



Department of Medicaid

FUNDING ANNOUNCEMENT:

REQUEST FOR APPLICATIONS for coordinated community approached to target the disparity in the African American infant mortality rate in Butler, Cuyahoga, Franklin, Hamilton, Lucas, Mahoning, Montgomery, Stark, and Summit Counties in Ohio.

Key Dates and Information:

Funding Opportunity	Coordinated Community Approaches to Target the Disparity in the African American Infant Mortality Rate in Nine Specific Ohio Counties.
Application Deadline	September 13, 2019 by 5:00 PM EDT
Notice of Awards	October 11, 2019
Anticipated Project Start Date	January 1, 2020
Length of Project Period	January 1, 2020 to December 31, 2021
Estimated Award Amount	<p>Funding will be awarded up to the following amounts to a single, primary applicant in each of the following nine targeted communities:</p> <ol style="list-style-type: none"> 1. Butler County: \$1,490,000.00 2. Cuyahoga County: \$4,800,000.00 3. Franklin County: \$4,520,000.00 4. Hamilton County: \$2,920,000.00 5. Lucas County: \$2,670,000.00 6. Mahoning County: \$1,880,000.00 7. Montgomery County: \$3,610,000.00 8. Stark County: \$1,630,000.00 9. Summit County: \$2,480,000.00
Eligible Applicants	<p>Eligible applicants must be domestic entities, including:</p> <ul style="list-style-type: none"> ◆ Community or faith based not-for-profit organizations; ◆ Local health departments; ◆ Public or private universities and colleges; or ◆ Early care and learning entities. <p>To qualify for the funding in the nine targeted counties, one single Primary Applicant must submit the application on behalf of itself and Partnering Agencies. The Primary Applicant and its Partnering Agencies must focus their collective efforts to target the disparity in the African American Infant Mortality rates. Primary Applicants with their primary owner being a health care system/network or hospital will not be considered for funding. Funding requests should not exceed the specified amount designated to each county.</p>

TABLE OF CONTENTS

TABLE OF CONTENTS.....	2
EXECUTIVE SUMMARY	3
I. PROGRAM DESCRIPTION.....	4
A. PURPOSE.....	4
B. EXPECTATIONS.....	4
II. ELIGIBLE APPLICANTS.....	4
III. APPLICATION AND SUBMISSION INFORMATION	6
A. REQUIRED APPLICATION COMPONENTS:.....	6
B. PROJECT NARRATIVE.....	6
C. DETAILED BUDGET INFORMATION	11
D. SUPPORTING DOCUMENTATION.....	12
IV. AGENCY CONTACTS.....	12
APPENDICES	13
Appendix A: Goals and Measurable Objectives	13
Appendix B: Data Collection and Performance Measurement.....	14
Appendix C: Sample Budget Formats.....	16
Appendix D: Sample Letter of Commitment.....	20
Appendix E: Sample Community-Based Interventions	21
Appendix F: Sample Applicant Information Page	22

EXECUTIVE SUMMARY

In collaboration with the Ohio Department of Medicaid (ODM), Ohio Medicaid's Managed Care Plans (MCPs) are accepting applications from eligible applicants to target the disparity in the African American infant mortality rate.

Infant mortality is a key indicator often used to measure the health and well-being of a population. Despite a decline in the infant mortality rate over the past several decades, the U.S. infant mortality rate has remained consistently higher than that of other developed countries.¹ Most alarming, improvements have not been equitable; the infant mortality rate for the African American population has not seen declines at the same rate as the Caucasian population. For African American infants, the numbers are devastatingly high. African American women experience the highest infant mortality rate among any racial or ethnic group in the United States.² The rate of infant mortality for babies born to African American women in the U.S. is more than two times the rate for babies born to Caucasian women.³ In order to decrease infant mortality, longstanding challenges and factors that maintain the disparity among African American women must be addressed directly.

In Ohio, African American babies died at nearly three times the rate of Caucasian babies in 2017.⁴ Ohio ranks near the bottom in African American infant deaths and overall infant mortality nationwide.⁵ Ohio's infant mortality rate fell in 2017 with 42 fewer infant deaths, leading to an infant mortality rate of 7.2 per 1,000 live births. However, the improvement was among babies born to Caucasian families: sixty fewer Caucasian babies died in 2017, while African American families saw an increase of 15 additional infant deaths.⁶ In 2017, the infant mortality rate for Caucasian babies in Ohio was 5.3 per 1,000 live births, which is well below the national Healthy People 2020 goal of 6 per 1,000 live births,⁷ but the infant mortality rate for African American babies was 15.6 per 1,000 live births. Moreover, despite attention and resources, the African American infant mortality rate increased in Ohio by over 3% between 2015 and 2017.⁸

Nine counties will be targeted for this funding. Collectively, these nine counties accounted for over 90 percent of African American infant deaths in the state in 2017. This funding opportunity is intended to align and create efficiencies with other funding for infant mortality reduction efforts provided by the Department of Health and the Ohio Commission on Minority Health. These counties are:

- ◆ **Butler**
- ◆ **Cuyahoga**
- ◆ **Franklin**
- ◆ **Hamilton**
- ◆ **Lucas**
- ◆ **Mahoning**
- ◆ **Montgomery**
- ◆ **Stark**
- ◆ **Summit**

Proposals for funding must be submitted to infantmortality@medicaid.ohio.gov by September 13, 2019 no later than 5:00pm EDT. Applicants will be notified regarding the status of their application by October 11, 2019 at which time selected applicants will need to sign a Grant Agreement and/or Memorandum of Understanding (MOU) with the awarding Managed Care Plans. Past funding under this program does not guarantee continued support. This biennium's funding is provided by the 133rd General Assembly and expires on June 30, 2021. All projects and actual work must be

¹ Journal of the American Medical Association. [US Infant Mortality Rate Declines but Still Exceeds Other Developed Countries](#). February 2016.

² U.S. Department of Health and Human Services, Centers for Disease Control. [User Guide to the 2016 Period Linked Birth/Infant Death Public Use File, see page 80](#). June 2018.

³ Organisation for Economic Co-operation and Development (OECD). [Infant Mortality Rates \(Indicator\)](#). 2017.

⁴ Ohio Department of Health. [2017 Infant Mortality Report](#). December 2018.

⁵ U.S. Department of Health and Human Services, Centers for Disease Control. [Infant Mortality Rates by State, 2017](#). 2018.

⁶ Ohio Department of Health. [2017 Infant Mortality Report](#). December 2018.

⁷ U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. [Healthy People 2020](#). April 2018.

⁸ Ohio Department of Health. [2017 Infant Mortality Report](#). December 2018.

completed by December 31, 2021. Available resources after that date will be dependent on the actions of the 134th General Assembly.

I. PROGRAM DESCRIPTION

A. PURPOSE

Managed Care Plans (MCPs), in partnership with the Ohio Department of Medicaid (ODM), are targeting the racial disparity in the African American infant mortality rate in nine counties that align with the Ohio Department of Health's Ohio Equity Institute (OEI) efforts. The goal of this funding opportunity is to improve birth outcomes and reduce disparities among the African American Medicaid population within these communities by implementing the most effective interventions to serve the unique needs of African American Medicaid consumers.

Medicaid MCPs will make funds available from the enhanced maternal care dollars they receive to fund coordinated community approaches that focus on eliminating or mitigating the racial disparity in the infant mortality rate within these nine communities. The purpose of this funding is to:

- ◆ Build capacity to expand or create services to reach and engage African American women most at risk for poor birth outcomes into services that fit the unique needs of African American women.
- ◆ Fill the gaps between existing services and systems within these nine communities.
- ◆ Increase engagement and retention of African American women in timely, patient-centered, unbiased, culturally appropriate, safe, evidence-informed interventions and high-quality health care across the life span, including before, during, after, and in-between pregnancies.
- ◆ Build coordinated and self-sustaining community efforts that bring together all relevant stakeholders.
- ◆ Achieve changes in the attitudes, norms, and practices at the level of service delivery institutions themselves that may be contributing to the observed disparate outcomes.

The funding for these grants will run from January 2020 to December 2021 and is not intended to supplant existing funding or services.

B. EXPECTATIONS

Ohio's Medicaid MCPs expects selected Applicants shall begin the delivery of services to the population of focus as soon as possible after award.

General expectations include the following:

- ◆ Applications should maximize funding for direct services.
- ◆ Applicants should include any information on their program's historical outcomes and/or results.
- ◆ Other funding sources should be identified and leveraged to support program activities.
- ◆ Applicants should provide details on their ability to be self-sustaining in the future.

Ohio's MCPs are under no obligation to issue an award as a result of this RFA if, in the opinion of the MCPs, none of the applications (or parts thereof) are responsive to the objectives and needs of the funding opportunity. Ohio's MCPs reserve the right not to select any application, should they decide not to proceed. After issuance of awards, the MCPs reserve the right to rescind the award if the MCPs and the recommended applicant are unable to come to a mutually acceptable agreement.

II. ELIGIBLE APPLICANTS

A. Eligible applicants must be domestic entities including:

- ◆ Community or faith based not-for-profit organizations;
- ◆ Local health departments;
- ◆ Public or private universities and colleges; or
- ◆ Early care and learning entities.

- B. To qualify for the funding in the nine targeted counties, one single Primary Applicant must submit the application on behalf of itself and Partnering Agencies. The Primary Applicant and its Partnering Agencies must design coordinated approaches focused on reducing the disparity in the African American Infant Mortality rates in their communities. Primary Applicants with their primary owner being a health care network or hospital will not be considered for funding. The Primary Applicant must:
- ◆ Submit a proposal that includes all the required application components.
 - ◆ Include any of the program’s historical outcomes and/or results.
 - ◆ Provide or have a direct link to one of the three following evidence-based models of intervention:
 - Centering Pregnancy;
 - Home Visiting; or
 - Community Health Workers.
 - ◆ Develop and manage ongoing program collaboration with Partnering Agencies, including:
 - Work with existing funded partners and new partners who are interested in becoming a Partnering Agency to provide services to the target population.
 - Assessments of Partner Agencies past funding levels, number of African American women served, compliance with program requirements including data submission, appropriate fiscal management, and fiscal sustainability.
 - Written communication strategies with previous awardees, should previously funded organizations from the county not be included in the current application. This communication must be sent prior to submission of this application for funding, and the communication must include the Primary Applicant’s reasoning for determining the partner organization is ineligible to participate. The Primary Applicant must submit copies of these communications with their application for funding.
 - ◆ Engage women and/or families within the community’s planning process.
 - ◆ Hold monthly meetings with Partnering Agencies and community stakeholders.
 - ◆ Implement an effective referral system to engage African American women in needed timely services.
 - ◆ Identify a process to inform MCPs when one of their members are pregnant and/or enrolled in one of the communities’ interventions and the organization can determine the member’s Managed Care Plan.
 - ◆ Complete Data Sharing Agreements with MCP, ODM and/or ODM’s selected evaluator for evaluation purposes.
 - ◆ Sign BAAs, along with community partners, to create an opportunity for greater interaction with each MCP’s members that will be referred or contacted by any of the community partners.
 - ◆ Complete data collection forms and ensure data is being submitted securely and in a timely manner to MCP, ODM and/or ODM’s selected evaluator for evaluation purposes.
 - ◆ Submit a quarterly progress report on funded activities.
 - ◆ Coordinate and hold professional development activities in the targeted community for partner agencies and others in the community to build capacity for trauma-informed care, cultural competence, and racial disparity efforts.
 - ◆ Identify a Program Coordinator working with the Primary Applicant who will be responsible for day-to-day operations of the project. This individual will be responsible for coordinating the community program, maintaining an effective referral system, coordinating data collection, holding stakeholder meetings, and establishing routine contact with Managed Care Plan Care Managers on behalf of program participants.
 - ◆ Identify **all** Primary Applicant personnel staff members who will work on this program, regardless of whether they receive a salary or compensation from the program.

III. APPLICATION AND SUBMISSION INFORMATION

A. REQUIRED APPLICATION COMPONENTS:

1. **Applicant Information Page:** The first page(s) of the application are to provide the MCPs with site specific information of the Primary Applicant and each Partnering Agency. A sample Applicant information page is included in Appendix F of this document.
2. **Project Narrative:** The project narrative should describe the proposed coordinated approach developed by the Primary Applicant and its Partner Agencies and consists of Sections A-G. **Sections A-G** together may not be longer than 25 pages. Detailed instructions for completing each section of the Project Narrative are provided in Section B: Project Narrative and Evaluation Criteria which includes Sections A-G.
3. **Detailed Budget Information:** Primary Applicant’s responding to this announcement may request funding for a project period of up to 2 years (January 2020 to December 2021). You must submit a detailed proposed budget and budget justification. A sample budget format is included in Appendix C of this document (It is highly recommended that you use the sample budget format). As the Primary Applicant, you must submit a detailed budget for your agency as well as a detailed budget for each Partnering Agency. Be sure to indicate the agency’s name on each Partnering Agency detailed budget. Total funding requests should not exceed the specified amount designated to each county listed on page 1 of the RFA.
4. **Supporting Documentation:** Primary Applicants must include the supporting documentation in their application for funding:
 - a. **Letters of Commitment:** The Primary Applicant must provide a letter of commitment from each Partnering Agency listed in the application (see Appendix D for a sample letter of commitment).
 - b. **Disclosure of Funding Agencies and Supporting Corporations:** For purposes of transparency and disclosure, the Primary Applicant and Partnering Agencies must list all the sources from which they receive financial support or reimbursement of services. Primary Applicants and Partnering Agencies must indicate whether they receive grant funding from the Ohio Department of Health, the Ohio Commission on Minority Health, the Ohio Commission on Fatherhood, or any other entities.
 - c. **If applicable, notification letters sent to agencies previously funded by ODM/Medicaid MCPs that are not included in this funding application,** as described in the Project Narrative, Section A 3. b. below.

B. PROJECT NARRATIVE

The Project Narrative describes the proposed coordinated approach developed by the Primary Applicant and its Partner Agencies and includes the Evaluation Criteria in Sections A-G below. Applications will be reviewed according to the quality of your responses to the requirements in Section A-G.

In developing the Project Narrative section of your application, use these instructions.

- ◆ The Project Narrative (Sections A-G) together may be no longer than **25 pages**.
- ◆ You must use the seven sections/headings listed below in developing your Project Narrative.
- ◆ You must indicate the Section Letter and Number in your response, e.g. “A-1”, “A-2”, etc., before your response to each question.
- ◆ You may not combine two or more questions or answer a question by simply referring to another section of the Project Narrative in your response, such as indicating that the response for B.2. is in C.3.

Section A: Population of Focus, Statement of Need, and Coordination Approach

1. Identify and describe the population characteristics (e.g. race/ethnicity, median household income) of the county/community where services will be delivered. If services will be delivered in a specific geographic catchment area within the county, describe the catchment area where services will be delivered. *(A geographic catchment area can be described as the geographic area for which your organization attracts and serves consumers or where you plan to provide services (e.g. a certain district and or neighborhood(s)).*

2. Describe the current prevalence rates or incidence data on low birth weight, preterm birth, and infant mortality among African American women in the county and/or catchment area you described in response A.1. Describe the extent of the problem/need in the population of focus. Describe any barriers and community challenges among the population of focus. Identify the source(s) of the data.
3. Describe the process the Primary Applicant used to identify, outreach to, and engage potential Partner Agencies to collaborate and develop a coordinated community-wide approach to target the disparity in the African American infant mortality rate. This section should describe how the Primary Applicant assessed previously funded partners and new potential partners interested in providing services to the target population, including:
 - a. Assessing potential partner agencies past funding levels, number of African American women served, compliance with program requirements including data submission, appropriate fiscal management, and fiscal sustainability.
 - b. Communicating in writing with Partner Agencies that were previously funded in the County that the Primary Applicant determines ineligible to participate in their current application. This communication must be sent prior to submission of this application for funding, and the communication must include the Primary Applicant's reasoning for determining the organization ineligible to participate. The Primary Applicant must submit copies of these communications with their applications for funding.
 - c. The Primary Applicant's plan for engaging Partner Agencies and other community stakeholders throughout the funding period, including a minimum of:
 - i. Holding monthly meetings with Partner Agencies and community stakeholders; and
 - ii. Coordinating and holding professional development activities in the targeted community for partner agencies and others in the community to build capacity for trauma-informed care, cultural competence, and racial disparity efforts.
4. Describe any gaps in services within the county/community and explain how the Primary Applicant and its Partner Agencies' coordinated approach will fill these gaps.

Section B: Proposed Coordinated Intervention Model

1. **Evidence-Based Models:** Identify which required Evidence-Based Model(s) will be used: Centering Pregnancy, Home Visiting, or Community Health Workers (if more than one model will be used identify each model). Identify:
 - a. Which Agency(s) (Primary Applicant and/or Partnering Agencies) will be providing the Evidence-Based Model(s).
 - b. An unduplicated number of individuals to be served with each evidence-based model over the entire program period.
 - c. For each model, describe:
 - i. The evidence or theory of effectiveness of the model to reduce preterm birth and infant mortality for African American women at higher risk of poor birth outcomes.
 - ii. Why the model(s) is appropriate for African American women and the outcomes you want to achieve.
 - iii. Any modifications that will be made to the evidence-based model(s) and the reason the modifications are necessary to better serve the needs of African American women.
 - d. If you are proposing to provide an Ohio Department of Health evidence-based home visiting model (e.g. Help Me Grow Home Visiting) indicate so, identify the model, and indicate whether the evidence-based model requires you to submit data to the Ohio Comprehensive Home Visiting Integrated Data System (OCHIDS).

2. **Additional Community-based Interventions:** Recognizing that the individual needs of African American women may not always fit into a pre-determined model, additional Community-Based Interventions that improve service delivery, maternal education, and/or health outcomes of African American women may be proposed by the Primary Applicant and/or Partnering Agencies. A sample list of Community-Based Interventions that could be funded in this category are listed in **Appendix E**.

Community-based interventions could be developed as smaller “pilots” targeted at specific subsets of the population, specific geographical areas, or could be developed for county/community-wide implementation. Community-based interventions should be proposed within the context of the community’s coordinated strategy to improve infant outcomes and reduce racial disparities in infant mortality and pre-term birth in the county. These interventions should be developed to do one or more of the following:

- ◆ Address social determinant of health strategies and/or barriers not addressed by one of the evidence-based models described above;
- ◆ Improve participant retention rates;
- ◆ Address racial equity;
- ◆ Expand peer support strategies and activities;
- ◆ Coordinate with early care and learning settings;
- ◆ Improve retention in the Medicaid eligibility for program participants;
- ◆ Use digital technology to support program efforts; and/or
- ◆ Increase cultural competency.

Applicants should specifically describe the following for *each* proposed community-based intervention:

- a. Which Agency(s) (Primary Applicant and/or Partnering Agencies) will be providing the proposed intervention.
- b. How the proposed community-based intervention fits within the overall context of the community’s plan to reduce poor birth outcomes for African American women, including discussion of:
 - i. How this intervention closes specified “gaps” in the community, and
 - ii. How this intervention complements other interventions being proposed in the application.
- c. An unduplicated number of individuals to be served through the proposed intervention over the entire program period.
- d. Why the intervention is appropriate for African American women at higher risk of poor birth outcomes.
- e. Anticipated effects of the intervention in reducing pre-term birth and infant mortality for the target population.
- f. How effectiveness of the proposed community-based intervention will be measured.

Section C: Proposed Implementation Approach

Please answer the following set of questions for this section for the coordinated community approach in its entirety. These questions should provide insight into the nature of coordination across the Primary Applicant and its Partner Agencies. These questions do not need to be answered for each individual Partner Agency.

1. Describe how the proposed coordinated community approach will address the reproductive health disparities among African American women, including how the program will mitigate both community and health care system challenges.
2. Describe how the proposed program will provide unbiased, respectful, culturally appropriate, safe, effective, patient-centered, high-quality interventions for African American women.

3. Describe how the proposed approach engages women and/or families in the target population within the community's planning process and ongoing implementation strategies.
4. Describe how the proposed program will collaborate with providers and hospital systems to ensure African American women receive timely, unbiased, high-quality, safe, effective, and evidence-based maternal healthcare.
5. Describe how the proposed program will develop an effective referral system to address other physical and/or behavioral healthcare for the population of focus, including but not limited to hypertension, gestational diabetes, anemia, substance use treatment programs, treatment for Sexually Transmitted Infections (STIs), and stress and/or anxiety exacerbated by racial inequality in healthcare. This description should address:
 - a. How participants in need of other physical and/or behavioral healthcare will be successfully linked to care within 30 days,
 - b. A process to inform Managed Care Plans when a member is pregnant and/or enrolled in one of the communities' interventions and the organization can determine the member's Managed Care Plan; and
 - c. A process to link individuals transitioning out of funded interventions (i.e. after delivery, or one year after delivery) to other long-term providers, services, and supports.
6. Describe how the proposed program will connect individual African American women to additional programs and services they may benefit from (e.g. food assistance program, transportation, housing assistance, and Women, Infants and Children (WIC)).
7. Describe how the proposed program will address community-wide social determinants of health among the population of focus to improve African American maternal health outcomes.
8. Describe how the proposed program will be successful in systematic change to improve maternal health outcomes for African American women.
9. Describe how the proposed program will align and create efficiencies with other community efforts funded by the Ohio Department of Health and/or the Ohio Commission on Minority Health.

Section D: Project Goals and Objectives

1. Describe the goals and objectives of the proposed program by providing a chart or graph depicting a realistic timeline for the entire program period showing dates, key activities, number of participants you plan to serve with key activities from each evidence-based model, and responsible staff (see Appendix A for an example of a graph timeline depicting goals & objectives).
 - a. This section should directly link program goals to the explicit goals of this funding opportunity: to improve birth outcomes and reduce disparities among the African American Medicaid population within these communities by implementing the most effective interventions to serve the unique needs of African American Medicaid consumers.
 - b. This section should also demonstrate that the program can be implemented and that service delivery will begin as soon as possible after January 1, 2020.

Section E: Participant Recruitment

1. Describe the recruitment plan to enroll participants. Describe how the proposed program will appropriately identify the population of focus and engage them in program interventions.
2. Describe how the proposed program will retain connectivity and engagement of the population of focus throughout the entirety of the proposed intervention(s), with follow up until the participant has experienced the desired health outcome.
3. Describe any incentives that will be used to recruit and/or retain participants in the programs.

Section F: Staff and Organizational Experience

1. Describe the experience of the Primary Applicant with similar projects and/or providing services to African American women and familiarity with their culture(s) and language(s). Describe your organizations capacity to serve African American women. Describe your organizations capacity to serve the most at-risk women.
2. Identify each Partnering Agency and describe their experience providing services to African American women and their capacity to serve the most at-risk women.
3. Provide a complete list of staff positions for the project, including the Program Coordinator and other significant personnel for the Primary Applicant and each Partnering Agency. Describe the role of each position and the position qualifications, or certifications of staff. You must include all Primary Applicant personnel staff members who will work on the project, regardless of whether they receive salary or compensation from the program.
4. Share details on how staff recruiting efforts will focus on improving diversity and inclusion among staff in the Primary Applicant organization.
5. Identify how staff working on the program have received trauma-informed care and cultural competency training, and what on-going training/certification efforts will occur during the program's funding.
6. NOTE: It is the affirmative responsibility of the Applicants to remove all personal confidential information of Primary Applicant staff and/or of any Partner Agency staff from resumes or any other part of the application submission. Following submission, all applications submitted may become part of the public record.

Section G: Data Collection and Reporting, Performance Measurement

1. Provide specific information about how the Primary Applicant will take responsibility for collecting the required data (see Appendix B for data collection requirements) for this program (Primary Applicant and all Partner agencies) in the following areas:
 - ◆ Who will collect participant data;
 - ◆ How participant consent is obtained when needed, and who will be responsible for obtaining participant consent;
 - ◆ Where data will be stored;
 - ◆ How data will be transmitted;
 - ◆ Who will have access to the collected data;
 - ◆ How the identity of the participants will be kept private;
 - ◆ How will the information be shared on a quarterly basis; and
 - ◆ How your organization will follow and comply with Title 42 of the United States Code (USC) 1320-d, and the implementing regulations found at 45 CFR 160 and 164 regarding disclosure of protected health information under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Explain how staff will be trained on Title 42 and HIPAA policies and procedures.
2. Commit to share the following with ODM and the MCPs through a process that will described at a later date:
 - ◆ All media advisories issued by the Primary Applicant and Partner Agencies.
 - ◆ Media coverage obtained by the Primary Applicant and Partner Agencies.
 - ◆ Quarterly financial and program reports, via a specified quarterly report format that will be distributed at a later date. Reporting will include:
 - i. Quarterly updates to the detailed budget,
 - ii. A budget narrative,
 - iii. Progress on the community-wide goals and objectives described in the grant application.
 - ◆ Any regular reporting the Primary Applicant shares with other funding sources.

3. Describe the process the Primary Applicant will use to evaluate program sustainability throughout the funding period.

C. DETAILED BUDGET INFORMATION

Primary Applicant's responding to this announcement may request funding for a program period of up to 2 years (January 2020 to December 2021). You must submit a detailed proposed budget and justification for *each* year of funding. You must use the sample budget format included in Appendix C of this document. Primary Applicant's must submit a detailed budget and justification as well as submit a detailed budget and justification for each Partnering Agency. Be sure to indicate on each proposed budget the agencies name the budget corresponds to.

In the event of award, if services provided from this funding opportunity become otherwise billable to Medicaid, the funded Applicants agree to not duplicate billing and work with the Managed Care Plans to develop a timeline for funding implications.

The funding restrictions for this project are as follows:

1. Salaries and wages allowable:

- ◆ Including vacation leave, holidays, sick leave, and other excused absences of employees working specifically on goals and objectives of the program, e.g. direct labor costs.
- ◆ Other employee fringe benefits allocable on direct labor employees.

2. Other Allowable Direct Costs, not to exceed 10% of total funding:

- ◆ Consultant and/or certification services to accomplish specific program objectives, including workforce development and staff training for direct labor employees. **Note:** Training must be completed within the State of Ohio.
- ◆ Travel, including:
 - Mileage for ground transportation for direct labor employees delivering program services.
 - Mileage for ground transportation for statewide meetings related directly to this funding opportunity.
 - Please note: The local travel rate is based on organization's policies/procedures for privately owned vehicle (POV) reimbursement rate. If policy does not have a rate use the state mileage reimbursement rate.
- ◆ Materials, supplies and equipment purchased for use directly related to interventions and women served through funded programs, including:
 - Computers;
 - IT systems development and design;
 - Printing, photocopying, and postage;
 - General office supplies;
 - Curricula; and/or
 - Communication costs (phone, cellphone for direct labor employees).
 - **Note:** materials, supplies, and equipment not directly tied to an intervention listed in the application will not be funded.
- ◆ On-demand transportation directly connected to an intervention funded through this process.
- ◆ Non-medical transportation, including bus tickets, when associated with addressing a social determinant of health and described in the funding application.
- ◆ Childcare for women attending a group pregnancy intervention.

- ◆ Purchasing of state identification documents and birth certificates for Medicaid-enrolled families being served by the programs. Other administrative and operating expenses directly tied to the funded interventions, as approved through the application process.
- 3. Allowable Costs for Incentives Tied Directly to Access and Quality:** Specific time-limited approval must be granted by the community’s primary managed care plan contact for all incentives and/or gifts, which must meet the following requirements:
- ◆ Incentives and/or gifts will be allowable only when they facilitate engagement, retention, and/or participation in the funded interventions.
 - ◆ Incentives and/or gifts must:
 - Be directly related to improving maternal and infant health.
 - Consider incentives that are offered by managed care and other community entities.
 - Not take the form of cash or instruments convertible to cash, and cannot influence the recipients’ choice of a provider, practitioner or supplier.
 - Limit the impact on recipients’ financial eligibility for Medicaid and other social services, and must be of “nominal value.”
- 4. Unallowable costs beyond those directly funded through the allowable cost categories above, including:**
- Rental or purchase of office space;
 - Insurance for the funded entities;
 - Subscriptions or membership dues;
 - Utilities;
 - Debt;
 - Food not connected to a service;

Please note: The Primary Applicant must conduct a funds reconciliation no later than 60 calendar days from the end of the award period. Applicant will return any advance funds that exceed actual expenditures paid by the Primary Applicant and Partner Agencies and confirmed by invoices. Further instructions will be given regarding the manner in which Primary Applicants will return unused funds.

D. SUPPORTING DOCUMENTATION

Applicants applying for this announcement must provide the following documentation.

- ◆ **Letters of Commitment:** The Primary Applicant must provide a letter of commitment from each Partnering Agency listed in the application (see Appendix D for a sample letter of commitment). Letters of Commitment should:
 - Spell out in writing the arrangement between each Partnering Agency and the Primary Applicant.
 - Describe the cooperative relationship between each Partnering Agency and the Primary Applicant.
 - Describe roles, responsibilities, and interventions/direct services to be provided by the Partnering Agency for the population of focus.
 - Be executed by authorized representatives of both organizations.
- ◆ **Disclosure of Funding Agencies and Supporting Corporations:** For purposes of transparency and disclosure, the Primary Applicant and Partnering Agencies must list all the sources from which they receive financial support or reimbursement of services. Primary Applicants and Partnering Agencies must be sure to indicate whether they receive grant funding from the Ohio Department of Health, the Ohio Commission on Minority Health, the Ohio Commission on Fatherhood, or any other entity.

IV. AGENCY CONTACTS

For questions about this application, please contact infantmortality@medicaid.ohio.gov.

APPENDICES

Appendix A: Goals and Measurable Objectives

Example of a Goal: Decrease the substance use in the community by getting more youth participating in after school programs.

Goals: A goal is a broad statement about the long-term expectation of what should happen as a result of your program (the desired result). It serves as the foundation for developing your program objectives. Goals should align with the statement of need that is described. Goals should only be one sentence.

The characteristics of effective goals include:

- Goals address outcomes, not how outcomes will be achieved
- Goals describe the behavior or condition in the community expected to change
- Goals describe who will be affected by the project
- Goals lead clearly to one or more measurable results
- Goals are concise

Objectives: Objectives describe the results to be achieved and the manner in which they will be achieved. Multiple objectives are generally needed to address a single goal. Well-written objectives help set program priorities and targets for progress and accountability. It is recommended that you avoid verbs that may have vague meanings to describe the intended outcomes, like “understand” or “know” because it may prove difficult to measure them. Instead, use verbs that document action, such as: “By the end of 2020, 80% of program participants will have completed all program activities.”

In order to be effective, objectives should be clear and leave no room for interpretation. **SMART** is a helpful acronym for developing objectives that are **specific, measurable, achievable, realistic, and time-bound**:

Specific: Includes the “who” and “what” of program activities. Use only one action verb to avoid issues with measuring success. **Example:** “Outreach workers will administer the risk assessment survey to at least 100 people in the population of focus” is a more specific objective than “Outreach workers will use their skills to reach out to people in the Lights District.”

Measurable: How much change is expected. It must be possible to count or otherwise quantify an activity or its results. It also means that the source of and mechanism for collecting measurement data can be identified and that collection of the data is feasible for your program. A baseline measurement is required to document change (e.g., to measure the percentage of increase or decrease). If you plan to use a specific measurement instrument, it is recommended that you incorporate its use into the objective. **Example:** By 10/15 increase by 10% the number of high school freshman who disapprove of alcohol use as measured by the annual school youth survey.

Achievable: Objectives should be attainable within a given time frame and with available program resources.

Example of an Objective: The new nutritionist will meet with 5 mothers each week to design a complete dietary plan.

Example Chart of Goals and Objectives:

Goal 1: Expand HIV counseling and testing services for college students aged 18-24 at Big Ten University.

- **Objective 3.1:** By June 30, 2019, 20 Peer Health Advocates will be trained to recruit students for HIV counseling and testing, with an additional 5 trained per month, totaling 75 trained Peer Health Advocates over the project.
- **Objective 3.2:** By June 30, 2019, 5 health workers will be trained in HIV counseling, testing and reporting; and HIPAA Privacy Laws.
- **Objective 3.3:** By September 30, 2019, a campus-wide Social Media Campaign will be initiated by Peer Health Advocates engaging 2200 target members over the project.
- **Objective 3.4:** By June 30, 2020, HIV counseling and testing will be provided to 100 target members per month, to a total 1,200 target members over the project.

Appendix B: Data Collection and Performance Measurement

Primary Applicants will be responsible for ensuring all community-based organizations (Primary Applicant and Partner Agencies) collect and submit the following data points on all program participants, unless a participant refuses. If primary applicants cannot agree to submit the data elements below by January 1, 2020, they must identify a plan to obtain these data elements within the first six months of the funding (by July 1, 2020).

Please note: required data points may change over the course of the funding cycle to accommodate evolving program needs.

Enrollment/Intake Form Data Collection Points
On what date did the participant enroll in the program
What is the participant's birth date
Participant's identification information
How did the participant learn about this program
Participant's employment status (please check all that apply)
Participant's marital status
Current relationship between participant and other biological parent
Living status between participant and other biological parent
Other biological parent's birth date
Participant's race/ethnicity (please check all that apply)
Other biological parent's race/ethnicity (please check all that apply)
Other biological parent's identification information
How many total adults live in the same household as the participant (including the participant)
How many total children live in the same household as the participant
What kind of housing does the participant have
Please check any home safety issues the participant is experiencing
Participant's primary method of transportation
Is the participant currently enrolled in any of the following public assistance programs
Is the participant financially stable (able to pay their bills without any monetary aid or help)
Does the participant have access to adequate food
Does the participant have current depression or a history of depression diagnosis or treatment
In the past month, did the participant feel they could not control important things in their life
Is there at least one person the participant can discuss their thoughts and feelings with
Does the participant or anyone in their household smoke
In the past month, has the participant drank any alcohol
In the past six months, has the participant used any illegal substances
Do any of the participant's friends or family members have problems with alcohol or other drug use
Participant's weeks of gestation at enrollment in the program
How many prenatal care visits has the participant had prior to enrollment
Did the participant have any prenatal visits in her first trimester (weeks 1-12)
Has the participant received treatment with progesterone during this pregnancy
Does the participant take folic acid/vitamins
Is transportation a barrier to the participant attending prenatal care appointments
Birth Form Data Collection Points
On what date is this form being filled out
What is the participant's birth date
Participant's identification information
Infant's identification information
On what date was the infant born
Was this a multiple birth
What is the infant's race/ethnicity

How is the infant being fed
Where does the infant sleep
What position is the infant put to sleep in most frequently
Does the infant ever share a sleeping surface with any other people or a pet
Did the participant receive treatment with progesterone during this pregnancy
How many total prenatal visits did the participant attend during this pregnancy
Exit Form Data Collection Points
On what date did the participant exit the program
What is the participant's birth date
Participant's identification information
Infant's identification information
On what date was the infant born
Was this a multiple birth
What kind of housing does the participant have
Please check any home safety issues the participant is experiencing
What is the participant's employment status
Is the participant currently enrolled in any of the following public assistance programs
Does the participant have adequate access to food
How many well-child medical visits did the participant and child attend to check on the child's health
How many ER/urgent care visits were attended for the child or participant since the child's birth
Has the child received recommended immunizations
When the participant is away from home, where does the child or children go for child care
How many postpartum medical visits did the mother attend to check on her health
Is the father involved in the care of the infant
Encounter Form Data Collection Points
On what date did this encounter occur
What is the participant's birth date
Participant's identification information
What is the next planned contact date
Was the participant referred to any additional programs or services
List any additional programs or services the participant was referred to
Group Encounter Form Data Collection Points
On what date did this encounter occur
What is the participant's birth date
Participant's identification information
List any additional programs or services the participant was referred to

Appendix C: Sample Budget Formats

The MCPs highly recommend using the following sample budget and justification format for your proposal submission.

Sample Budget and Justification

This is a sample detailed budget and narrative with guidance for completing Section C: Detailed Budget Information.

PRIMARY APPLICANT REQUEST (Insert Primary Applicant Name)

A. Personnel: Provide employee(s) (including names for each identified position) of the Primary Applicant.

Position	Name	Annual Salary/Rate	Level of Effort	Cost
Program Coordinator	Jane Doe	\$65,000	100%	\$65,000
Community Health Worker 1	Jane Doe	\$45,000	100%	\$45,000
Community Health Worker 2	John Doe	\$45,000	20%	\$9,000
Nurse Family Partnership	Jane Doe	\$65,400	100%	\$65,400
			TOTAL	\$184,400

JUSTIFICATION: Describe the role and responsibilities of each position.

1) The Program Coordinator will provide daily oversight of the coordinated community approach led by the Primary Applicant, including coordination of an effective referral system, project activities, data collection efforts, communication and information dissemination, coordinating stakeholder meetings, and training. This position will be considered key staff.

2) The Community Health Worker 1 will build trust with the population of focus and community leaders. This position will be responsible for helping individuals, families, and groups. Responsible for helping patients connect to maternal health care services, CenteringPregnancy, Home Visiting, health insurance/Medicaid, food, housing, and health information.

3) The Community Health Worker 2 will build trust with the population of focus and community leaders. This position will be responsible for helping individuals, families, and groups. Responsible for helping patients connect to maternal health care services, CenteringPregnancy, Home Visiting, health insurance/Medicaid, food, housing, and health information.

4) Nurse Family Partnership (NFP) responsibilities include enrolling and conducting home visits to women and their families eligible for the NFP program, adhere to nursing process and the NFP model of home visitation by scheduling visits and maintaining contact through on site visits, phone and/or drive-by visits, plan home visits in accordance with client goals and NFP outcomes, perform assessments on moms, infants and toddlers, perform developmental assessments on infants and toddlers, evaluate the safety of the home and baby's sleep environment, develop therapeutic relationships, use concepts of reflection and motivational interviewing with women and their families in a home visiting environment, assess physical, emotional, social and environmental needs of women and their families as they relate to the NFP domains, assist women and their families in establishing goals and outcomes, provide education, support and referral resources in assisting women and their families in attaining their targeted goals, formulate nursing diagnosis based on nursing assessment and client goals and evaluate client progress toward stated goals and NFP outcomes, and complete forms and documentation and submit within a timely basis.

B. Fringe Benefits: List all components of fringe benefits rate

Component	Rate	Wage	Cost
FICA	7.65%	\$184,400	\$14,107
Workers Compensation	2.5%	\$184,400	\$4,610
Insurance	10.5%	\$184,400	\$19,362

		Total	\$38,079
--	--	--------------	-----------------

JUSTIFICATION: Fringe reflects current rate for agency.

C. Travel: Explain need for all travel.

Purpose of Travel	Location	Item	Rate	Cost
Local Travel		Mileage	10,000 miles @ .42/mile	\$4,200
			Total	\$4,200

JUSTIFICATION: Describe the purpose of travel and how costs were determined.

1) Local travel is needed to attend local meetings, project activities, and training events. Local travel rate is based on organization’s policies/procedures for privately owned vehicle (POV) reimbursement rate. If policy does not have a rate use the state mileage reimbursement rate.

D. Materials: Materials utilized by direct labor employees as an operational need to meet the goals and objectives of the program.

Item(s)	Rate	Cost
General office supplies	\$50/mo. x 12 mo.	\$600
Postage	\$37/mo. x 8 mo.	\$296
Laptop Computer	900 x 2	\$1800
Copies	8000 copies x .10/copy	\$800
Curriculum	\$20/curriculum x 30	\$600
	Total	\$4,096

JUSTIFICATION: Describe the need and include an adequate justification of how each cost was estimated.

- 1) Office supplies, copies and postage are needed for general operation of the program.
- 2) The laptop computers are needed for both project work and presentations.
- 3) Curriculums are needed for program participants enrolled in evidence-based interventions.

E. Training: Consultant services contracted to accomplish specific program objectives (workforce development and staff training for direct labor employees).

Training(s)	Rate	Cost
Cultural Competency	\$100/hour X 5 hours	\$800
Motivational Interviewing	\$300/person X 4	\$1,200
	Total	\$2,000

JUSTIFICATION: Describe the need and include an adequate justification of how each cost was estimated.

- 1) Cultural competency training approves program accountability and fidelity of interventions intended to serve African American women.
- 2) Motivational interviewing is a patient-centered method often used to address addiction and the management of physical health conditions such as diabetes, heart disease, and asthma. This intervention helps people become motivated to change the behaviors that are preventing them from making healthier choices.

PARTNERING AGENCY 1 REQUEST (Insert Partnering Agency 1 Name)

A. Personnel: Provide employee(s) (including names for each identified position) of the Partnering Agency 1, including in-kind costs for those positions whose work is tied to the grant project.

Position	Name	Annual Salary/Rate	Level of Effort	Cost
Community Health Worker 1	Jane Doe	\$45,000	100%	\$45,000
Community Health Worker 2	John Doe	\$45,000	100%	\$45,000
Community Health Worker 3	Jane Doe	\$45,000	50%	\$22,500
			TOTAL	\$112,500

B. Fringe Benefits: List all components of fringe benefits rate

Component	Rate	Wage	Cost
FICA	7.65%	\$112,500	\$8,606
Workers Compensation	2.5%	\$112,500	\$2,813
Insurance	10.5%	\$112,500	\$11,813
		Total	\$23,232

JUSTIFICATION: Fringe reflects current rate for agency.

C. Travel: Explain need for all travel.

Purpose of Travel	Location	Item	Rate	Cost
Local Travel		Mileage	20,000 miles @ .42/mile	\$8,400
			Total	\$8,400

JUSTIFICATION: Describe the purpose of travel and how costs were determined.

1) Local travel is needed to attend local meetings, project activities, and training events. Local travel rate is based on organization's policies/procedures for privately owned vehicle (POV) reimbursement rate. If policy does not have a rate use the state mileage reimbursement rate.

D. Materials: Materials utilized by direct labor employees as an operational need to meet the goals and objectives of the program.

Item(s)	Rate	Cost
General office supplies	\$50/mo. x 12 mo.	\$600
Postage	\$37/mo. x 8 mo.	\$296
Laptop Computer	900 x 3	\$2,700
Copies	8000 copies x .10/copy	\$800
	Total	\$4,396

JUSTIFICATION: Describe the need and include an adequate justification of how each cost was estimated.

- 1) Office supplies, copies and postage are needed for general operation of the program.
- 2) The laptop computers are needed for both project work and presentations.

E. Training: Consultant services contracted to accomplish specific program objectives (workforce development and staff training for direct labor employees).

Training(s)	Rate	Cost
-------------	------	------

Cultural Competency	\$100/hour X 5 hours	\$800
Motivational Interviewing	\$300/person X 4	\$1,200
	Total	\$2,000

JUSTIFICATION: Describe the need and include an adequate justification of how each cost was estimated.

1) Cultural competency training approves program accountability and fidelity of interventions intended to serve African American women.

2) Motivational interviewing is a patient-centered method often used to address addiction and the management of physical health conditions such as diabetes, heart disease, and asthma. This intervention helps people become motivated to change the behaviors that are preventing them from making healthier choices.

TOTAL COORDINATED COMMUNITY APPROACH

AGENCY	BUDGET REQUEST
PRIMARY APPLICANT (Insert Name)	
Personnel	\$184,400
Fringe benefits	\$38,079
Travel	\$4,200
Materials	\$4,096
Training	\$2,000
PARTNERING AGENCY 1 (Insert Name)	
Personnel	\$112,500
Fringe benefits	\$23,232
Travel	\$8,400
Materials	\$4,396
Training	\$2,000
TOTAL	\$383,303

Appendix D: Sample Letter of Commitment

Letter of Commitment

Coordinated Community Infant Mortality Reduction Effort in [INSERT NAME] County

This letter of commitment is between (Partnering Agency Name) and (Primary Applicant Name).

This letter of commitment identifies the commitment of (Partnering Agency Name), a nonprofit organization dedicated to targeting the disparity in the African American infant mortality rate in (Name of County), to partner and collaborate with (Primary Applicant Name) on a coordinated community approach in (name of county).

(Partnering Agency Name) agrees to perform the following functions for the period of (Insert Project Period Dates, e.g. January 2020 to December 2021):

- Provide direct services to African American women through Community Health Workers (an evidence-based intervention)
- Assist in coordinating and planning outreach
- Connect consumers to timely services
- Conduct data collection requirements

Note: The above functions are examples. Please list detailed functions that each Partnering Agency will be conducting as a collaborating entity on the proposed program.

(Primary Applicant Name) agrees to perform the following functions for the period of (Insert Project Period Dates, e.g. January 2020 to December 31, 2021):

- Refer consumers to Partnering Agency,
- Conduct outreach to the population of focus,
- Responsible for maintaining project goals & objectives, and
- Responsible for data collection and submission to the MCPs and ODM and/or its selected evaluator for evaluation purposes.

Note: The above functions are examples. Please list detailed functions that the Primary Applicant will be conducting as the lead agency on the proposed program.

(Partnering Agency Name)	(Primary Applicant Name)
(Authorizing Authority Signature)	(Authorizing Authority Signature)
(Title of Authorizing Authority)	(Title of Authorizing Authority)
Date of Signature	Date of Signature

Appendix E: Sample Community-Based Interventions

ODM and the MCPs recognize the individual needs of African American women may not always fit into a pre-determined model to meet them where they are or address their individual needs; therefore, additional Community-Based Interventions that improve the maternal education and health of African American women may be proposed by the Primary Applicant and/or Partnering Agencies. The following lists examples of Community-Based interventions that may be funded as part of the coordinated community approach.

Doulas: Doulas are specifically trained to provide continuous support through pregnancy and especially childbirth. They promote health literacy and healthy behavior among pregnant women and, like CHWs, can help address unmet social needs. Doula services can be key to helping health care system navigation, promoting birthing choice and reproductive autonomy for African American women, helping them feel more autonomous over the health care decisions they make for themselves and their families.

Peer-to-Peer Outreach / Peer Support Groups: Peer-to-peer outreach and peer support groups should be patient-centered and designed to identify African American women most at-risk for negative birth outcomes. Interventions should include meeting the social support needs of African American women, connections to unmet social services, maternal health education, promotion of healthy behaviors among pregnant women, support for chronic toxic stress and mental health, and engaging women in timely prenatal health care. Peer-to-peer outreach and peer support groups could include:

- ◆ Neighborhood Peer-to-Peer African American Women-Led Outreach Programs utilizing maternal care experts to identify and provide one-on-one social support to pregnant African American women to make sure women have healthy, positive birth and postpartum experiences (e.g. Granny Models).
- ◆ Neighborhood African American Women-Led Maternal Health Education Peer Support Groups focusing on providing maternal health literacy programs that help pregnant women read, understand, and act upon pregnancy information and empower them to be active participants.
- ◆ Neighborhood African American Women-Led Peer Support Groups for Mental Health focusing on supporting and building protective factors for pregnant African American women experiencing chronic toxic stress, depression, and/or other mental health related issues. Support groups should provide safe places to discuss toxic stress related to the experience of African American women which may include toxic stress related to racism, maternal exposure to racial discrimination, racial disparities in health care, social determinants of health, and interpersonal relationships.
- ◆ Neighborhood Peer-Led Outreach Programs to Identify and Connect African American Women Most At-Risk for Negative Birth Outcomes. Outreach programs/models that train peers (persons from the targeted at-risk communities) to be community advocates, to distribute information, and to identify the most at-risk pregnant African American women should be utilized to connect women to maternal care services. Outreach programs/models should train peers that live in the same communities and have shared experiences as the population of focus and be effective at identifying most at-risk African American women who may be socially isolated and successfully engage them in services. Outreach programs/models should utilize innovative social networking techniques to identify most at-risk African American women.
- ◆ Neighborhood Peer-to-Peer African American Women-Led Breastfeeding Support Groups utilizing maternal breastfeeding experts to identify and provide breastfeeding education, best practices, and social support groups for African American women.

Appendix F: Sample Applicant Information Page

The first page of the application should contain the title of the coordinated effort and site-specific information for the Primary Applicant and each Partnering Agency.

Coordinated Community Approach Title:
COMMUNITY NAME:

Primary Applicant (Coordinating Entity):

Street Address:
City/Town:
County:
Zip Code:
Program Contact Name:
Program Contact Phone Number:
Program Contact Email Address:
Fiscal Agent Contact Person Name:
Fiscal Agent Contact Phone Number:
Fiscal Agent Contact Email Address:

Partnering Agency 1:

Street Address:
City/Town:
County:
Zip Code:
Program Contact Name:
Program Contact Phone Number:
Program Contact Email Address:
Fiscal Agent Contact Person Name:
Fiscal Agent Contact Phone Number:
Fiscal Agent Contact Email Address:

Partnering Agency 3:

Street Address:
City/Town:
County:
Zip Code:
Program Contact Name:
Program Contact Phone Number:
Program Contact Email Address:
Fiscal Agent Contact Person Name:
Fiscal Agent Contact Phone Number:
Fiscal Agent Contact Email Address:

Partnering Agency 2:

Street Address:
City/Town:
County:
Zip Code:
Program Contact Name:
Program Contact Phone Number:
Program Contact Email Address:
Fiscal Agent Contact Person Name:
Fiscal Agent Contact Phone Number:
Fiscal Agent Contact Email Address:

Partnering Agency 4:

Street Address:
City/Town:
County:
Zip Code:
Program Contact Name:
Program Contact Phone Number:
Program Contact Email Address:
Fiscal Agent Contact Person Name:
Fiscal Agent Contact Phone Number:
Fiscal Agent Contact Email Address:

Note: Please make sure to list each Partnering Agency.