception women.

29) If grantees are required to serve preconception women, what is the expectation to capture them in HSMED when grantees can’t use the same screening tools as those for prenatal/postpartum clients?

ANSWER: Grantees are not required to serve preconception women, but if you do serve preconception women, there is a screening tool in the current HSMED.

30) The guidance states that “your program cannot deny services to any eligible member of the community.” How is eligibility defined in this context?

ANSWER: An applicant must define eligibility for their proposed project.

31) Please clarify statement on p 12: "Your program cannot deny services to any eligible member of the community." How is eligibility defined in this context? We have a high African-American IMR, so does this mean that we cannot deny services if someone of a different race/ethnicity wants services?

ANSWER: An applicant must define eligibility for their proposed project. You cannot deny services to anyone within your proposed project area; however, the majority of your services should be delivered to your target population, which should be the population with the highest IMR (Urban or Rural) or meet at least three of the indicators (Other project area).

32) Would you need to serve 100% of your proposed target population or can you have a mix of population? Example: African Americans and Immigrant Africans (refugees)? And if a mix, what are the guidelines of serving the majority of your proposed target population?

ANSWER: The HS program requirement is to serve at least 700 program participants per calendar year (300 pregnant women, 300 infants/children up to 18 months, preconception
women, and interconception women (combined), and 100 fathers/male partners affiliated with HS women/infants/children). The majority of your services should be delivered to your target population which should be the population with the highest IMR (Urban or Rural) or meet at least three of the indicators (Other project area) – that is, the population that makes your application eligible.

33) Say 51% of my target population lives in an urban area. Does that define my target geography as urban, understanding that services [up to 49%] may be targeted to the same population in a rural area surrounding the urban area?

ANSWER: You applicant must designate their proposed project area as urban or rural based on the majority of where your project is located.

34) Can the target population be different within your target area? i.e.: 7 zip codes/ 5 the population is black non-Hispanic population and 2 zip codes the population is black AND Hispanic?

ANSWER: You cannot deny services to anyone within your proposed project area, however, the majority of your services should be delivered to your target population which should be the population with the highest IMR (Urban or Rural) or meet at least three of the indicators (“Other” project area).

35) Does the NYC Office of Vital Statistics qualify as an acceptable confirmation?

ANSWER: Yes, as long as HRSA has access to the data to allow for independent verification of the data submitted by the applicant.

36) Does the data in the needs assessment need to be in the same 2013-2015 period and from the CDC?

ANSWER: Yes, the data must be 2013-2015. However, the allowable data are not limited CDC – they must be from a data source that HRSA can use to independently verify.

37) If we meet eligibility through the Black/African American population, is it allowable to serve other racial/ethnic groups (with the primary focus being Black/African Americans)?

ANSWER: You cannot deny services to anyone within your proposed project area, however, the majority of your services should be delivered to your target population which should be the population with the highest IMR (Urban or Rural) or meet at least three of the indicators (Other project area).
Eligibility Factors Demonstrating Need

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

Applications that do not provide this information, in the manner described within this NOFO, will be considered ineligible and the application will not proceed to the Objective Review Committee. (Pg5-6 of NOFO)

38) Does the 8.8 IMR eligibility requirement apply to the "project area" or the "target population" or both?

ANSWER: An applicant can use either the IMR for their proposed project area OR the IMR for their target population to determine eligibility. While you cannot deny services to anyone within your proposed project area, the target population should be the population with the highest IMR (for Urban or Rural) or meet at least three of the indicators (Other project area). An applicant must clearly define both their proposed project area and proposed target population.

39) If we target homeless pregnant women and the IMR is not available for this subset - we use the geographic IMR that applies, even though it doesn't represent the greater IMR that homeless pregnant women may have?

You can use either the IMR for their proposed project area OR the IMR for their target population to determine eligibility. While you cannot deny services to anyone within your proposed project area, the target population should be the population with the highest IMR (for Urban or Rural) or meet at least three of the indicators (Other project area). If the IMR is not available for your proposed target population “homeless women,” HRSA will not be able to verify these data. Therefore, you need to choose a population where verifiable data are available.

40) Does the entire "project area" have to meet the 8.8 IMR eligibility, or just the "target population" within the project area?

ANSWER: An applicant can use either the IMR for their proposed project area OR the IMR for their target population to determine eligibility. An applicant must clearly define both their proposed project area and proposed target population.

41) So does the majority of services, i.e., 51% or more, delivered in an urban or rural area define the target geographic area as urban or rural?
ANSWER: You should designate your project as urban or rural based on where the majority of your project area is located.

42) The NOFO says “your program cannot deny services to any eligible member of the community.” What makes a person eligible? Living in the project area; anything else?

ANSWER: An applicant must define eligibility for their proposed project. You cannot deny services to anyone within your proposed project area; however, the majority of your services should be delivered to your target population which should be the population with the highest IMR (Urban or Rural) or meet at least three of the indicators (Other project area).

43) Is it okay to use IMR within sub population in our county area for example black infant rates being 8.8 /1000 or above or it is meant to be generalized to rates for entire area population?

ANSWER: An applicant must define eligibility for their proposed project. You cannot deny services to anyone within your proposed project area; however, the majority of your services should be delivered to your target population which should be the population with the highest IMR (Urban or Rural) or meet at least three of the indicators (Other project area). An applicant must clearly define both their proposed project area and proposed target population.

Transmittal Letter (page 7 of NOFO)

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

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

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

Examples of verifiable and acceptable data sources:
2) Your state’s public health/vital statistics office.
APPLICATION SUBMISSION REQUIREMENTS (PAGE 7 OF NOFO)

44) Is it possible to extend the page limit beyond 80 pages? Alternatively, is it possible to exclude Attachments 9 and 10 from the page limit? They apply to competing continuations only, which would put existing grantees at a disadvantage if these attachments counted toward the 80-page limit.

ANSWER: No.

45) For competing continuations does the progress report count in the page limit?

ANSWER: Yes

46) Is the page limit 80 pages inclusive of all attachments?

ANSWER: Yes, except the SF424A for the 5th year budget.

47) Is there a font size requirement?

ANSWER: Yes, please see the SF-424 application guide.

48 Letters of Support – It is understood that applicants will be providing Letters of Agreement and MOUs for the grant from key partners and subgrantees are Letters of Support showing project collaborations not required/desired?

ANSWER: Letters of support are not required, but if an applicant chooses to include letters, they will count towards the page limit.

49) Are endnotes included in the page limit?

ANSWER: Please see the SF-424 Application Guide,

50) It is clear applicants cannot blend funding for direct program services such as care coordination, but is it possible to do so for shared expenses? For example, our CAN is co-convened under two programs at our agency. If we hire a CAN coordinator, is this an allowable cost-share? And how would we report their outreach and education efforts (e.g., if they trained 100 people, would we report the full 100 to HS, or would we report 50?

ANSWER: This is not a cost sharing program.

51) Funding /Cost Sharing- Page 27: If cost-sharing is allowed, do “costs borne by the recipient” under Total Program Costs include funds granted to other programs? Would it also include the total agency budget if HS is contributing to administrative salaries?

ANSWER: This is not a cost sharing program.
52) Is the Attachment 9, Request for Funding Factors, included in the 80-page count?

ANSWER: Yes

53) Is the Attachment 10, Progress Report, included in the 80-page count?

ANSWER: Yes

54) Do applicants need to include complete questions in the headings?

ANSWER: No, just the question number

55) Is a Logic Model no longer required?

ANSWER: A logic model is not required.

56) Does the “Areas Affected by Project” Attachment uploaded in Box 14 of the SF424 count in the page limit.

ANSWER: No

PROJECT NARRATIVE (Page 9 OF NOFO)

Program Requirements:

Evidenced-Based Interventions

57) Would this program fund a Nurse Family Partnership program up to the time the infant was 18 months old as long as we meet all other Healthy Start benchmarks and requirements? (We would find other funding sources to complete the last 6 months of NFP services).

ANSWER: An applicant can propose to include an evidence-based home visiting model as part of their HS program as long as each component of the program addresses the four HS approaches and the evidence-based model allows for the HS program to collect the data included in the HS screening tools. That is, the requirements of any curriculum or model chosen do not supersede the requirements of Healthy Start.

58) The guidance states "Identify and justify other evidence-based models and approaches proposed for use (e.g., Centering Pregnancy, MIECHV evidence-based home visiting models, Bright Futures guidelines for health supervision).” Does this mean that the Healthy Start model proposed needs to be both evidence based and incorporate some of these models and approaches?
ANSWER: Each applicant is expected to develop their program based on their community resources and program capacity to address each perinatal phase. Applicants should identify and justify any approaches selected that are appropriate for the services being provided. The NOFO provided examples of evidence-based models that can be used, but this is not a complete list and each applicant can develop their program using any evidence-based models to achieve their goals.

59) All throughout the NOFO it mentions the need for evidence-based approaches and curricula. We’ve been in the process of switching from Partners for a Healthy Baby to an evidence-based curriculum in anticipation of this NOFO and were surprised to see that Partners for a Healthy Baby is listed in Appendix B: Resource List. Does this mean this curricula meets HRSA’s requirement of evidence-based curriculum despite it technically only being evidence-informed?

ANSWER: The NOFO requests that each applicant identify, describe, and justify the evidence-based curricula to be used in the program. It is expected that HS programs use evidenced-based curricula for activities such as health education, fatherhood, depression screening, etc.

60) Are use of evidence based curriculums and models (page 14, 17) required, or suggested? Will use of evidence informed models be scored differently than evidence based models? There is a conflict between most evidence based models and the NOFO requirement to end services at 18 months.

ANSWER: Any evidence-based curriculums and models referenced in the NOFO are examples for applicants. Applicants should choose curricula that are appropriate to their community resources, services provided, and program capacity. Scoring for applications are based on the review criteria outlined in the NOFO. An application should clearly describe and justify their choice for proposed curricula and models.

Fatherhood

61) Will funded fatherhood initiatives be able to have a broader scope than the 100 father mentioned in the NOFO if they have the capacity?

ANSWER: Funds from this opportunity may only be used to serve partners of women and/or infants in the HS program. If an organization has the capacity to serve more, they can serve more.

62) Is it a HRSA expectation the men are to be provided services for the entire 18 months?

ANSWER: Yes

63) What kind of data needs to be collected and reported on for fathers and other male participants?
ANSWER: The only data collected currently collected on fathers is numbers served, the percent of Healthy Start women participants that demonstrate father and/or partner involvement during pregnancy and the percent of Healthy Start women participants that demonstrate father and/or partner involvement with child <24 months.

64) Grantees are expected to have a male case management program but what about those that “identify as male”?

ANSWER: The NOFO states a program participant is an individual having direct contact with HS staff or subcontractors and receiving HS case management/care coordination services on an ongoing systematic basis to improve perinatal and infant health. Specifically, program participants are pregnant women and women of reproductive age, infants, and children up to 18 months. Participants also include fathers/male partners who are affiliated with women and/or infants who receive services from HS.

65) Will we have to administer assessment tools to fathers? If so they are not currently set up for this.

ANSWER: There are currently no screening tools for fathers. Successful applicants will be notified of any changes in the screening tools.

66) Benchmarks that are to be used to measure how the program is succeeding with male participants?

ANSWER: The only data collected currently collected on fathers is numbers served, the percent of Healthy Start women participants that demonstrate father and/or partner involvement during pregnancy and the percent of Healthy Start women participants that demonstrate father and/or partner involvement with child <24 months.

67) Will grantees be required to gather and report data on fathers monthly?

ANSWER: All requested data will be collected monthly, unless otherwise notified.

68) Will there be a Screening Tool for fathers? Does a father and his child count as 1 project participant, or 2?

ANSWER: There are currently no screening tools for fathers. Successful applicants will be notified of any changes in the screening tools. A father is considered one participant and his child is counted as a separate participant towards the minimum numbers served in the NOFO.

69) Will screening tools be developed and required for adult male participants? If not, how will they “count” in the HSMES/D system since it is based on screening tool data?

ANSWER: There are currently no screening tools for fathers. Successful applicants will be notified of any changes in the screening tools.
70) The language in the NOFO defines male participants as fathers or partners of the women who are enrolled as participants. Can single fathers who have an infant that qualifies as a participant also be enrolled as a participant? In the last grant, in cases like these, we were only allowed to count/enroll the baby, but it seems now that we have a way to include and serve males so this should be considered, especially since one reason single dads may be raising a child on their own is because of maternal mortality. Health equity implications are at play here.

ANSWER: The NOFO states that male participants are fathers/male partners who are affiliated with women and/or infants who receive services from HS. If an infant is receiving HS services then the father can be enrolled as a participant as well.

71) If a mom/baby has involvement from both the biological father and a social father/partner can both of these males be enrolled as participants since both may influence the mom & baby outcomes? Health equity implications are at play here.

ANSWER: No, we only count one.

72) Must fathers be affiliated with HS participants, or is it only male partners who must be affiliated?

ANSWER: The NOFO states that male participants are fathers/male partners who are affiliated with women and/or infants who receive services from HS.

73) How can grantees be culturally competent and inclusive in addressing same sex or transgendered parents as far as both partner involvement (lesbians are not male but are partners in raising the child) and also FTM moms in transition who identify as male but may be pregnant and/or parenting? We do not want to miss the opportunity to provide services to an infant or to caregivers because this has not been defined. Health equity implications are at play here.

ANSWER: The NOFO states that a program participant is individual having direct contact with HS staff or subcontractors and receiving HS case management/care coordination services on an ongoing systematic basis to improve perinatal and infant health. Specifically, program participants are pregnant women and women of reproductive age, infants, and children up to 18 months. Participants also include fathers/male partners who are affiliated with women and/or infants who receive services from HS. You must case manage your program participants, and your program must be able to collect data on all HS program participants.

74) How do grantees address the issue of grandparents raising an infant? In the past, we could only enroll the infant, is this still the case? If grandma is still of reproductive age can we enroll her as Interconceptional? Can grantees enroll grandpa as male participant since he is fathering the child and acting as social father? Health equity implications are at play here.
ANSWER: The NOFO states that a program participant is individual having direct contact with HS staff or subcontractors and receiving HS case management/care coordination services on an ongoing systematic basis to improve perinatal and infant health. Specifically, program participants are pregnant women and women of reproductive age, infants, and children up to 18 months. Participants also include fathers/male partners who are affiliated with women and/or infants who receive services from HS. You must case manage your program participants, and your program must be able to collect data on all HS program participants.

75) For moms who have adopted an infant and are not the biological mom, do grantees enroll them as a preconception or Interconceptional mom rather than as the mother of the child? How do we account for this in the screening tools in order to capture the proper data for the child in HSMES/D? Health equity implications are at play here.

ANSWER: In this case, the program needs to complete the demographic, pregnancy history, and Interconception/parenting tools since the preconception tool does not allow for linkage to the child. A successful applicant can address these specific questions to their federal project officer upon receipt of award.

Evaluation/QI

76) Is an annual local evaluation report required?

ANSWER: Yes, an annual local evaluation report will be required.

77) Is it required that an outside evaluator be hired rather than use funds to support internal evaluation staff to evaluate the project?

ANSWER: The NOFO states “your local evaluations must be conducted by an independent evaluator.” The evaluator should not be involved in day-to-day HS operations, but could be affiliated with the organization.

78) Is it a requirement to use an independent local evaluator if our agency has its own evaluation department with several staff dedicated to evaluation?

ANSWER: The NOFO states “your local evaluations must be conducted by an independent evaluator.” The evaluator should not be involved in day-to-day HS operations, but could be affiliated with the organization.

79) Is there an expected percentage of the grant to be spent on the evaluation?

ANSWER: No, but the percent time should be adequate in order to complete a thorough evaluation.
80) How is "independent" evaluator for Healthy Start defined? If the position is not funded by Healthy Start but a staff of the backbone organization is considered outside/independent?

ANSWER: The NOFO states “your local evaluations must be conducted by an independent evaluator.” The evaluator should not be involved in day-to-day HS operations, but could be affiliated with the organization.

81) Is participatory evaluation included in your definition of evaluation?

ANSWER: The applicant must clearly describe their proposed evaluation plan. This plan will be assessed by the Objective Review Committee based on the review criteria.

82) What is the annual QI plan mentioned on page 24, and will there be a template provided for this and will it be submitted as part of the future progress report?

ANSWER: No, a template will not be provided. Awardees should develop a QI plan and report in future progress reports.

83) Will there be a continuation of the National Healthy Start Evaluation?

ANSWER: There will be a National Evaluation in new project period. Successful applicants will be required to participate. The details of the evaluation plan will be shared with the awardees.

84) Is there an expectation that we are to link participants and birth outcomes to the VRO like we are for the national evaluation? I ask because of the section about using the standardized HS screening tools and the need to insure organizational approvals are in place (e.g. IRB, DUA, etc.) on page 24.

ANSWER: Yes, there will be a National Evaluation in new project period. Successful applicants will be required to participate. The details of the evaluation plan will be shared with the awardees.

85) NOFO does not include a prescribed a list of QI topics as was included in the last guidance. Do you think they will add this later or would you develop a QI plan based on our assessment?

ANSWER: An applicant should develop a QI plan based on their individual assessment.
Miscellaneous

86) Is there a standard gestational period guideline that is optimal for enrolling pregnant women?

ANSWER: The HS program strongly encourages program participants to be enrolled in the first trimester of pregnancy to allow for greater opportunity to influence birth outcomes.

87) If your state has not enrolled in AIM, will your grant application lose points?

ANSWER: No

88) Approximately when should sites expect to be notified of award status?

ANSWER: HRSA will issue the Notice of Award prior to the start date of April 1, 2019. See Section 5.4 of HRSA’s SF-424 Application Guide for additional information.

89) Since the Technical Assistance Grant is up for competition, how will projects continue to access the CHW training/resources, should another organization receive funding?

ANSWER: HRSA is working to ensure that the TA resources will be available beyond the project period of the current cooperative agreement.

90) Page 21 says, “Describe how you will work with the HS Technical Assistance Center to identify technical assistance with the core competencies.” Does this mean identify our own needs for technical assistance? Or help provide technical assistance to other grantees?

ANSWER: The applicant should identify their own TA needs

91) Mentor/ Mentee- Page 20: Applicants are asked to indicate our interest in participating in the Mentoring Program. Does this specifically mean volunteering as a mentor, or should we also indicate whether we are interested in being a mentee?

ANSWER. The applicant may indicate either volunteering as a mentor or being a mentee.

92) Is there more guidance around how sites to determine client risk level?

ANSWER: Awardees should develop a protocol to determine risk level of client, and level of service based on the risk score.

93) Pages 25-26 refer to “the consortium”—Is this the Community Action Network, or something else?
ANSWER: Yes, it is the Community Action Network

94) Community Coalitions (reporting) - Page 19, section vi: “Reporting on progress will occur annually, along with any revisions to the approved proposal.” Is this specifically re: role in community coalitions? It seems out of place.

ANSWER: In order to be effective, Community Coalitions should establish a plan with measurable goals and objectives. Reporting on the progress of the plan will occur in the annual progress report submitted to HRSA.

95) For positions that will be filled post award, should we specify “To be submitted upon hiring” in Attachment 4 (bio sketches)?

ANSWER: Yes

96) Please clarify what the expectation is for preconception focus?

ANSWER: The purpose of this Healthy Start (HS) program is to improve health outcomes before, during, and after pregnancy, and reduce racial/ethnic differences in rates of infant death and adverse perinatal outcomes. Therefore, the expectation is for applicants to propose their approach to addressing each of these perinatal phases. Since at least half of the program participants served must be pregnant women, there is a focus on prenatal women to contribute to birth outcomes. In addition, infants/children program participants must be served until 18 months so there is a focus on the Interconception period as well. Other perinatal phases should be addressed based on the applicant’s program capacity.

97) What are the criteria to “count” preconception women?

ANSWER. Preconception woman is a woman before a first pregnancy or between pregnancies (i.e., commonly known as Interconception care). The program needs to be able to complete the demographic, pregnancy history, and preconception tool for this participant.

98) If we are required to serve preconception women, how do we capture them in HSMED when we can’t use the same screening tools as those for prenatal/postpartum clients?

ANSWER: There is a preconception screening tool that all grantees will use. More information on screening tools are included in the NOFO.

99) Can grantees simply report how they will collaborate with HIV/AIDS programs in their community, regardless of whether they are Part D Ryan White programs?
ANSWER: If there is a Ryan White Part D program in the target area to be served, HRSA expects you to collaborate with the program.

100) FIMR- As written, it appears that grantees are required to provide details and report on FIMR even if grantee is not the lead organization for FIMR. Please clarify.

ANSWER: Details and reporting are only required for awardees who are conducting their own FIMR program.

101) Can an existing Healthy Start program continue to provide program participants the same level of services in January-March 2019 as is currently provided?

ANSWER: Yes, programs should continue to provide the same level of service to participants for the entire current project period, which ends March 31, 2019.

102) Definition Clarification/ Pregnant/ Interconception - Please confirm definitions for "pregnant" and Interconceptional and provide definition of preconception women:

ANSWER: A pregnant woman is a female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus. An Interconceptional woman is a female between pregnancies, including but not limited to the postpartum period. Preconception woman is a woman before a first pregnancy or between pregnancies (i.e., commonly known as Interconception care).

103) Please define the word “serve” on page 5, as it relates to serving 300 pregnant women, 300 infants, and 100 fathers served. Does this mean # of individuals touched? Assessed? Referred?

ANSWER: To serve a client means that the individual is receiving Healthy Start case management/care coordination services on an ongoing systematic basis. Additionally, the program must collect data on program participants.

Data Collection and Performance Monitoring  (Page 19 of NOFO)

Benchmarks

104) In the application, Benchmarks are listed on page 20 and Performance Measures on pages 39-40. How are these different?

ANSWER: The benchmarks are a means of assessing progress on a select group of outcomes and activities, and are to be achieved by the end of the project period. Performance measures are yearly targets.
105) What is the definition of the stated timeframe for a woman’s postpartum visit: does it have to be 4-6 weeks?

ANSWER: Yes, the timeframe for the postpartum visit is 4 – 6 weeks after birth of the infant.

106) For benchmark #1, what is considered insurance?

ANSWER: Insurance is health care coverage for the payments of benefits as a result of sickness or injury. Insurance can be given by public or government (e.g., Medicaid) or private provider (e.g., Blue Cross).

107) Please clearly delineate performance measures from benchmarks?

ANSWER: Benchmarks are listed on page 20 of the NOFO, and Performance Measures begin on page 43 of the NOFO.

108) At least one of the benchmarks still uses language of up to 24 months-is that a typo? (Page 23, xvi)

ANSWER: HRSA is working on updating the performance measures through OMB to reflect the information in the NOFO. Successful applicants will be presented with any updated performance forms.

109) Benchmarks- Page 38: Will the benchmark definitions remain the same as the current ones?

ANSWER: At this time, yes.

110) Can you comment on the wording of the Benchmarks on pages 22-23, which does not entirely match the language that is part of the DGIS performance reporting? Can we expect one or the other to be the actual standard for objectives? For example, item iii for postpartum visit completion rate doesn’t mention “between 4 to 6 weeks after delivery”; item v for well woman exam doesn’t specify in the past year).

ANSWER: The DGIS performance reporting will be the standard. Although the performance measure by itself does not mention a timeframe, if you review the full performance package the numerator is defined and includes the timeframe.
Performance Measures

111) The guidance make reference to a section for Reporting for a list of performance measures associated with the Improve Women’s Health approach, and one associated with Benchmarks. Exactly where is that in the guidance or anywhere is that listing.


Screening Tools

112) When will the updated screening tools be available? When do you expect the screening tools to be approved by OMB? Will there be a reduction in the number of questions? What will be the guidance around re-screening and frequency standards?

ANSWER: HRSA will post a Federal Register Notice announcing the intent to update the HS screening tools. During this time, there will also be a public comment period. HRSA anticipates the any revised HS screening tools will be available after the award date. Successful applicants will be notified of the final screening tools.

113) We noticed that the screening tools were not a requirement to use as a method to count Healthy Start participants? Will this change in the future?

ANSWER: The screening tools are a method for counting HS participants. The demographic and pregnancy forms are required for ALL HS women participant. ALL prenatal HS participants complete a prenatal form. And interconception HS participants and children are counted either using the postpartum and/or interconception/parenting tools.

114) For those grantees not currently using the screening tools, would it be possible to pull internal data and upload into the screening tool on the backend? Uploading on the backend would be much easier for staff (and cheaper) and would allow grantees to continue using their more comprehensive and useful tools.

ANSWER: The NOFO states that your program must use the standardized HS screening tools for collection of universal data elements. Your program must be ready and able to report on data collected through the screening tools. Your program must ensure organizational approvals are in place to do so (e.g., Internal Review Board, data use agreements, etc.). The process for ensuring these requirements is dependent on each program. The use of these tools is mandatory and a requirement of accepting HS funds.

115) Has an analysis been done on the most cost-effective data system as HS moves to a new competitive cycle of funding with a lesser amount of available funding per grantee?
ANSWER: HRSA does not have a financial relationship or endorse any specific vendor data system. Therefore, HRSA is not in a position to complete a cost-effective analysis of these systems because the HRSA does not have authority or access to the financial information needed for this type of analysis. Each grantee should make their own determination on the data system that best meets their needs.

116) Will there be a certain number of screening tools that must be completed? Encounters?

ANSWER: The screening tools are a method for counting HS participants. The demographic and pregnancy forms are required for ALL HS women participant. ALL prenatal HS participants complete a prenatal form. And interconception HS participants and children are counted either using the postpartum and/or interconception/parenting tools.

117) How do grantees properly account for infant participants if the parent is not the biological mother? Will screening tools be created for parenting or infants? If not, how do we properly capture data for the infant participant using the existing screening tools so that it is properly accounted for in HSMES/D? Health equity implications are at play here.

ANSWER: Infants/children are counted either using the postpartum and/or interconception/parenting tools.

Maternal Mortality Work Plan and Budget (Page 24 of NOFO)

118) Can the additional $120K for clinical service activities be used by applicants that do not operate in a clinical (i.e., medical setting)? If so, can an applicant propose to fund staffing at a partner agency?

ANSWER: Yes, the funds can be used to support existing services or as seed funding to begin service provision. Yes, the applicant would need to include a MOU from the partner agency.

119) Do doulas count as "clinical"?

ANSWER: No, as doulas do not provide direct clinical care but support women and their families with direct emotional and physical support through labor and postpartum recovery.

120) Is the $120K REQUIRED to go only to expansion of clinical services, or could it go towards clinical QI activities to improve the quality and safety of clinical services (so implementing AIM/CMQCC toolkits, for example)?

ANSWER: The funds are required to support direct clinical services.

121) Does the "clinical provider" under the additional $120,000 have to provide direct PHYSICAL health care services such as well woman care or maternity care? We are
thinking of applying for a Clinical Psychologist to address the mental health concerns that are so often present in cases of maternal mortality/morbidity.

ANSWER: No, the provider does not need to provide direct physical health care services. These funds can be used to support a Clinical Psychologists to address mental and behavioral health concerns.

122) Do the clinical provider have to provide billable services?

ANSWER: No.

123) Would a clinician who serves as a maternal morbidity and mortality abstractor for an MMR team count satisfy the requirements for the "clinical services" even though they are not providing direct client services?

ANSWER: No.

124) Can you state minimum information for morbidity and mortality since page limits are precious

ANSWER: There is no minimum information for maternal mortality rate/severe maternal morbidity requirement for these funds.

125) If we apply for expanded clinical support in Attachment 11, do we need to include a separate SF424, SF424A and budget narrative in Attachment 11, separate from the SF 424, 424A for the entire project?

ANSWER: Only a separate SF424A and budget narrative.

126) Will that be $120,000 for the each of the 5-year project period?

ANSWER: The $120,000 is currently only appropriated for FY19. If these funds are appropriated in future years, they will be made available to the grantees.

Budget (Page 24 of NOFO)

127) NOFO refers to the SF-424 Application Guide for budget information. Based on page 17 of that document, should we use rows 1-4 in Section A to provide the budgets for Years 1-4? We want to confirm, since the column heading suggests that each row is for a "program or activity." And should we provide the Year 5 budget in a second copy of same budget information form?

ANSWER: Please follow the instructions for the SF-424A, and the NOFO instructions for the 5th year budget.

128) Is a budget necessary for all 5 years?
ANSWER: An applicant must submit 5 line item budgets on the SF 424 and 5 budget narratives. If there is any change from year to year, it must be documented in the narrative pertaining to that budget period. If there are no changes in budget periods 2-5, the applicant can complete one narrative indicating the budget will be the same for the 4 years with no change.

129) To confirm the information in the last NoA, Will we be allowed to carry-over unspent funds without needing prior approval, simply inform our PO, if the amount is <25% of our total budget or $250K?

ANSWER: Correct – under expanded authority. This is subject to change, but correct at this time.

130) Will HRSA allow latest NOA Amount of Financial Assistance, lapse funding, etc. be used for transitional and ramping down planning and downsizing HS service sites (April 1, 2019 – December 31, 2019)?

ANSWER: Decisions on funds that have been unspent by March 31, 2019 have not yet been made. More information on no-cost extensions or close-out funding will be forthcoming.

131) Clarification on “Key Personnel” would be helpful. Is it anyone who is funded under HS (e.g., van drivers and child care workers), or only staff directly responsible for program activities (care coordinators, supervisors, etc.)? Clarification on how to determine who should be Key Personnel vs be covered under Indirect Expenses would also be helpful.

ANSWER: The PI/PD and other individuals who contribute to the programmatic development or execution of a project or program in a substantive, measurable way, whether or not they receive salaries or compensation under the grant.

132) Is it possible to claim 10% De Minimis Indirect Cost Rate if we do not have a negotiated rate?

ANSWER: The applicant may elect to use a De Minimis rate of 10 percent if they have never received an approved negotiated indirect cost rate.

133) Do we need to submit separate budget narratives and budgets for Years 1 and 2 with the different levels of funding?

ANSWER: An applicant must submit 5 line item budgets on the SF 424 and 5 budget narratives. If there is any change from year to year, it must be documented in the narrative pertaining to that budget period. If there are no changes in budget periods 2-5, the applicant can complete one narrative indicating the budget will be the same for the 4 years with no change.

ATTACHMENTS (Page 25 of NOFO)
Attachment 9: Funding Factors

Request for Funding Factors (for competing continuations only)

To receive a funding priority, include a statement that you are eligible for a funding priority and identify the priority. Include documentation of this qualification. See Section V.2. Of NOFO. This program includes priority points. Priority points are the favorable adjustment of combined review scores of individually approved applications when applications meet specified criteria. The Healthy Start Initiative program has three funding priorities. HRSA will assign up to 3 priority points for prior performance. Priority points will be given based on data submitted to HRSA in the last progress report (Benchmarks), and the HS aggregate data reporting (total served).

134) What are the requirements and timeframe to receive the extra points?

ANSWER: For current HS grant recipients with an April 1 budget period start date: Benchmark data reporting period is January 1, 2016-December 31, 2016.
For current HS grant recipients with a November 1 budget period start date: Benchmark data reporting period is January 1, 2017-December 31, 2017.
For all current HS grant recipients, regardless of budget period start date, total served data will be for the January 1, 2017 – December 31, 2017 period.

Priority 1: Number of pregnant program participants served. (1 point)
You can request priority points (via Attachment 9) if: In CY2017, you met the required number of pregnant program participants served. Priority 1 will be verified by HRSA using monthly aggregate.

Priority 2: Total number of total participants served. (1 point)
You can request priority points (via Attachment 9) if: In CY2017, you met the required total number of program participants served. Priority 2 will be verified by HRSA using monthly aggregate.

Priority 3: Benchmarks. (1 point)
You can request priority points (via Attachment 9) if: Based on your last submitted progress report, you met 14 out of 19 program performance measures (benchmarks).

135) The guidance states you can request priority points if in CY2017 you met 14 out of the 19 program performance measures (Benchmarks). Which benchmarks will you be using?

ANSWER: You will use the benchmarks outlined on page 20 of the NOFO
136) We re-ran some of our benchmark outcomes using VR data, e.g., WCV, found they were higher than we reported in our 2017 Work Plan. Can we submit the corrected data on the Form 9?

**ANSWER:** No, deadlines for submission of final data were very clear. In order to be fair and consistent we are using the numbers that were reported to HRSA for the time period specified.

137) How many benchmarks must be met if we are current level three sites where there are 21 BMs?

**ANSWER:** Fourteen out of 19 benchmarks have to be met. Priority points will be given based on benchmark data submitted to HRSA in the last progress report. You will use the benchmarks outlined on page 20 of the NOFO.

138) For priority point 1- that would be 100% of pregnant women enrollment the goal for that year? And not 70 or 80% of goal?

**ANSWER:** It would be 100% of the goal.

139) Can HRSA make a statement about the expectation for “required number of program participants served” based on Levels of Funding and the 10% reduction in funds that resulted in reduction of expected #'s of participants served?

**ANSWER:** In calendar year 2017, Level 1 programs were expected to serve 450 total program participants and 225 pregnant woman. Level 2 programs were expected to serve 720 total program participants and 360 pregnant woman. Level 3 programs were expected to serve 900 total programs participant and 450 pregnant woman.

140) Regarding benchmark priority points: there were more than 19 benchmarks reported in 2016; how do we determine our eligibility regarding the benchmarks?

**ANSWER:** The benchmarks are listed on page 20 of the NOFO.

**Attachment 10: Progress Report**

141) Does the progress report related to the funding factors?

**ANSWER:** No, the funding factor time frame information are separate from the progress report.

142) What time-frame/reporting periods to be used for the progress report?
ANSWER: Competing continuations will use January 1, 2018 to July 31, 2018 for the progress report.

143) Would a table that summarizes HS benchmarks/objectives and progress be sufficient for the progress report.

ANSWER: Yes, as long as the applicant includes the period covered, specific objectives related to the benchmarks, and results as of July 31, 2018.

144) What is the reporting period for the benchmarks in the progress report - would it be just for 1/1/2018-6/30/2018, even though that's not a full calendar year and we don't have targets for that particular period

ANSWER: January 1, 2018 to July 31, 2018

145) Projects with an April 1st start date have been asked to submit CY 2016 data for the progress report. What benchmark definitions are to be used?

ANSWER: No, all competing continuations have been asked to submit benchmark data from January 1, 2018 – July 31, 2018 for the progress report. The benchmark definitions for this period would be from the data dictionary on the HS EPIC website dated in late 2016.

146) Will a guideline outline be provided for the Progress Report?

ANSWER: There will not be an outline provided for the progress report.

147) For the progress report do we only need to include information for the priority points we are eligible to receive or all of the information for each of the 3 priority points.

ANSWER: Please include information for the measure that you qualify for.

148) Will the Progress Report be required to be submitted via the EHBs as well as an attachment for the application.

ANSWER: The progress report will not be required to be submitted through the EHB.

149) Benchmark data period for priority points doesn't match any report we've previously submitted- how will information submitted be verified?
ANSWER: HRSA is using past progress reports for benchmark priority points. The timeframe listed matches the timeframe listed in the progress report instructions. No new information can be submitted for this funding factor.

REVIEW AND SELECTION PROCESS (Page 34 of NOFO)

150) The RFP states that a maximum of 6 grants will be awarded per state and a maximum of 1 grant per project area. If there are 6 existing applicants in a state that can re-compete, will new grants be made in that state?

ANSWER: This is a competitive announcement. All applicants are welcome to apply. HRSA will not fund more than 6 grants per state.

151) The guidance says that the number of awards is limited to six per state. Does this consider the size of the population for each state? For example, some states are more densely populated with significant health disparities in multiple regions.

ANSWER: The size of the state was not a factor in this consideration.

152) As there are up to 6 awards per state, can applicants submit a bi-state proposal if the targeted high-risk community is in two states?

ANSWER: Yes, an applicant can submit a bi-state proposal if the targeted high-risk community is in two states. However, the proposed project area needs to fit the definition in the NOFO.

153) Is the 25 grant for the rural grantees included in the overall count of 100 awardees?

ANSWER. Yes