Request for Applications

RFA # A393

Improving Community Outcomes for Maternal and Child Health

FUNDING AGENCY:	North Carolina Department of Health and Human Services Division of Public Health Women's and Children's Health Section
ISSUE DATE:	Tuesday, October 26, 2021
DEADLINE DATE:	Tuesday, December 21, 2021

INQUIRIES and DELIVERY INFORMATION:
Direct all inquiries concerning this RFA to:
LaDonna F. Warren, MHS
Program Manager
Ladonna.warren@dhhs.nc.gov
919-707-5690   Office
919-870-4827   Fax

Applications will be received until 5:00 pm on Tuesday, December 21, 2021.
Electronic copies of the application are available by request.

Send all applications directly to the funding agency address as indicated below:

Mailing Address:
NC DHHS – Division of Public Health
WCHS, Women's Health Branch
Attn: LaDonna Warren
1929 Mail Service Center
Raleigh, NC 27699-1929

Street/ Hand Delivery Address:
NC DHHS – Division of Public Health
WCHS, Women's Health Branch
Attn: LaDonna Warren, Building 2, 2nd floor
5601 Six Forks Road
Raleigh, NC 27609-3811

IMPORTANT NOTE: Indicate agency/organization name and RFA number on the front of each application envelope or package, along with the RFA deadline date.

RFA Table of Contents

I.   **INTRODUCTION**

The mission of the Women's and Children's Health Section (WCHS), within the North Carolina Division of Public Health (DPH), is to assure, promote and protect the health and development of families with emphasis on women, infants, children, and youth. WCHS programs place a major emphasis on the provision of preventive health services beginning in the pre-pregnancy period and extending throughout childhood. WCHS also administers several programs serving individuals who are developmentally disabled or chronically ill.

The Improving Community Outcomes for Maternal and Child Health (ICO4MCH) Program was established in 2015 to provide a competitive grants process among local health departments (LHDs) to provide funding to improve birth outcomes, reduce infant mortality, and improve health among children aged 0-5. Grants will be awarded for a two-year period and will be administered by the North Carolina Department of Health and Human Services (DHHS), DPH, WCHS, Women's Health and Children and Youth Branches.

The health of women of reproductive age and of children aged 0-5 is critical to the health of communities. Some key indicators that provide information on the health of women and young children include:

Infant Mortality
In 2019, the infant mortality rate in North Carolina (NC) was tied for the twelfth highest in the country with a rate of 6.8 per 1,000 live births as compared to the national rate of 5.6 per 1,000 live births.
(https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm).
Significant variance in rates among racial/ethnic groups continues in NC. The combined 2017-2019 Non-Hispanic (NH) Black infant mortality rate was 12.4 per 1,000 live births while NH White rate was 4.9, with the infant mortality rate disparity ratio equal to 2.5. The rate of NH American Indian and Hispanic infant deaths was 11.3 and 5.4 per 1,000 live births, respectively. Thirty-five counties had a disparity ratio higher than the state ratio.

Child Poverty
The percent of children under five years of age living in poverty in NC decreased from 26.4% in 2015 to 21.5% in 2019, according to the U.S. Census Small Area Income and Poverty Estimates. NC continues to have higher rates of poverty than the national rate, which decreased from 22.8% in 2015 to 18.2% in 2019. NC ranked tenth highest among all states for poverty rates of children under five years of age. County-level data estimates for the percent of children under the age of five are available from the US Census Bureau 2015-2019 American Community Survey (ACS). While the state estimate from this survey period is 23.8%, the estimated poverty levels ranged from 7% to 55.9% among NC counties.

Child Health Insurance
According to U.S. Census Small Area Health Insurance Estimates (SAHIE), 94.2% of children under the age of 19 in NC had health insurance in 2019, an increase from 92.1% in 2011. However, disparities exist among racial/ethnic groups. Per 2017-2019 American Community Survey (ACS) data, 91.8% of American Indian, 88.8% of Hispanic, and 94.3% of Asian children had health insurance compared to 96.1% of African American and 96.3% of non- Hispanic white

children. According to 2015-2019 ACS data, 41.9% of all children under the age of 19 in NC are covered by public health insurance

ELIGIBILITY

Only local health departments/districts are eligible to apply for this RFA. Given the amount of funding available, the awarding of these funds is competitive. Single, regional, or multi-county applications are encouraged. For a multi-county application that includes different local health departments, one county must take the lead in submitting the application. DPH will accept applications from single or multi-county Local Health Departments (LHDs) that meet certain criteria of need.

The criteria include:

1,000 or more births in 2019 in the county(ies)

AND

1. At least ONE of the following:
    * Combined 2017-2019 infant mortality rate must be 10.4 or higher per 1,000 live births and 20 or more infant deaths;
    * Combined 2017-2019 infant mortality disparity ratio must be 2.5 or higher;
    * Percent of children <5 years of age living in poverty must be 35.7% or higher (ACS 2015-2019 data); or
    * Percent of children <19 years of age who are uninsured must be 8.7% or higher (2019 SAHIE).

LHDs should determine their eligibility, either as a single county or multi-county project, by assessing the data above using the tool provided by DPH in September 2021. The eligibility tool can be found online: https://whb.ncpublichealth.com/

FUNDING

Between four (4) and six (6) ICO4MCH projects will be funded at an award level of $350,000 - $500,000 annually. Funding is available for two years, contingent upon contract compliance, program performance, and the availability of funding. The project period for agreement addendum awarded through this competitive application will begin June 1, 2022, and end May 31, 2024.

II.   BACKGROUND

Session Law 2017-57, Section 11E.3. (a.- d.) continues funding to the DPH to implement evidence-based strategies (EBS) that are proven to lower infant mortality rates, improve birth outcomes, and improve the overall health status of children ages birth to five. The law requires the establishment of a competitive process to award grants to local health departments to implement evidenced-based strategies to achieve these aims. The law places the following requirements on the DPH when selecting local health departments to be funded:

- the Division shall prioritize grant awards to local health departments that are able to leverage non-State funds in addition to the grant award;
- the grant awards to local health departments are dedicated to providing services on a county-wide basis;
- the local health department shall participate in evaluation, including measurable impact or outcomes; and
- the local health department ensures that funds received to implement the plan will supplement and not supplant existing funds for health and wellness programs and initiatives.

III.   SCOPE OF SERVICES

The ICO4MCH Program includes three program aims: improve birth outcomes; reduce infant mortality; and improve the health status of children, aged 0 – 5. The table below outlines each program aim and the evidence-based programs that can assist LHDs to achieve each program aim. **Each Applicant must address all 3 program aims. Each Applicant must select one of the evidence-based/evidence-informed strategies for each aim**.

PROGRAM AIMS	EVIDENCE-BASED STRATEGIES
A. Improved Birth Outcomes	Reproductive Life Planning (RLP)
	Improving Preconception and Interconception Health
B. Reduced Infant Mortality	10 Successful Steps for Breastfeeding, with a specific focus on Step 3 and Step 10
	Tobacco Cessation and Prevention
C. Improved Health Status of Children Ages 0-5	Positive Parenting Program (Triple P)
	Family Connects Newborn Home Visiting

Appendix A contains the detailed program descriptions for each of the evidence-based strategies. The detailed program descriptions include the scope of services, performance measures, and reporting requirements.

To address the program aims listed above, each funded site should implement the project using the required and optional components described below. Each funded site is **required** to use the Collective Impact framework and address health inequities that results from health disparities in each of their selected evidence-based strategies. In at least one of the selected evidence-based strategies, the funded site should consider incorporating a Community Health Worker model (optional).

COLLECTIVE IMPACT
The complexity and challenges facing communities to improve the health of women of reproductive age and children aged 0-5 can be overwhelming. Collaboration between community organizations, local health departments, as well as other key stakeholders can lead to long-term systematic change. Collective impact is an effective means of collaboration and a proven approach for helping organizations work together. Each funded ICO4MCH project is required to utilize a Collective Impact framework and to implement the evidence-based strategies (EBS).

Within the Collective Impact framework, the development and maintenance of a Community Action Team (CAT) is critical. The CAT is composed of local health department management, program participants, community members, caretakers, and other representatives, including hospital administrators, faith leaders, other public and private maternal and child health providers, as well as additional partners working to improve the population health of women, infants, children, and families. The CAT must convene at least quarterly throughout the funding period. The CAT will provide guidance and expertise during the planning, implementation, and evaluation of the project.

HEALTH EQUITY
Health equity is the attainment of the highest level of health for all people. Health inequities are preventable differences in health status or risk between different population groups. Inequities are caused by the differences in the root causes of health that are avoidable, unnecessary, and unjust. Health disparities are the differences in health status or outcomes between different population groups. Groups may differ by race, ethnicity, gender, geographic location, disability, immigration status, income, and sex (among others). Health inequities perpetuate health disparities. Health disparities in infant mortality rates, birth outcomes, and child health indicators exist in North Carolina; thereby increasing the inequities our state faces. Each funded ICO4MCH project should utilize stratified local and state data to identify the health disparities among the impacted population(s) within each aim in order to address the root causes of the health inequities that exist. In addition, each funded ICO4MCH project should examine the social determinants of health within each aim to fully understand the health inequities that exist and how to address them. Each section of the application should clearly address health disparities and health inequities. Trainings, such as those provided by the Racial Equity Institute, are acceptable and appropriate trainings to learn about equity.

COMMUNITY HEALTH WORKERS
As our current North Carolina public health system maneuvers through the transition to managed care, public health leaders agree that coordinating efforts to address population health is even more critical than ever. One intervention that is associated with improved health outcomes is the use of community health workers (CHW). The American Public Health Association (APHA) defines a community health worker as "a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served" whose relationship with the community "enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery." Therefore, we believe that CHWs are uniquely qualified to work with women of reproductive age, their children, and their families in our effort to improve community outcomes for maternal and child health. Each applicant is strongly encouraged to incorporate a CHW model in at least one evidence-based strategy.

In May 2018, DHHS released a report entitled, "*Community Health Workers in North Carolina: Creating an Infrastructure for Sustainability*". The findings from this report and results of the pilot of the CHW curriculum and certification process can be utilized to train CHWs to work with women of reproductive age, their children, and their families. The ICO4MCH Program shall recognize the role of CHWs as the liaison; health navigator; health and wellness promoter; or advocate for women and their families in the community.

IMPLEMENTATION SCIENCE

Newly funded ICO4MCH projects will be required to work with an Implementation Coach from the National MCH Workforce Development Center https://mchwdc.unc.edu during the 1st year of the project period to: 1) increase their understanding of and capacity to use effective Implementation Science practices; 2) support the Implementation of the project, using relevant tools, assessments, and methods; 3) provide trouble shooting and guidance as projects evolve; and 4) support projects to measure and improve implementation processes. Newly funded ICO4MCH project's CAT will participate in implementation capacity building. Each newly funded ICO4MCH project should expect to work with the Implementation Coach at a minimum of two days per month during the 1st year of the project period. The program manager at the funded ICO4MCH site will serve as the primary contact for the Implementation Coach. Applicants who plan to work with National MCH Workforce Development Center should budget $2,000 per month for the Implementation Coach.

If an existing ICO4MCH project is selected for the June 1, 2022 – May 31, 2024, project period, working with the National MCH Workforce Development Center will be optional, not required.

IV.   GENERAL INFORMATION ON SUBMITTING APPLICATIONS

1. **Award or Rejection**
   All qualified applications will be evaluated, and award made to that agency or organization whose combination of budget and service capabilities are deemed to be in the best interest of the funding agency. The funding agency reserves the unqualified right to reject any or all offers if determined to be in its best interest. Successful applicants will be notified by (01/20/2022).

2. **Decline to Offer**
   Any agency or organization that receives a copy of the RFA but declines to make an offer is requested to send a written "Decline to Offer" to the funding agency. Failure to respond as requested may subject the agency or organization to removal from consideration of future RFAs.

3. **Cost of Application Preparation**
   Any cost incurred by an agency or organization in preparing or submitting an application is the agency's or organization's sole responsibility; the funding agency will not reimburse any agency or organization for any pre-award costs incurred.

4. **Elaborate Applications**
   Elaborate applications in the form of brochures or other presentations beyond that necessary to present a complete and effective application are not desired.

5. **Oral Explanations**
   The funding agency will not be bound by oral explanations or instructions given at any time during the competitive process or after awarding the grant.

6. **Reference to Other Data**

   Only information that is received in response to this RFA will be evaluated; reference to information previously submitted will not suffice.

7. **Titles**

   Titles and headings in this RFA and any subsequent RFA are for convenience only and shall have no binding force or effect.

8. **Form of Application**

   Each application must be submitted on the form provided by the funding agency and will be incorporated into the funding agency's Performance Agreement (contract).

9. **Exceptions**

   All applications are subject to the terms and conditions outlined herein. All responses will be controlled by such terms and conditions. The attachment of other terms and conditions by any agency or organization may be grounds for rejection of that agency or organization's application. Funded agencies and organizations specifically agree to the conditions set forth in the Performance Agreement (contract).

10. **Advertising**

    In submitting its application, agencies and organizations agree not to use the results therefrom or as part of any news release or commercial advertising without prior written approval of the funding agency.

11. **Right to Submitted Material**

    All responses, inquiries, or correspondence relating to or in reference to the RFA, and all other reports, charts, displays, schedules, exhibits, and other documentation submitted by the agency or organization will become the property of the funding agency when received.

12. **Competitive Offer**

    Pursuant to the provision of G.S. 143-54, and under penalty of perjury, the signer of any application submitted in response to this RFA thereby certifies that this application has not been arrived at collusively or otherwise in violation of either Federal or North Carolina antitrust laws.

13. **Agency and Organization's Representative**

    Each agency or organization shall submit with its application the name, address, and telephone number of the person(s) with authority to bind the agency or organization and answer questions or provide clarification concerning the application.

14. **Subcontracting**

    Agencies and organizations may propose to subcontract portions of work provided that their applications clearly indicate the scope of the work to be subcontracted, and to whom. All information required about the prime grantee is also required for each proposed subcontractor.

15. **Proprietary Information**

    Trade secrets or similar proprietary data which the agency or organization does not wish disclosed to other than personnel involved in the evaluation will be kept confidential to the extent permitted by NCAC TO1: 05B.1501 and G.S. 132-1.3 if identified as follows: Each page shall be identified in boldface at the top and bottom as "CONFIDENTIAL." Any section of the application that is to remain confidential shall also be so marked in boldface on the title page of that section.

16. **Participation Encouraged**

    Pursuant to Article 3 and 3C, Chapter 143 of the North Carolina General Statutes and Executive Order No. 77, the funding agency invites and encourages participation in this RFA by businesses owned by minorities, women and the disabled, including utilization as subcontractor(s) to perform functions under this Request for Applications.

17. **Agreement Addendum**

    The Division will issue an Agreement Addendum to the recipient of the RFA funding. Expenditures can begin immediately upon receipt of a completely signed Agreement Addendum.

V.   APPLICATION PROCUREMENT PROCESS AND APPLICATION REVIEW

The following is a general description of the process by which applicants will be selected for funding for this project.

1. **Announcement of the Request for Applications (RFA)**
   The announcement of the RFA and instructions for receiving the RFA will be posted at the following DHHS website on 10/26/2021 http://www.ncdhhs.gov/about/grant-opportunities/public-health-grant-opportunities and may be sent to prospective agencies and organizations via direct mail, email, and/or the Program's website.

2. **Distribution of the RFA**
   RFAs will be posted on the Program's website http://whb.ncpublichealth.com/ and may be sent via email to interest agencies and organizations beginning 10/26/2021.

3. **Bidder's Conference / Teleconference / Question & Answer Period**
   All prospective applicants are required to attend a Bidder's webinar Conference on November 2, 2021, from 10:00 am-11:00 am. The link to the Bidder's Webinar will be posted on the Women's Health Branch's website: http://whb.ncpublichealth.com/

   Written questions concerning the specifications in this Request for Applications will be received until 5:00 p.m. on Tuesday, November 9, 2021. Written questions should be emailed to: **ladonna.warren@dhhs.nc.gov** at the DPH, Women's Health Branch. As an addendum to this RFA, by Tuesday, November 19, 2021. A summary of all questions and answers will be placed on the Women's Health Branch's website: http://whb.ncpublichealth.com/ on www.ncpublichealth.com website..

4. **Applications**
   Applicants shall submit **one** (1) **original**, four (4) copies of the application in its entirety. All copies should include the required attachments. Electronic submission will not be accepted in lieu of an original. Faxed applications will not be accepted.

5. **Original Application**
   The original application must contain original documents, and all signatures in the original application must be original. Mechanical, copied, or stamped signatures are not acceptable. The original application should be clearly marked "original" on the application face sheet.

6. **Copies of Application**
   Along with the original application, submit four (4) photocopies of the application in its entirety. Copies of the application should be clearly marked "copy" on the application face sheet. In addition to paper copies, please include a flash drive that contains the application in PDF with a copy of the Open Windows Budget Worksheet in Excel.

7. **Format**
   The application must be typed, single-side on 8.5" x 11" paper with margins of 1". Line spacing should be single-spaced. The font should be easy to read and no smaller than an 11-point font.

8. **Space Allowance**
   Page limits are clearly marked in each section of the application. Refer to *VIII.3 Applicant's Response* for specifics.

9. **Application Deadline**
   All applications must be received by the date and time on the cover sheet of this RFA. Faxed or emailed applications **_will not_** be accepted in lieu of the original and required number of hard copies. Original signatures are required. Note: If the US Postal Service is used, allow sufficient time for delivery to the funding agency by 5:00 PM, close of business, on 12/21/2021.

10. **Receipt of Applications**
    Applications from each responding agency and organization will be logged into the system and stamped with the date received on the cover sheet.

11. **Review of Applications**
    Applications are reviewed by a multi-disciplinary committee of public and private health and human services providers who are familiar with the subject matter. Staff from applicant agencies may not participate as reviewers.

    Applications will be evaluated by a committee according to completeness, content, experience with similar projects, ability of the agency's or organization's staff, cost, etc. The award of a grant to one agency and organization does not mean that the other applications lacked merit, but that, all facts considered, the selected application was deemed to provide the best service to the State. Agencies and organizations are cautioned that this is a request for applications, and the funding agency reserves the unqualified right to reject any and all applications when such rejections are deemed to be in the best interest of the funding agency.

12. **Request for Additional Information**
    At their option, the application reviewers may request additional information from any or all applicants for the purpose of clarification or to amplify the materials presented in any part of the application. However, agencies and organizations are cautioned that the reviewers are not required to request clarification. Therefore, all applications should be complete and reflect the most favorable terms available from the agency or organization.

13. Additional Documentation to Include with Application
All applicants that identify as the lead health department are required to include documentation of their tax identification number.

14. Audit
G.S. 159-34 states that each unit of local government and public authority must have its accounts audited as soon as possible after the close of each fiscal year.

15. Application Process Summary Dates
10/26/2021: Request for Applications released to eligible applicants.
11/2/2021:   Required Bidder's Conference / Teleconference.
11/09/2021: End of Q&A period. All questions due in writing by 5pm.
11/19/2021: Answers to Questions posted as an addendum to the RFA.
12/21/2021: Applications due by 5pm.
01/20/2022: Successful applicants will be notified.
06/01/2022: Contract begins.

VI. PROJECT BUDGET

Budget and Justification
Applicants must submit a budget, using the Open Windows budget worksheet, which requires a line-item budget for each year of funding [Year 1 (June 1, 2022 – May 31, 2023) and Year 2 (June 1, 2023 – May 31, 2024)] and a narrative justification. An electronic version of the Open Windows budget worksheet can be found at http://whb.ncpublichealth.com/. A copy of the budgets should be submitted with the application.

Narrative Justification for Expenses
A narrative justification must be included for every expense listed in the Year One and Year Two budgets. Each justification should show details of how the amount on the line-item budget was calculated and it should be clear how the expense relates to the program. The instructions on **How to Fill Out the Open Windows Budget Form** are posted on the Women's Health Branch website at http://whb.ncpublichealth.com/.

Travel Reimbursement Rates
Mileage reimbursement rates must be based on rates determined by the North Carolina Office of State Budget and Management (OSBM). Because mileage rates fluctuate with the price of fuel, the OSBM will release the "Change in IRS Mileage Rate" memorandum to be found on OSBM's website when there is a change in this rate. The current state mileage reimbursement rate is $.56 cents per mile.

For other travel related expenses, please refer to the current rates for travel and lodging reimbursement, presented in the chart below. However, please be advised that reimbursement rates periodically change. The DPH will only reimburse for rates authorized in OSBM's North Carolina Budget Manual or adopted by means of an OSBM Budget Memo. These documents are located here: https://www.nc.gov/services/budget-and-management-library

Current Rates for Travel and Lodging

Meals	In State	Out of State
Breakfast	$13.00	$13.00
Lunch	$14.00	$14.00
Dinner	$23.00	$23.00
Total Meals Per Diem Per Day	*$50.00*	*$50.00*
Lodging *(Maximum rate per person, excludes taxes and fees)*	$96.00	$96.00
Total Travel Allowance Per Day	**$146.00**	**$146.00**
Mileage	$0.56 per mile	

Equipment
Expenses for any equipment to be purchased may not exceed $2,000 per item.

Administrative Personnel Costs
Personnel costs for any program staff that will not be providing direct services to program participants may not exceed ten percent (10%) of the total budget.

Incentives
Incentives can be provided to program participants to ensure the level of commitment that is needed to achieve the expected outcomes of the program. While there is no maximum amount of funding that may be used to provide incentives for program participants, the level of incentives must be appropriate for the level of participation needed to achieve the expected outcomes of the program.

State funds may not be used to provide cash payments as incentives. Ensure that incentives and gift cards provided to program participants using program funds will be logged by date, type of incentive, serial number (if gift card), and total cost of incentive/gift card within twenty-four hours of event and maintained in locked storage. Gift cards should contribute to and link back to the ICO4MCH EBS. Merchandise gift cards may be provided to participants as incentives for participation. After purchase, gift cards shall be logged by the serial number and maintained in a locked storage cabinet. Recipients shall sign the log upon receipt of the cards. Under no circumstances shall "cash" (e.g., VISA) cards be purchased or distributed. Merchandise cards may not allow participants to purchase alcohol, tobacco, or firearms/ammunition.

Each recipient of an incentive or gift card must provide a complete signature (first and last name) and include date when they received incentive/gift card on a written log. Original copies of incentive/gift card logs should be available for review during required site visits.

State funds may be used to provide meals (based on approved State rates) during meetings or events for program participants.

Indirect Costs
Indirect costs are not allowed.

VII. <u>EVALUATION CRITERIA</u>

The application is worth 100 points. The page limit for the narrative sections of the application, including the cover letter, is 40 pages. Budget pages and endnote pages are not counted in the total page limit. Point values are clearly marked beside each item on the Application Form. The total point value for each section of the application is listed below. A multi-disciplinary team will review the application for both content and quality of responses to each item on the application.

1. Cover Letter (1 point)
2. Health Equity (15 points)
3. Needs Assessment (10 points)
4. Program Plan (21 points)
5. Data Collection and Evaluation (15 points)
6. Agency Ability (15 points)
7. Collective Impact/Community Involvement (15 points)

8. Budget (8 points)

VIII. APPLICATION

Application Checklist
The following items must be included in the application. Please use a binder clip at the top left corner on each copy of the application and assemble the application in the following order:

1. **Cover Letter**

2. **Application Face Sheet**

3. **Applicant's Response/Form**

4. **Project Budget**
    Include a budget in the format provided.
    Budget Narrative

5. **Attachment A: Agency Ability**
    Organizational Chart
    Current staff position resumes/future staff job descriptions

6. **Attachment B: Letters of Commitment or Statements of Support**

7. **Attachment C: Letters of Agreement**

8. **IRS Letter documenting agency tax identification number**

1. **<u>Cover Letter (1 point)</u>**
   The application must include a cover letter, on agency letterhead, signed and dated by an individual authorized to legally bind the Applicant.

   Include in the cover letter:
   - The legal name of the Applicant agency.
   - The RFA number.
   - The Applicant agency's federal tax identification number.
   - The Applicant agency's DUNS number.
   - The closing date for applications.
   - The Applicant's mission, background and current services offered.
   - Indicate a clear understanding of the Improving Community Outcomes for Maternal and Child Health project (ICO4MCH) and a strong commitment of replicating the program requirements.
   - State which three evidence-based strategies are selected, one for each of the three program aims.
   - The contact information listed on the template.
   - Signed and dated by an authorized individual to legally bind the Applicant.

2. Application Face Sheet

This form provides basic information about the applicant and the proposed project with the Improving Community Outcomes for Maternal and Child Health (ICO4MCH) Project, including the signature of the individual authorized to sign "official documents" for the agency. This form is the application's cover page. Signature affirms that the facts contained in the applicant's response to RFA #A393 are truthful and that the applicant is in compliance with the assurances and certifications that follow this form and acknowledges that continued compliance is a condition for the award of a contract. Please follow the instructions below.

1. Legal Name of Agency:	
2. Name of individual with Signature Authority:	
3. Mailing Address (include zip code+4):	
4. Address to which checks will be mailed:	
5. Street Address:	
6. Contract Administrator: Name: Title:	Telephone Number: Fax Number: Email Address
7. Agency Status (check all that apply): ☐ Public ☐ Private Non-Profit ☐ Local Health Department	
8. Agency Federal Tax ID Number:	9. Agency DUNS Number:
10. Agency's URL (website):	
11. Agency's Financial Reporting Year:	
12. Current Service Delivery Areas (county(ies) and communities):	
13. Proposed Area(s) To Be Served with Funding (county(ies) and communities):	
14. Amount of Funding Requested	
15. Projected Expenditures: Does applicant's state and/or federal expenditures exceed $500,000 for applicant's current fiscal year (excluding amount requested in #14) Yes ☐ No ☐	
The facts affirmed by me in this application are truthful and I warrant that the applicant is in compliance with the assurances and certifications contained in NC DHHS/DPH Assurances Certifications. I understand that the truthfulness of the facts affirmed herein and the continuing compliance with these requirements are conditions precedent to the award of a contract. The governing body of the applicant has duly authorized this document and I am authorized to represent the applicant.	
16. Signature of Authorized Representative:	17. Date

3. **Applicant's Response**

    <u>Health Equity (15 points)</u>
    As previously defined, health equity is the attainment of the highest level of health for all people. Health inequities are preventable differences in health status or risk between different population groups. Inequities result from the differences in the root causes of health that are avoidable, unnecessary, and unjust. Health disparities are the differences in health risks or status between different population groups. Groups may differ by race, ethnicity, gender, geographic location, disability, immigration status, income, and sex (among others).

    Throughout the application, the Applicant must address how they will ensure the three evidence-based strategies (EBS) will address health disparities in the service area(s) which perpetuate the health inequities. Each program aims and EBS should clearly identify how the Applicant will use resources, materials, program planning, implementation, and evaluation to ensure their EBS are addressing the root causes of the disparities within infant mortality, birth outcomes, and child health outcomes.

    Within the first six months of funding, the Applicant will conduct a Health Equity Impact Assessment (HEIA) with at least one of the three selected EBS. **NOTE:** If the Applicant has completed a HEIA or similar assessment that is associated with a maternal and child health program within the local health department, within the past 12 months, DPH will accept this in lieu of conducting a new assessment. The DPH will support each Applicant in the implementation of the HEIA. The HEIA will evaluate the impact of the selected EBS on the local health disparities and provide guidance on how to modify the program and/or evaluation plan. The Applicant will implement the second EBS using the HEIA within the first quarter of the second year of funding. To access a full copy of the HEIA, visit appendix D https://ncchild.org/health-equity-impact-assessmen/provides an overview of the HEIA tool.

    <u>Section 1: Needs Assessment (10 points)</u>

    In order to implement evidence-based strategies (EBS) that are proven to lower infant mortality rates, improve birth outcomes, and improve the overall health status of children ages birth to five in their communities, the applicants must demonstrate an: 1) understanding how health inequities contribute to health disparities in North Carolina among the chosen EBS; 2) understanding of the factors that contribute to high infant mortality rates, particularly among minority populations; 3) understanding of the factors that contribute to poor maternal and infant birth outcomes; 4) understanding of the factors that contribute to improving the health status of children ages birth to five; 5) an assessment of which of the factors are most relevant for the population they intend to serve; and 6) rationale for the selected EBS and policies that will be implemented to address gaps and unmet needs. All data should be stratified at the county level, whenever possible. Demographic data, such as race/ethnicity, age, education, and other social determinants of health, should be included in the needs assessment.

    Selection of the evidence-based strategies
    Applicants are required to state which three evidence-based strategies (EBS) they are selecting for each of the three program aims. Applicants must provide a rationale for how these EBS were

selected and how the priority population(s) were selected. The EBS must be addressed to the population within the entire county or multi-county area.

Evidence of Need

The infant mortality, birth outcome, child health insurance, and child poverty criteria described in Section II of this RFA, must convincingly describe and document the need for services. Data should describe the impacted population(s) to be served. Data should be stratified, when possible, at the county and state level. Data should be compared to other counties and the state. Data provided should be associated with the EBS selected by the agency. Additional information about birth outcomes, infant mortality, and early childhood health may be included. Appropriate data and statistics should be provided as evidence to support the statement of need as related to the goals of the ICO4MCH project. *Please refer to Appendix B for a list of recommended data resources.*

a. Demographic statistics for individuals who gave birth (i.e., age, education level, health status, pre-pregnancy body mass index, marital status);
b. Infant mortality and disparity rates;
c. Pregnancy intendedness rates;
d. Birth outcomes (i.e., low and very low birth weight rates, preterm birth rates, etc.);
e. Prenatal care (i.e., initiation rates, adequate prenatal care rates, etc.);
f. Child poverty rate (children <5years of age);
g. Uninsured child rate (children <19 years of age);
h. Clients seen by LHD using family planning methods such as: long-acting reversible contraception (LARC) [i.e., implants, intrauterine devices (IUDs)], DepoProvera, oral contraceptive pills, patch, ring, diaphragm;
i. Number of providers in the county or multi-county area that offer LARC;
j. Tobacco use/smoking during pregnancy rates;
k. Tobacco use/smoking rates among individuals of reproductive age;
l. Breastfeeding initiation rates among individuals;
m. Rates of infants who are exclusively breastfed at six (6) months;
n. Rates of infants who are breastfed at one year of age;
o. Description of businesses/organizations that accommodate breastfeeding individuals;
p. Description of county policies regarding tobacco-free workplaces

Additional relevant data should be included beyond these requirements, including qualitative data (e.g., focus groups, key informant interviews). **Applicants are encouraged to present data in tables or graphs as appropriate.**

Citations

Appropriate data sources must be cited in the needs assessment. One way this can be done is by using endnotes. If you use endnotes, the citation list can be included on a separate page and will not count against the page limit for this section. For further information on citing references using endnotes, please refer to the handout posted on the Women's Health Branch website titled, "Guidance for Citing Sources in the Needs Assessment," http://whb.ncpublichealth.com/.

Section 2: Program Plan (21 points)

Applicants will be required to describe in detail their program and implementation plan of the three EBS chosen to address the three program aims: reduce infant mortality, improve birth outcomes, and improve health status of children ages birth to five. Applicants should describe their experience with implementing the selected EBS. Applicants will describe how their program will meet or exceed the program service deliverables, and describe the activities involved to meet the deliverables. Applicants will describe how their program will meet each of the program performance outcome measures.

Section 3: Data Collection and Evaluation (15 points)

Applicants will be required to describe how data will be collected and evaluated for each of the three EBS based upon the scope of services and performance measures listed for each EBS. Applicants will describe how they will monitor and evaluate activities and outcomes provided in the proposed program plan, and the type of evaluation tools that will be used (e.g., assessments, pre/post-tests, questionnaires, surveys, data tracking methods/tools, reports). Applicants will describe their policies and procedures for maintaining client confidentiality. Applicants can refer to Appendix E for additional information regarding the data that will be provided by the Applicant and by DPH.

Section 4: Agency Ability (15 points)

Applicants will describe their agency's mission, background, and services and how these relate to the goals of the ICO4MCH Program. Applicants should include their experience working with and implementing maternal and child health programs in the community. The agency's organizational chart must be included in Attachment A.

Applicants must indicate experience that program staff has with the chosen EBS and training they have received or plan to receive if awarded funding. Required trainings are described in the Scope of Services Section for each EBS, if applicable. If program staff is already in place, provide resumes in Attachment A. If program staff is not in place, provide a job description for each program position in Attachment A.

Section 5: Collective Impact and Community Involvement (15 points)

Applicants should describe their experience utilizing the Collective Impact framework in previous maternal and child health programs in the service area. Applicants can include trainings or technical assistance they or others who will be involved with the ICO4MCH project have received within the last two years, as well as past or current outcomes of their work.

If Applicant is planning to incorporate Implementation Science into project, please describe experience in utilizing the principles of implementation science in other public health programs

in the service area. Additional applicable information regarding Collective Impact or Implementation Science should be included.

Applicants must provide a list of their current or potential Community Action Team (CAT) members. The CAT is composed of management, consumers, community/family leaders, and other representatives, which can include hospital executives, faith leaders, maternal and child health providers as well as other partners working to improve the population health of women, infants, children, and families. Potential CAT members must submit a letter of commitment (LOC) outlining their unique role and contribution to the CAT. Current CAT members may utilize the LOC they provided when joining the CAT. LOC must be included in Attachment B.

The CAT must convene at least quarterly. Meeting minutes shall be taken and should include the names of the attendees, along with their organization or role. Minutes should document the role of the CAT in advising, assisting, and collaborating to meet the goals of the ICO4MCH project in the service area.

Applicants are expected to collaborate with other community agencies to assist with implementing the proposed EBS and to refer clients for services that are beyond the scope of the program. A Letter of Agreement (LOA) must be included from each agency that is committed to assist with implementation and/or serve as a referral agency to provide services to clients. Each LOA should include the specific contribution from the agency to the specific evidence-based strategy. All LOA must be included in Attachment C.

Project Budget (8 points)

Additional budgetary items to consider:

Staffing
Each Applicant must adhere to the following guidelines for staffing the ICO4MCH project, unless otherwise noted in the scope of services: 1.0 FTE Program Manager, and at least one 0.50 FTE per EBS which are paid staff positions. Note: Triple P and Family Connects Newborn Home Visiting Program have specific staffing requirements that must be followed. In addition, staff hired to implement the project can be contract employees and/or salaried employees with this state funding. All applicants should follow county guidelines for hiring.

Implementation Science Costs
As described in the Scope of Services Section of this RFA, each newly funded ICO4MCH project will be required to budget funds for an Implementation Coach from the National MCH Workforce Development Center for at least the first year of the grant period. Re-funded Applicants are not required to budget funds for an Implementation Coach. The monthly cost for the Implementation Coach is $2,000. This monthly cost must be included in the project budget(s). Each project should expect to work with the Implementation Coach at a minimum of two days per month in the early stages of the project.

Attachments

Attachment A: Agency Information
This attachment must include each of the following:
1. Organizational chart of the LHD. If this is a multi-county proposal, include an organizational chart for each LHD.
2. Job descriptions or resumes for all staff positions that are necessary to implement and support the project. Current staff should submit a resume; for future or proposed staff positions a job description should be submitted.

Attachment B: Letters of Commitment

This attachment must include LOC from current and/or prospective Community Action Team (CAT) members indicating both their commitment to serve and the responsibilities they will assume as a member of the CAT.

Attachment C: Letters of Agreement

This attachment must include LOA from agencies that are committed to assist with implementation and/or serve as a referral agency to provide services to clients. Each LOA should include the specific contribution from the agency to the specific evidence-based strategy. LOA should also be included for any agency that the Applicant will sub-contract with for this project.

Cover Letter

Total Point Value:
1
Page Limit:
2 single-spaced

The application must include a cover letter, on agency letterhead, signed and dated by an individual authorized to legally bind the Applicant.

Include in the cover letter:
- The legal name of the Applicant agency.
- The RFA number.
- The Applicant agency's federal tax identification number.
- The Applicant agency's DUNS number.
- The closing date for applications.
- The Applicant's mission, background and current services offered.
- Indicate a clear understanding of the ICO4MCH project and a strong commitment of replicating the program requirements.
- State which three evidence-based strategies are being chosen; one for each of the three program aims.
- The contact information listed on the template.
- Signed and dated by an authorized individual to legally bind the Applicant.

Application Form

The application is worth a total of 100 points.
Point values and page limits are clearly marked for each section of the application form.
Do not delete the question headers within the application form.
Please provide your response to each question under the heading.

Section 1
Needs Assessment

Do not delete the question headers
Please provide your response to each question under the heading.

Total Point Value:
10

Page Limit:
8 single-spaced, not including citation page(s)

1-1.   Define the specific area that will be served by the ICO4MCH project. An area may be a county or multi-county area. (1 point)

1-2.   For each evidence-based strategy (EBS), provide recent data to demonstrate the need for the ICO4MCH project in the county or multi-county area you propose to serve. For each EBS, describe the impacted population(s) to be served. Data should be stratified, when possible, at the county and state level. Data should be compared to other counties and the state. Data provided should be associated with the EBS selected by the agency. Additional information about birth outcomes, infant mortality, and early childhood health may be included. (5 points)

        a. Demographic statistics for individuals who gave birth (i.e. age, education level, health status, pre-pregnancy body mass index, marital status);
        b. Infant mortality and disparity rates;
        c. Pregnancy intendedness rates;
        d. Birth outcomes (i.e., low and very low birth weight rates, preterm birth rates, etc.);
        e. Prenatal care (i.e., initiation rates, adequate prenatal care rates, etc.);
        f. Child poverty rate (children <5 years of age);
        g. Uninsured child rate (children <19 years of age);
        h. Clients seen by LHD using family planning methods such as: long-acting reversible contraception (LARC) [i.e., implants, intrauterine devices (IUDs)], DepoProvera, oral contraceptive pills, patch, ring, diaphragm, etc.;
        i. Number of providers in the county or multi-county area that offer LARC;
        j. Tobacco use/smoking during pregnancy rates;
        k. Tobacco use/smoking rates among individuals;
        l. Breastfeeding initiation rates among individuals;
        m. Rates of infants who are exclusively breastfed at six (6) months;
        n. Rates of infants who are breastfed at one year of age;
        o. Description of businesses/organizations that accommodate breastfeeding individuals;
        p. Description of county policies regarding tobacco-free workplaces;

Additional relevant data should be included beyond these requirements, including qualitative data (i.e., focus group, key informant interviews, etc.). Applicants are encouraged to present data in tables or graphs as appropriate.

1-3.   Describe the availability and accessibility of health services and other support services in the community. Describe strengths, barriers, and gaps in services. Services should include both internal and external health and other support services to the LHD. (2 points)

1-4.   For each EBS, describe how the impacted/priority population was identified. (2 points)

1-5.   Appropriate data sources must be cited in the needs assessment. The citation list can be included on a separate page and will not count against the page limit for this section.

Section 2
Program Plan

Do not delete the question headers.
Please provide your response to each question under the heading.

Total Point Value:
21

Page Limit:
12 single-spaced

2-1.   Restate the three EBSs your agency will implement to address each of the three program aims. (1 points)

2-2.   For each EBS, describe how the Applicant will implement and potentially exceed the scope of services, performance measures, and reporting requirements. In the description, include detailed activities for each EBS. Information such as who will oversee each EBS and the activities, what activities will take place, where and when activities will be implemented, etc. Applicants are encouraged to use tables to clearly identify each EBS, scope of service, performance measure, activities, etc. (11 points)

2-3.   For each EBS, describe how the impacted/priority population(s) has been or will be involved in the program planning, implementation, and evaluation. (3 points)

2-4.   Describe your experience implementing maternal and child health EBS. In the description, include how your agency has collaborated with other organizations; how your agency will collaborate with other organizations to implement the three EBS chosen for the ICO4MCH project. (3 points)

2-5.   For each EBS, what change do you expect to see because of the implemented strategies? (2 points)

2-6.   For each EBS, which factors will the intervention impact? (Check all that apply) (1 point)

Evidence-based strategy	Impacted area(s)
1. _____	☐ Housing ☐ Jobs & Economic Stability ☐ Neighborhood & Community Supports ☐ Health & Health Care ☐ Public Services & Supports ☐ Education ☐ Criminal Justice ☐ Environment ☐ Other _____
2. _____	☐ Housing ☐ Jobs & Economic Stability ☐ Neighborhood & Community Supports ☐ Health & Health Care ☐ Public Services & Supports ☐ Education ☐ Criminal Justice ☐ Environment

	☐ Other _____
3. _____	☐ Housing ☐ Jobs & Economic Stability ☐ Neighborhood & Community Supports ☐ Health & Health Care ☐ Public Services & Supports ☐ Education ☐ Criminal Justice ☐ Environment ☐ Other _____

Section 3
Data Collection and Evaluation

Do not delete the question headers.
Please provide your response to each question under the heading.

Total Point Value:

15

Page Limit:
9 single-spaced

3-1.   For each evidence-based strategy (EBS), describe how your agency will monitor and evaluate the performance measures. Include past experiences monitoring and evaluating similar maternal and child health programs. (4 points)

3-2.   For each EBS, describe the evaluation tools that will be used to monitor and evaluate each activity described in your program plan (e.g., assessments, pre/post-tests, questionnaires, surveys, data tracking methods/tools, reports). Refer to Appendix E that identifies the data that can be provided by the DPH. (10 points)

3-3.   Describe how you will maintain client confidentiality for each of the selected three EBS. (1 point)

Section 4
Agency Ability

Do not delete the question headers.
Please provide your response to each question under the heading.

Total Point Value:

15

Page Limit:
3 single-spaced

4-1. Describe your agency's mission, background, and services and how these relate to the program aims for ICO4MCH. Applicants should include their experience working with and implementing maternal and child health programs in the community. Include the agency's organizational chart in Attachment A. (5 points)

4-2. Describe the agency's staff that will oversee the grant funds (budgeting, billing, sub-contracts, contract expenditure reports, etc.), if awarded? (5 points)

4-3. Use the chart below to list the current and/or new staff positions that will be necessary to implement and support the three EBS. For each staff listed, please highlight their qualifications, FTE, or percent effort on the ICO4MCH project and which EBS they will be working with. Administrative, management staff, or in-kind staffing should be accounted for in the chart below. Please insert additional rows, if needed. Include copies of job descriptions of future staff and/or resumes of current staff in Attachment A. (5 points)

Evidence-based strategy	Position Title	Current Employee Name. If employee is to be hired, put TBD	Briefly highlight qualifications for position or involvement	Full Time Equivalency (FTE)	Percent (%) of time dedicated to EBS	Check the box to indicate if the correct classification	Check the correct box to indicate which is included in Attachment A
						☐ Current staff ☐ New Hire	☐ Job Description ☐ Resume
						☐ Current staff ☐ New Hire	☐ Job Description ☐ Resume
						☐ Current staff ☐ New Hire	☐ Job Description ☐ Resume
						☐ Current staff ☐ New Hire	☐ Job Description ☐ Resume
						☐ Current staff ☐ New Hire	☐ Job Description ☐ Resume
						☐ Current staff ☐ New Hire	☐ Job Description ☐ Resume
						☐ Current staff ☐ New Hire	☐ Job Description ☐ Resume
						☐ Current staff ☐ New Hire	☐ Job Description ☐ Resume
						☐ Current staff ☐ New Hire	☐ Job Description ☐ Resume
						☐ Current staff ☐ New Hire	☐ Job Description ☐ Resume
						☐ Current staff ☐ New Hire	☐ Job Description ☐ Resume

Section 5
Community Involvement/ Collective Impact

Do not delete the question headers.
Please provide your response to each question under the heading.

Total Point Value:

15
Page Limit:
7 single-spaced

5-1.   Describe how the Community Action Team (CAT) or other stakeholders from the community were involved in the selection of the evidence-based strategies (EBS), the program, implementation, and evaluation plans. Include information on how the CAT or other stakeholders from the community with maternal and child health programs will be involved in the ICO4MCH project. (4 points)

5-2.   Describe how the agency will collaborate with community members, consumers, advocates, content experts, other health and human services agencies, community-based or faith-based organizations to implement the three EBS. The Collective Impact framework should be addressed when describing this collaboration. (4 points)

5-3.   Use the chart below to identify the CAT members currently collaborating with the LHD. Identify their name, role, and how long they have been involved with the CAT. Roles includes community members, content experts, health care providers, local health department staff, impacted groups, community leaders, or advocates. Provide a letter of commitment from each member in Attachment B.

       If the agency does not have a CAT or similar team, use the chart below to identify potential stakeholders from the county/community and what their role will be in implementation of the EBS. Include LOC in Attachment B.

       Please insert additional rows if needed. (3 points)

Participant Name	Role & Affiliation	Length of participation (months/years)	LOC Attached?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

5-4.   Use the chart provided to list the other health and human services agencies, community-based or faith-based organizations that will assist with implementing the EBS.

Organizations may include those that will sub-contract with the Applicant to provide services associated with the EBS, assist in services such as referrals, transportation, childcare, programming, training, etc.

Include a Letter of Agreement (LOA) from each agency describing the agency's contribution to the specific EBS. Include the LOA in Attachment C.

Please insert additional rows if needed. (4 points)

Organization	Services Provided	EBS focus	Sub-Contract?	LOA Attached?
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

Note: It is possible that a collaborating agency may also be a CAT member. If so, one letter (either a LOC or LOA) is acceptable. Identify in the chart where the LOC or LOA can be found.

Section 6
Budget

Total Point Value:
8
Page Limit:
Not Applicable

Applicants must complete the Open Windows Budget Form for Year 1 (6/1/22 through 5/31/23) and Year 2 (6/1/23 through 5/31/24). Applicants must ensure that all worksheet cells **are expanded** to expose the full narrative justification. Do not copy Year 1 budget into Year 2 budget. Please consider the needs for each year of the budget. The Open Window Budget Form can be downloaded from the Women's Health Branch website at http://whb.ncpublichealth.com/.

A narrative justification must be included for every expense listed in the Year 1 and 2 budgets. Each justification should show how the amount on the line-item budget was calculated and clearly state how the expense relates to the program. The instructions on **How to Fill Out the Open Windows Budget Form** are posted on the Women's Health Branch website at http://whb.ncpublichealth.com/.

The legislation authorizing this program requires "that the Division prioritize grant awards to those local health departments that are able to leverage non-State funds in addition to the grant award." Funding award for Year 1 and 2 will be the same amount.

Applicants should describe how they plan to leverage non-state funds in a narrative. Include approximate amount of funding, and the source of funding, in the narrative, as they relate to the program plan. This is not a match requirement, but a statement of local support for the services to be carried out.

Attachment A
Agency Information

This attachment must include each of the following:
- Organizational chart of the applying agency.
- Job descriptions of new staff and/or resumes of current staff, including in-kind staff.

Attachment B
Community Involvement/
Collective Impact

This attachment must include each of the following:
- Letters of Commitment from existing or potential Community Action Team (CAT) members or stakeholders

Note: It is possible that a collaborating agency may also be a CAT member. If so, one letter (either a LOC or LOA) is acceptable.

Attachment C
Letters of Agreement

This attachment must include each of the following:
- Letters of Agreement (LOAs) from organizations who will be sub-contracting, providing services, referrals, etc., with agency.

Note: It is possible that a collaborating agency may also be a CAT member. If so, one letter (either a LOC or LOA) is acceptable.

**<u>Appendix A: Evidence-based Strategy Scope of Services,
Performance Measures, and Report Requirements</u>**

PROGRAM AIM 1: Improve Birth Outcomes

1. Using a Reproductive Justice Framework to improve the utilization of reproductive life planning (RLP)

Reproductive Justice is a framework built on the belief in the "complete physical, mental, spiritual, political, economic, and social well-being of women and girls".[1] It is also the recognition that historically, women, girls, and individuals have experienced reproductive abuses based on "race, ability, class, gender, sexuality, age, and immigration status".[2] These abuses have resulted in harmful outcomes that have lasting community effects.[1]

Reproductive Life Planning (RLP) is a strategy that aims to encourage both women and men to reflect on their reproductive intentions and to find family planning strategies that function for them.[1] The guidelines associated with RLP seek to develop a set of standardized questions to guide conversations with patients that would support a life course perspective.[5] The Centers for Disease Control and Prevention (CDC) recommend the use of RLP questions with all clients "receiving contraceptive, pregnancy testing and counseling, basic infertility, sexually transmitted disease and preconception health services…"[6]

Paired with the RLP strategy, the Reproductive Justice framework will provide additional resources to health care professionals (clinical and non-clinical) as well as individuals of reproductive age to engage in decisions about their reproductive future. Based on this framework all individuals should 1) have access to their contraception method of choice, 2) be able to decline a contraception method without judgement or pressure and 3) have access to contraception removal services when they desire.[3,4]

Long-acting reversible contraception (LARC) methods are effective for three to 10 years, and do not require any action on the part of the user after insertion. LARCs include hormonal intrauterine devices (IUDs) such as Mirena®, Skyla®, Lilleta® and Kyleena®; the non-hormonal IUD known as ParaGard®; and the implant known as Nexplanon®. Research shows that more patients opt to use a LARC when it is in stock and available for same-day insertion.[7]

Tiered contraceptive counseling is a recommended best practice per the Providing Quality Family Planning Services guidelines, developed by the CDC and the U.S. Office of Population Affairs.[8] The evidence supports increased use of LARCs and a substantial reduction in unintended pregnancy when the tiered approach to contraceptive counseling is utilized.[8,9]

The Oregon Foundation for Reproductive Health developed and tested the One Key Question® for primary care providers.[10] Asking "Would you like to become pregnant in the next year" opens a discussion with patients to begin assessing their RLP as part of their overall life plan.

For same-day insertion to be viable, health care practices/clinics/local health departments must have sufficient numbers of trained health care providers and staff to facilitate clinic flow and must stock LARC devices in advance rather than purchasing a particular device for a particular patient. Programs for the uninsured, such as Access and Resources in Contraceptive Health (ARCH) Patient Assistant Program, supply Bayer brand IUDs

at no cost for specific patients who apply. Health care practices may opt to order devices for specific patients under their pharmacy benefit, which can create barriers for the patient, since this practice generally requires more than one provider visit.   Patients that receive Medicaid can have LARC devices provided from stock and the providers can bill Medicaid for reimbursement. For more information, visit: Obstetrics and Gynecology Clinical Coverage Policies (1E-7): https://medicaid.ncdhhs.gov/media/10112/open

Scope of Services

Offer educational workshops and trainings, within the LHD and at other public/private health care facilities* to educate individuals of reproductive age about family planning methods, such as LARCs, using the reproductive justice approach and evidence-based and evidence-informed protocols, such as reproductive life planning (RLP), which may include One Key Question® and a tiered approach to contraceptive counseling. Topics for participants include the principles and application of Reproductive Justice, patient centered and culturally sensitive counseling, learning how access to family planning methods, such as LARCs; potential side effects; informed consent and confidentiality. Individuals should not be coerced into selecting a specific method.

Involve consumers of service (individuals of reproductive age) in developing and implementing educational materials, protocols, policies, and strategies to increase access to RLP and family planning methods, including LARCs.

Provide outreach and awareness to members of the community-at-large about the benefits, potential side effects, and informed consent surrounding family planning methods, including LARCs, within the framework of reproductive justice, using the principles of RLP.

Collaborate with other entities, such as your regional Area Health Education Center (AHEC) and Upstream NC, to educate and train health care providers, staff at the LHD, and other public/private health care facilities. Education and training may include the utilization of reproductive justice framework and evidence-informed principles of RLP, utilization of the One Key Question® as well as a tiered approach, implicit bias, and patient centered and culturally sensitive counseling to all patients of reproductive age.

Provide same-day availability and insertion (when applicable) for LARC methods at the local health department.

Provide training, resources, and technical assistance to increase access to same-day insertion of LARC and the availability of full range birth control methods at the LHD, community health clinics, and private healthcare facilities. Training can include insertion and removal of IUDs/implants, tiered counseling, informed consent, and possible side effects for a full range of birth control methods. Reimbursement/billing procedures and the Be Smart Family Planning Program should also be included. Furthermore, encouraging collaboration is highly recommended to provide or assist with trainings. Potential collaborators include AHEC and Upstream NC (www.upstream.org).

Performance Measures

Conduct education with a minimum of 300 individuals of reproductive age, using a reproductive justice framework, about family planning methods, including LARCs, reproductive life planning (RLP), and a tiered approach to contraceptive counseling.

Conduct outreach and awareness based on the reproductive justice framework, to a minimum of 1,000 members of the community-at-large about the benefits, potential side effects, and informed consent of family planning methods, specifically, LARCs.

Increase the number of trainings offered to LHD providers and other public/private health care providers. Topics include insertion/ removal of IUDs/implants, billing and reimbursement, tiered contraceptive counseling, postpartum IUD/implant insertion, clinic flow, and other topics as relevant.

Increase the percent of LHD providers who provide consistent and regular same-day insertion of LARCs when requested.

Reporting/Monitoring Requirements
The following reporting/monitoring requirements.

The number of individuals of reproductive age educated during workshops/trainings. Data should include topic of the workshop/training, location, basic demographic information, and resources distributed.

The number of community members who receive outreach and awareness. Data should include topics discussed, location, basic demographics, and resources shared.

The number of LHD and other public/private health care providers who participate in an in-person or webinar training or technical assistance with regards to any of the following topics: insertion/removal of IUDs/implants, tiered contraceptive counseling, motivational interviewing, postpartum IUD/implant insertion, reproductive justice, or implicit bias.

NOTE: Other private/public health care providers or facilities include, but are not limited to federally qualified community health centers (FQHC), OB/GYN, family medicine, pediatric practice, rural/migrant health centers, etc.

2. Preconception and Interconception Health

Most efforts to reduce infant and maternal mortality have historically focused on prenatal care and interventions during labor and delivery. Unfortunately, after several decades of emphasis in this area, birth outcomes are not improving as much as expected. The importance of prenatal care and delivery management cannot be overstated, but there remain many additional ways to make a greater impact on improving birth outcomes for mothers and babies. However, these supports, and services needs to happen prior to pregnancy. (http://beforeandbeyond.org/wp-content/uploads/2017/01/Zero-to-Three-Article-for-Dr.-Frayne.pdf)

Preconception health refers to the health of individuals during their reproductive years, which are years they can have a child. It focuses on taking steps now to protect the health of a baby they might have sometime in the future. Preconception care is aimed at identifying and modifying physical, behavioral, and social risks through preventive and management interventions. (https://www.cdc.gov/preconception/overview.html)

Common modifiable risk factors in individuals that influence birth outcomes for themselves and the baby include: pregnancy intention, interpregnancy interval, maternal age, folic acid supplementation and other nutritional factors, exposure to substances, chronic disease control and toxic stress. Also preconception health interventions should be focused on reproductive planning and contraception, infection/immunizations, genetics/family history, social and behavioral issues and interpersonal violence. Engaging individuals during

the preconception period is an excellent opportunity to discuss their important role in parenting.

Scope of Services

Implement a community-based health education and outreach program for individuals of reproductive age and/or individuals during the interconception period in partnership with a community partner. The program should provide opportunities for individuals to build social support, learn health information, adopt healthy life skills, become knowledgeable of resources and increase motivation to adopt health improving behaviors. To address issues prevalent during the preconception and/or interconception periods, program content should include, but limited to 1) Healthy Eating/Active Living, 2) Mental Health, and 3) Relationships

Implement the **Mothers and Babies Program** designed to promote healthy mood management while teaching pregnant individuals and new moms how to effectively respond to stress in their lives through increasing the frequency of thoughts and behaviors that lead to positive mood states. Mothers and Babies offers a "toolkit" of approaches for individuals to observe their mood, note factors affecting their mood, and make changes in their daily lives to impact these areas.
(http://www.mothersandbabiesprogram.org/mothers-clients/)

Utilize social media, along with radio, television, billboards, web banners or newspapers to increase public awareness of preconception and interconception health. Campaigns should promote information and behaviors that can improve birth outcomes, such as reducing tobacco use, starting prenatal care within first trimester, responsible use of alcohol, healthy diet and optimal weight, value of postpartum visit, resources that support maternal and paternal mental wellness, breastfeeding support, and reproductive life planning (RLP).

Select one (1) of the following Scope of Services to implement in addition to the above listed activities:

1. Establish a partnership with local community colleges or four-year universities or agencies that serve individuals of reproductive age to implement a **Preconception Health Peer Educator program (PPE)**. The PPE program was initiated by the U.S. DHHS Office of Minority Health to train and raise awareness among college students about healthy behaviors that can impact birth outcomes and the social determinants of health that impact health disparities. The PPE program aims to reach college-aged students with targeted health messages emphasizing preconception health and care.
These PPE student groups are led by a college/university faculty member or staff. The goals of the PPE program are to:

    a. Train college students as peer educators

    b. Arm the peer educators with materials, activities, and exercises to train their peers in college and in the community at large.

    c. Reach the college-age population with targeted health messages emphasizing preconception health and healthcare

    d. Provide targeted health messages to and activities for non-college individuals, ages 18 – 30 years old, within the funded county(ies).

2. Enhance efforts in promoting and increasing utilization of pre-pregnancy services by individuals of reproductive age, including under-and un-insured, to reinforce the importance of pregnancy planning and preparedness among individuals in the LHD Family Planning clinic or within other primary care practices. This visit should include physical assessment, completion of the reproductive life plan tool/assessment and provide education and/or referral on folic acid supplementation, oral health, healthy diet and optimal weight, family and genetic history, social and behavioral history, chronic disease management, physical/sexual/emotional abuse and importance of early prenatal care. Funds may support the provision of

pre-pregnancy services for individuals of reproductive age, including under- and un-insured clients, or funds may be used to implement strategies to identify individuals in the community who would benefit from these services and raise awareness of pre-pregnancy services available. (Source: https://www.aafp.org/about/policies/all/preconception-care.html)
Performance Measures
Increase the number of unduplicated individuals of reproductive age and/or during interconception who receive education, support, and information to increase the awareness and adoption of healthy eating and active living skills as well as enhanced mental wellness.
Increase the number of individuals of reproductive age who complete a reproductive life plan assessment.
Facilitate a minimum of 25 Mothers and Babies sessions with individuals of reproductive age
Increase the presence of social media messages that provide information about issues related to preconception and interconception health.
Select the appropriate performance measure to match the selected scope of service above:
1. Coordinate with the DPH Program Manager or designee to plan and conduct two PPE trainings.

2. Develop a written agreement with a minimum of 2 partnering community colleges, universities and/or organizations that serve individuals of reproductive age to implement the PPE program. Agreement components shall include:
 	
    a. Identify a PPE Advisor at each community college, university and/or agency. The PPE Advisor will oversee student PPE outreach on their campus.
 	
    b. Recruit and maintain a minimum of 10 PPE students each academic year. These PPE students will serve as peer educators to reach their peers with targeted health messages emphasizing preconception health and healthcare.
 	
    c. Develop and carry out a PPE workplan consisting of at least two on-campus and two community activities each academic year.

3. Increase the percent of LHDs providing a pre-pregnancy visit for individuals of reproductive age.
Reporting Requirements
The number of unduplicated individuals of reproductive age and/or during interconception who receive education, support, and information to increase the awareness and adoption of healthy eating and active living skills as well as enhanced mental wellness.
Number of RLP assessments/tool completed by program participants
The number of individuals of reproductive age reached through the Mothers and Babies program. Data should include format (one-on-one or group); basic demographic information, and resources/referrals made.
Select appropriate reporting requirement to match the selected scope of service above:

Evidence of participation in and completion of PPE activities by providing campus/agency workplans and student rosters detailing current PPE students, on-campus and community activities and outcome of activities. A campus workplan template will be provided. The campus workplans are to be emailed to the DPH Program Manager or designee within two weeks following PPE training completion and at the end of each academic semester by December 31, 2022, and May 31, 2023.

PROGRAM AIM 2: Reduce Infant Mortality

1. Tobacco Cessation and Prevention

Tobacco use (inclusive of electronic nicotine devices such as e-cigs and vaping pens), screening and counseling should be provided to all pregnant and postpartum individuals at each health care visit. All clients should be assessed for primary, secondary, and tertiary exposure to tobacco use/smoking (including electronic nicotine devices and vaping). If a client reports tobacco use/smoking, the approved 5A's method of cessation counseling should be offered. The 5A's (Ask, Advise, Assess, Assist, Arrange) is the evidence-based, best practice approach for tobacco cessation. Clients should be referred to QuitlineNC (1-800-QUIT-NOW) and/or appropriate community resources. As clinically appropriate, clients should be offered Food and Drug Administration (FDA) approved tobacco treatment pharmacotherapy support. Evidence supports that a combination of tobacco cessation counseling and pharmacotherapy increases quit rates. Counseling on the risks of second- and third-hand smoke exposure should also be provided during all health care visits.

To increase the capacity of staff to provide tobacco cessation services in the clinical setting, LHDs should send key staff to become certified tobacco treatment specialists (CTTS, Council on Tobacco Treatment Specialist, http://ctttp.org/). Research has found that tobacco cessation counseling that is delivered by a variety of clinician types, including physicians and non-physicians, increases quit rates. Tobacco cessation resources are available to assist projects with incorporating tobacco cessation screening, counseling, and documentation: Treating Tobacco Use and Dependence Clinical Practice Guideline 2008 Update http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco.index.html and tools for tobacco cessation can be found at http://publichealth.nc.gov/lhd/.

In addition to providing direct clinical support around primary, secondary, and tertiary tobacco use/smoking screening, and counseling, LHDs should engage in evidence-based policy support efforts that limit second- and thirdhand smoke exposure. Evidence-based interventions include but are not limited to:
- Local regulations that make local government buildings, grounds, and public places tobacco free.
- Smoke-free multi-unit housing that also bans e-cigarettes, including public housing, affordable housing, and as resources allow, market rate housing, Tobacco-free colleges and community colleges, local tobacco-free mental health, and substance abuse facilities along with evidence-based tobacco treatment provided by counselors, and tobacco-free childcare centers.

Mass health communication interventions are effective in reducing initiation of tobacco and increasing quit attempts. LHDs should investigate ways to develop and implement earned and paid media opportunities to educate the public and decision-makers about the dangers of tobacco use, secondhand smoke exposure and evidence-based interventions to reduce tobacco use and secondhand smoke exposure among target populations. For more information, please refer to the www.thecommunityguide.org or www.tobaccopreventionandcontrol.ncdhhs.gov/

Scope of Services
Train at least four key licensed professionals (physicians and non-physicians), along with a key staff/leader from a local health system, to become certified tobacco treatment specialists (CTTS) through the Duke-UNC CTTS Program or another nationally accredited CTTS Program. At least 25% of trained CTTS should be from facilities external to the LHD. Maintain engagement, collaboration, and opportunities for additional training with previously trained CTTS.
Refer at least 75% of clients who use tobacco or have secondhand smoke exposure from the LHDs and/or private providers' offices such as OB/GYN, pediatric offices, family medicine, FQHC/community/rural/migrant health centers/clinics to the QuitlineNC (1-800-784-8669) and/or the National Institute of Health's Smoke-Free text line support line (Smokefree TXT, text QUIT to 47848).
Integrate approved tobacco treatment pharmacotherapy or Nicotine Replacement Therapy (NRT) in LHD and non-LHD clinic services, when clinically appropriate.
Assess 100% of all individuals, caretakers/for tobacco/smoke use, including electronic nicotine devices, such as, e-cigs vaping, and second- and third-hand smoke exposure during each health care visit.
Using the 5As (Ask, Advise, Assess, Assist, Arrange) method, provide a minimum of six trainings for LHD health care providers and staff, private health care providers and staff (such as OB/GYN, pediatric offices, family medicine, FQHC/community/rural/migrant health centers/clinics), and other stakeholders (health educators, peer counselors, outreach workers, and volunteers/staff from faith-based and/or community-based organizations, schools, community colleges, four-year college, universities, etc.) on tobacco/smoking cessation counseling.
Using the 5As (Ask, Advise, Assess, Assist, Arrange) method, within the LHD health care providers and staff, private health care providers and staff (such as OB/GYN, pediatric offices, family medicine, FQHC/community/rural/migrant health centers/clinics), provide tobacco use/smoking screening and cessation counseling to 100% of all pregnant and postpartum individuals who use tobacco and to at least 50% of all adults, children, and youth who use tobacco during all health care visits.
Document at least 50% of patients' tobacco use/smoking (inclusive of electronic nicotine delivery systems, such as e-cigs and vaping pens) and second- and third-hand smoke exposure status in the client's electronic medical record (EMR) at the initial visit and at every follow-up visit.
Document the use of the 5A's counseling, type and amount of tobacco used, outcome of counseling session (plan of action including referral and follow-up), and length of service provided in at least 50% of all client's electronic medical record. The length of service should follow the guidelines in the Treating Tobacco Use and Dependence Clinic Practice Guideline 2008 Update.
Engage in evidence-based policy support efforts that promote 100% smoke-free or tobacco-free government buildings, groups, and public places. Locations may include, but are not limited to public and private work sites/businesses, schools, community colleges, four-year colleges/universities, public outdoor spaces, etc.
Engage in evidence-based support efforts with at least five businesses/work sites to increase the number of cessation programs and/or contracts with the QuitlineNC.
Develop and/or utilize existing advertisements to implement paid and earned media opportunities to educate the public and decision-makers about the dangers of primary, secondary, and tertiary tobacco/smoke exposure in the service area(s). Locations may include, but are not limited to, community colleges and four-year colleges/universities, community-based organizations, faith-based organizations, work sites, and businesses.
Performance Measures
Decrease the percentage of pregnant individuals who smoke by 5%.

Increase the number of health care professionals that incorporate the 5A's (ask, advice, assess, assist, arrange) smoking cessation and counseling method into their clinical setting by 5%.
Increase the number of public policies for smoke-free or tobacco-free workplaces and other indoor public places within the service area(s) by 20%.
Increase the number of worksites within the service area(s) with a cessation program or a contract with Quitline NC by 10%.
Increase the number of licensed providers in the service area(s) that are Certified Tobacco Treatment Specialists (CTTS).
Increase the awareness of secondhand smoke, environmental and tobacco policies through paid and earned media opportunities in the service area(s).
Reporting/Monitoring Requirements The following reporting/monitoring requirements may be tracked by the grantee and/or the grantor.
The number of CTTSs trained in the county. At least 25% of the trained CTTSs should be external health care professionals from locations outside of the LHD. Summarize the engagement, maintenance, and collaboration with previously trained CTTS.
Number of pregnant individuals who use any form of tobacco (inclusive of electronic nicotine devices such as e-cigs and vaping pens).
Number of 5A's trainings and number of staff and health care providers who participate. Specific data should be provided, including place of employment (LHD, FQHC, hospital, and other public/private health clinics, etc.).
Number of clients with documentation of primary, secondary, or tertiary tobacco/smoke exposure in their electronic medical records.
Number of public policies (including workplace policies) for smoke-free or tobacco-free workplaces and other indoor public places within the service area. Data should include qualitative information about workplaces, policies, and more.
Number of new businesses/work sites with a cessation program for employees and/or patrons.
Summary of paid and earned media opportunities in the service area, including samples of the paid and earned media.
Number of clients who received counseling and cessation services using the 5A's method and referrals made, in the electronic medical record.
If the LHD chooses to enter into an annual contract with the QuitlineNC for counseling and cessation services in the service area, a copy of the contract is to be sent to the DPH Program Manager within 60 days of that contract's execution.
2. Ten Steps for Successful Breastfeeding, with a focus on Steps 3 & 10

Breastfeeding is a well-documented preventative health measures and one of the best modalities available to health care providers to reduce the risk of common causes of infant mortality in the US and globally. Infants who receive any breastmilk have a significantly lower rate of diarrhea, otitis media, lower respiratory tract infections, Type 1 and Type 2 diabetes, childhood leukemia, necrotizing enterocolitis, and Sudden Infant Death Syndrome.[1,2] The American Academy of Pediatrics (AAP) recommends exclusive breastfeeding for 6 months, followed by continued breastfeeding as complementary foods are introduced, with continuation of breastfeeding for one year or longer.[3] While 85.0% North Carolina's infants are breastfed initially, many mother infant dyads are unable to meet AAP recommendations. By six months, only 20.2% of North Carolina's infants are exclusively breastfed, below the national average and Healthy People 2030's target of 42.4%.[4,5] Although breastfeeding rates have increased over the past decade at both a State and National level, racial/ethnic disparities continue to persist.[6-8] The Pregnancy Risk Assessment Monitoring System (PRAMS) provides breastfeeding rates by race/ethnicity at a State level. North Carolina's data mirrors national trends in racial and ethnic disparities. In North Carolina, there is 17.2 percentage point different between Latina (96.2%) and Non-Hispanic Black (79.9%) women initiating breastfeeding.[9] The disparity widens as the infant ages. Between Non-Hispanic White women and Non-Hispanic Black women, we see an 8.7 percentage point difference for breastfeeding initiation, but by 8 weeks postpartum the disparity between rates widens by almost 60% (68.6% vs. 54.8%)[9,10]

The Ten Steps for Successful Breastfeeding is an evidence-based protocol used by Baby-Friendly USA to encourage and promote breastfeeding.[17] This evidence-based protocol is best implemented by hospitals; however, Steps 3 and 10 focuses on broader strategies to increase initiation, duration, and support of breastfeeding. Step 3 of the Ten Steps for Successful Breastfeeding states to "*Inform all pregnant women about the benefits of and management of breastfeeding.*" Step 10 of the Ten Steps for Successful Breastfeeding states to "*Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center*."

To address the racial/ethnic disparities in breastfeeding initiation and duration in NC, this strategy will target minority-women and their social networks to increase support, access, knowledge, and resources. In NC, NH African American, NH-Native American/American Indian, and Hispanic women have the lowest rates of breastfeeding.

Scope of Services
Provide culturally and linguistically appropriate education to individuals of reproductive age to increase the initiation and continuation of breastfeeding. Educational opportunities may include community outreach events; educational workshops; distribution of educational materials; or preconception, prenatal, and postnatal counseling.
Provide education and training on breastfeeding guidelines as recommended by the American Academy of Pediatrics (AAP) to all clinical and non-clinical staff in the local health department and other public/private health care practices* who interact with women of reproductive age or infants to recognize that breastfeeding is a normal physiologic process that has short- and long-term benefits for the mother-baby dyad.
Implement and enhance connections with community-based and faith-based organizations to promote the normalcy of breastfeeding within the social support systems (fathers, partners, grandmothers, church members, and neighbors) for individuals of reproductive age. This includes, but is not limited to, implementing or enhancing breastfeeding support groups, breastfeeding classes, breastfeeding rooms, or

education for family and social networks.

Maintain a designated group to manage breastfeeding policy development and review LHD staff orientation, and education in the service area(s).

Strengthen partnerships between the LHD and Title V program providers, WIC, maternity care/perinatal care, quality improvement partners, state and local breastfeeding coalitions, and faith-based and community-based organizations. Partnerships should focus on increasing access to peer support groups within the community.

Utilize social media, including radio, television, the internet, billboards, or newspaper, to increase the awareness of breastfeeding for the mom-baby dyad.

Select one (1) of the following Scope of Services to implement in addition to the above listed activities:

Making it Work: Empowering Employers and Mothers:
Utilize approved resources for increasing the number of breastfeeding friendly businesses/worksites in the service area. LHDs should provide education, consultation, and information to the businesses/worksites. Resources include the adapted Making It Work Toolkit (https://www.workwellnc.com/NCMakingItWork.php) and the Businesses Leading the Way: (http://www.nutritionnc.com/breastfeeding/index.htm)

Breastfeeding Friendly City Program:
Collaborate with communities in the service area(s) to increase the support for breastfeeding family through the implementation of the Breastfeeding Friendly City program, which includes implementing some of the following strategies within designated communities:

Developing or enhancing a local breastfeeding coalition;

Developing community-based peer support groups, such as La Leche League or similar mother-to-mother groups;

Working with at least one community hospital to apply for the North Carolina Maternity Center Breastfeeding Designation or to pursue designation as a Baby Friendly Hospital;

One public establishment for every 1000 community citizens or 25 (whichever is less) participate in the "Breastfeeding Welcomed Here" program; and

One employer for every 5000 community residents or 10 (whichever is less) to receive the "Breastfeeding Employee Support Award" from the Making It Work initiative.

For more information, review

AMCHP Communities Supporting Breastfeeding
Carolina Global Breastfeeding Institute (CGBI): Breastfeeding Friendly Community Designation

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Shared Decision-Making using Patient Decision Aids:
Implement a shared decision-making process with the use of patient decision aids that will promote the best

clinical evidence for breastfeeding. Patient decision aids must be integrated into the clinical workflow to assist with the patient's "decision journey". This strategy will allow patients to contemplate options, gather additional information, consult with family and friends, consider individual preferences, and address their personal concerns. The shared decision-making process will increase provider-patient engagement and allow health care providers and patients to make informed, explicit decisions together. Patient decision aids can be in the following formats written, video, or web based. Breastfeeding decision aids will include evidence-based information & practices; present information objectively; be written in appropriate reading and literacy level; and allow patients to clarify their preferences/values. LHDs selecting this strategy will incorporate breastfeeding-focused decision aids at specific prenatal care visits as well as targeted decision aids for the support systems of patients. After patient or family member reviews the decision aid, the provider will follow up with a targeted discussion to engage the patient in dialogue about the content just reviewed. Additional information about Patient Decision Aids can be found: https://decisionaid.ohri.ca/implement.html or http://familiesusa.org/sites/default/files/product_documents/Shared-Decision-Making.pdf

Implement Prenatal Breastfeeding Education:
The LHD shall provide prenatal breastfeeding education that follows the Carolina Global Breastfeeding Institute's (CGBI) Ready, Set, BABY curriculum (or similar curriculum that adheres to Baby-Friendly, USA's requirements for prenatal breastfeeding education) for increasing pregnant families access to prenatal breastfeeding education. This may include the development of free prenatal breastfeeding classes offered on a consistent schedule and advertised to the community, partnering with external entities (breastfeeding support groups, medical providers, maternity care centers, and retailers) to develop or enhance prenatal breastfeeding support. CGBI's Ready, Set, BABY curriculum can be found at: https://sph.unc.edu/cgbi/resources-ready-set-baby/

Establish Public Lactation Rooms:
The LHD shall provide a lactation room for the public in accordance with the "Fairness for Breastfeeding Mothers Act of 2019". The LHD should work with other "Covered Public Buildings" to establish the required Lactation Room. Additional information about the requirements of the "Fairness for Breastfeeding Mothers Act of 2019" can be found at https://www.congress.gov/bill/116th-congress/senate-bill/528/text.

Performance Measures

Increase the percentage of infants who are breastfeeding at discharge from the hospital.

Increase the percentage of WIC-eligible infants who are breastfeeding at six and 12 months.

Increase the number of unduplicated individuals of reproductive age, and members of their social support who received education, support, and information to increase the initiation and continuation of breastfeeding.

Increase the number of staff and health care providers from the local health department and other public/private health care practices* that receive training to support the initiation and continuation of breastfeeding individuals.

Increase the number of collaborations with partner organizations, community-based and faith-based organizations that support breastfeeding individuals and their families.

Increase the presence of social media messages that provide information about the importance of breastfeeding.

Select appropriate performance measure(s) to match the selected scope of service above:

Increase the number of businesses/worksites that are breastfeeding-friendly for patrons and/or employees.
The number of organizations, businesses, hospitals, day care/childcare centers, etc. that are engaged in working towards the Breastfeeding Friendly City Program.
Increase the number of staff and health care providers from the LHD and other public/private health care practices* who are trained and implementing Patient Decision Aid practices.
Engage 100% of individuals during their prenatal care visit in one or more targeted decision aids followed by prompted discussion with provider about breastfeeding during their prenatal visit at the LHD and other public/private health care practices.
Increase the number of public lactation rooms in the service area.
Reporting/Monitoring Requirements The following reporting/monitoring requirements may be tracked by the grantee and/or the grantor.
The number and type of breastfeeding education training that staff and health care providers in the local health department and at other public/private health care practices* participate.
The number of community-based and faith-based organizations that support breastfeeding individuals and their families with breastfeeding support groups, breastfeeding education classes, breastfeeding rooms, etc.
The number and type of partnerships that have developed in the service area with stakeholders and other programs.
Select the appropriate reporting requirement(s) to match the selected scope of services
The number of businesses/worksites that are engaged in becoming breastfeeding-friendly for patrons and/or employees.
Provide information on the initiation and progress of counties/ communities/etc. that begin the process to becoming a Breastfeeding Friendly City Program.
The number of staff and health care providers who are trained and implementing Patient Decision Aid method.
The number of individuals who have been engaged with one or more of the patient decisions aids during their prenatal visit in the LHD and other public/private health care practices.
The number of public lactation rooms available in the service area.

*Other private/public health care providers or facilities include, but are not limited to federally qualified community health centers (FQHC), OB/GYN, family medicine, pediatric practice, rural/migrant health centers, etc.

PROGRAM AIM 3: Improve Child Health, age 0 - 5
1. Triple P

The overarching goals of Triple P are:

- To promote the independence and health of families through the enhancement of parents' knowledge, skills, confidence, and self-sufficiency.
- To promote the development of non-violent, protective, and nurturing environments for children.
- To promote the development, growth, health, and social competence of young children.
- To reduce the incidence of child maltreatment and behavioral/emotional problems in childhood and adolescence.
- To reduce out-of-home placements.
- To reduce emergency department visits related to child abuse and neglect.
- To reduce out of childcare/school suspensions related to behavioral issues.

There are five levels of Triple P which go from conducting a media-based parent information campaign, to providing brief group and individual sessions, to providing intensive individually tailored programs. The level of intervention is based upon the needs of the parents and family. A Triple P provider must receive training to become an accredited provider in each Triple P level of services. The five Triple P levels are:

- Level one – conduct a media-based parent information campaign.
- Level two – provide specific advice to parents on solving common child developmental issues and minor behavioral problems.
- Level three – provide brief programs (60 minutes over four sessions) combining advice with rehearsal and self-evaluation as required to teach parents to manage discrete child problem behaviors.
- Level four – provide a broad-focus program (about 10 hours over 8 to 10 sessions) for parents requiring intensive training in positive parenting skills, generalization enhancement strategies and application of parenting skills to a range of target behaviors.
- Level five – provide intensive individually tailored programs (up to 11 sessions) for families with child behavior problems and family dysfunction. Program modules include practice sessions, mood management strategies, stress coping skills, partner support skills, attribution retraining and anger management

Scope of Services

Adhere to the standards set by Triple P America, as described in the *Triple P Implementation Manual*, to ensure that the project is implemented with model fidelity.

Hire and maintain a 1.0 FTE local Triple P Implementation Specialist (Coordinator) to oversee the expansion of Triple P under this Agreement Addendum. This person will participate in quarterly North Carolina Triple P State Learning Collaboratives, work collaboratively with DPH's Triple P Program Manager, and participate on other local community advisory boards to assure integration of Triple P into the system of care as applicable.

By August 31, 2022, develop an implementation plan for the service area and submit it to the DPH Triple P Program Manager for review and approval using the template provided by Triple P America with guidance from the DPH Triple P Program Manager and Triple P America. The implementation plan is to include:

1. A training schedule for practitioners to access the various levels of Triple P to be implemented in the service area.

2. A plan for peer-to-peer coaching sessions for trained practitioners.

3. A plan for data collection across the service area.

4. A community outreach plan that includes media strategies for both caregivers (families) and practitioners (those providing services to families).

5. An annualized budget.

6. A practitioner/child-serving agency support plan, including the use of parent support materials, refresher and attrition training, Peer Assisted Supervision and Support (PASS), Triple P integration into the child-serving agency, and practitioner service delivery plan.

7. Job descriptions and work plans for key staff.

8. Only one implementation plan for both Title V and ICO4MCH Triple P activities needed.

Maintain membership and participation in the service area - Triple P Implementation Team that includes representatives from the other partner counties in the service region. The Triple P Implementation Team will meet quarterly and will advocate for the implementation or continuation of Triple P in the county or counties and support strategies for sustainability. They will also develop, maintain, and update, as needed, Memoranda of Agreement with local child serving agencies and practitioners to engage them in participation in Triple P provider training courses (inclusive of pre-accreditation, accreditation, and workshops), delivery of Triple P, and support (peer coaching and data reporting) for the local Triple P efforts.

Develop, maintain, and update as needed a Letter of Agreement (LOA) with local agencies participating in the coordinating council that support the local Triple P efforts.

Develop and maintain an agreement with Triple P America for ongoing technical assistance and support.

Participate in the NC Triple P State Learning Collaborative (Collaborative). The Collaborative will share best practices, provide peer support, monitor data collection, and develop quality improvement strategies, share social marketing strategies, establish a network of open enrollment trainings, and participate in professional development opportunities.

Coordinate with the Triple P Online State Coordinator to provide local support for families in the service area(s) who are accessing Triple P via the online modules.

Performance Measures

Increase the number of families/caregivers with children ages 0–5 served.

Increase the number of children ages 0–5 served.
Increase satisfaction among families/caregivers with children ages 0–5 within the pre-test and post-test intervention surveys.
Increase the number of Triple P Online users who have children ages 0–5.
Increase the number of practitioners (child serving agencies and other practitioners) where children ages 0–5 are served who receive accreditation by Triple P America, including childcare centers, day care centers, home visiting programs, pediatric and family practice clinics, faith-based facilities, etc.
Decrease the number of childcare suspension or expulsions due to behavioral issues for children ages 0–5 served.
Increase outreach and educational activities among parents/caregivers of children, ages 0 – 5, for the Triple P Online program and Triple P programs.
Reporting/Monitoring Requirements   The following reporting/monitoring requirements may be tracked by the grantee and/or the grantor.
The number of children, 0–5 served.
The number of practitioners who provide services for families with children ages 0 – 5, who are trained and accredited.
The number of outreach and educational events for Triple P online programming and Triple P in the service area(s) for parents/caregivers.
LHDs that are interested in selecting Triple P (Positive Parenting Program) as one of its evidence-based programs **must contact Triple P America** in Columbia, South Carolina **before responding to this RFA**. The contact for Triple P America is Sara van Driel at sara@triplep.net or 803-719-1110.
2. Family Connects Newborn Home Visiting Program
The overarching goal of the Family Connects Newborn Home Visiting program is to reduce emergency medical care costs through improvement in parenting and infant well-being. All parents of newborns 2–12 weeks old born in the service area are eligible for this service. Family Connects Newborn Home Visiting provides the following services: 1. One home visit by a registered nurse to all parents of newborns living in service area   2. Two additional home visits are available from the nurse home visitor for families who need additional support.   The grantee will sub-contract with the Center for Child and Family Health (CCFH) for technical assistance, data management, and model implementation.

Scope of Services
Hire and maintain a home visiting staff composed of 1.0 FTE Nurse Home Visitor for every 200 births in the service area (total FTE will depend on the total number of births in the service area).
For each active family, utilize the required service delivery and assessment forms collected and stored in the CCFH database.
Contact the families of at least 70% of all resident births within the service area by telephone.
Conduct an initial home visit with the families of at least 75% of the resident births who received an initial phone call inquiry.
Utilizing the Family Support Matrix, nurses will maintain an inter-rater agreement of at least 75%. The nurse home visitor rating for each factor reflects the level of family needs and risk of future problems. The Family Support Matrix includes four domains known to predict parent and child well-being and to prevent child maltreatment. These include four domains (health care, caring for an infant, safe home and parent support) with three questions in each domain (a total of 12 factors). The following scores indicate the level of risk and subsequent action: • A score of 1 is identified as "no or low risk" and receives no subsequent intervention. • A score of 2 is identified as "mild to moderate risk" and receives short-term nurse-delivered intervention on a topic over 1 -3 sessions. • A score of 3 is identified as "high risk" and receives a connection or referral to a community resource tailored to address the specific family need. • A score of 4 is identified as "immediate danger" and receives immediate emergency intervention. • The inter-rater agreement metric is the cumulative rate of agreement between nurse home visitors and the nursing supervisor in rating the family risk during the Quality Assurance checks conducted quarterly by the nursing supervisor.
Maintain nurse fidelity to the home visit model protocol of at least 75%. The metric is a cumulative rate of overall nurse home visitor adherence to the manualized protocol as measured by the Quality Assurance checks conducted quarterly by the nurse supervisor. The nurse fidelity checklist contains 62 individual model components which are covered in each integrated home visit. The components cover the following domains: • Introduction by the nurse (a total of 4 components); • Support for health care with supportive guidance (a total of 17 components); • Support for caring for the infant with supportive guidance (a total of 8 components); • Support for a safe home with supportive guidance (a total of 15 components); • Support for parents with supportive guidance (a total of 8 components); • Written screeners (a total of 2 components); and • Planning (a total of 8 components).

Deliver all program services based on the *Family Connects Implementation and Policies Manual*.
Performance Measures
Complete home visits in the service area with 60–70% of all births in the service area.
Complete an integrated home visit with at least 75% of all families who agreed to participate in the program.
Complete successful home visits with families who require one or more visits after the completion of the initial integrated home visit with at least 75% of all families.
Complete successful follow-up phone calls with families who require one or more substantive phone calls after completion of the initial integrated home visit.
Complete successful referral linkages with parents who received one or more referrals for long-term support.
Have observed fidelity to the home visitor model protocol in at least 75% of home visits.
Have nurse inter-rater reliability agreement with the Family Status Index in at least 75% of home visits
Participate in weekly case conference meetings at the CCFH.
Complete documentation of family demographics on all families participating in the program.
Reporting Requirements   The following reporting/monitoring requirements may be tracked by the grantee and/or the grantor. Data shall be submitted from the monthly-quarterly reports provided by the purveyor, when available.
Number of infants born in the service area to residents.
The number of home visits scheduled.
The number of in-home visits completed.
The number of families receiving one or more follow-up in-home visits or telephone calls after completion of initial integrated home visit.
The number of families receiving one or more referrals for long-term support.
The number of referrals resulting in successful connections with community agency/ resource.

The percentage of nurse fidelity to the home visit model protocol.
The percentage of nurse inter-rater agreement the rating family risk using the Family Support Matrix.
Documentation and summary of case review meetings as required by CCFH and the LHD.
Family demographics which include maternal and child characteristics collected on all families participating in the program.
Local Health Departments that are interested in selecting the Family Connects program as one of its evidence-based programs **must contact the Center for Child and Family Health** (CCFH) in Durham, North Carolina **before responding to this RFA**. The contact at the CCFH is at 919-491-9883 or visit the website: https://www.ccfhnc.org/

Appendix B: Online County-Level Data Sources

A. STATE CENTER FOR HEALTH STATISTICS (SCHS) WEBSITE

1. Basic Automated Birth Yearbook (BABYBOOK)
   Table 1 - By Age of Mother and Birth Order
   Table 2 - By Age of Mother and Birth Order According to Marital Status
   Table 3 - By Age of Mother and Birth Weight in Grams
   Table 4 - By Education of Mother and Birth Weight in Grams
   Table 5 - By Month Prenatal Care Began and Education of Mother
   Table 6 - By Month Prenatal Care Began and Age of Mother
   Table 7 - By Month Prenatal Care Began and Marital Status of Mother
   Table 8 - By Month Prenatal Care Began and Birth Order
   Table 9 - By Month Prenatal Care Began and Birth Weight in Grams
   Table 10 - By Number of Prenatal Visits and Education of Mother
   Table 11 - By Number of Prenatal Visits and Age of Mother
   Table 12 - By Number of Prenatal Visits and Marital Status of Mother
   Table 13 - By Number of Prenatal Visits and Birth Order
   Table 14 - By Number of Prenatal Visits and Birth Weight in Grams
   Table 15 - By Month Prenatal Care Began and Number of Prenatal Visits
   Table 16 - By Medical History, This Pregnancy, and Birth Weight in Grams
   Table 17 - By Maternal Smoking, This Pregnancy, and Birth Weight in Grams
   Table 18 - By Maternal Pre-Pregnancy BMI, This Pregnancy, and Birth Weight in Grams
   Table 19 - By Characteristics of Labor and Delivery and Birth Weight in Grams
   Table 20 - By Onset of Labor and Birth Weight in Grams
   Table 21 - By Method of Delivery and Birth Weight in Grams
   Table 22 - By Conditions of Newborn and Birth Weight in Grams

2. BRFSS Survey Results (not county specific, but state and regional data available)

3. Child Deaths in NC (grouped by cause and also by age group)

4. County Health Data Book
   Population
   - July 1, 2017, Population Estimates by Age, Race, and Sex

   Pregnancy and Live Births
   - 2013-2017 Pregnancy Rates per 1,000 Population, by Race/Ethnicity for Females 15-17, 15-19, and 15-44
   - 2013-2017 Fertility Rates per 1,000 Population, by Race/Ethnicity for Females 15-17, 15-19, and 15-44
   - 2013-2017Abortion Rates per 1,000 Population, by Race/Ethnicity for Females 15-17, 15-19, and 15-44
   - Live Birth Rates per 1,000 Population, 2013-2017
   - 2013-2017 Number At Risk NC Live Births due to High Parity by County of Residence Age of Mother Under 30 and Age of Mother 30 or More

- [2013-2017 NC Live Births by County of Residence; Number with Interval from Last Delivery to Conception of Six Months or Less](#)
- [Low (<2500 grams) and Very Low (<1500 grams) Weight Births by Race/Ethnicity, 2013-2017](#)
- [Births Delivered by Cesarean Section, 2013-2017](#)
- [Births Delivered by Gestation, 2013-2017](#)
- [Births Where Mothers Smoked During Pregnancy, 2013-2017](#)
- [Births to Medicaid and WIC Mothers, 2012-2016](#)

2017 Birth Indicator Tables by State and County - Risk Factors and Characteristics by Race/Ethnicity for All Births, Medicaid Mothers, and Mothers Receiving WIC during the Prenatal or Postpartum Period: https://schs.dph.ncdhhs.gov/data/births/2017.htm

Tables include:
- [Birthweight Group](#)
- [Weeks of Gestation](#)
- [Mother's Age](#)
- [Mother's Education](#)
- [Marital Status](#)
- [Parity](#)
- [Plurality](#)
- [Trimester Care Began](#)
- [Kotelchuck Adequacy of Prenatal Care Index](#)
- [Mother Smoked](#)
- [Gestational Diabetes](#)
- [Maternal Pre-Pregnancy BMI](#)
- [Method of Delivery](#)
- [Infant Breastfed at Discharge](#)

Life Expectancy
- [Life Expectancy at Birth for State, 2017 and County, 2015-2017](#)
- [Years of Potential Life Lost, Totals and by Sex, 2013-2017](#)

Mortality
- [Fetal Death Rates per 1000 Deliveries, 2013-2017](#)
- [Neonatal (<28 Days) Death Rates per 1000 Live Births, 2013-2017](#)
- [Postneonatal (28 Days - 1 Year) Death Rates per 1000 Live Births, 2013-2017](#)
- [Infant Death Rates per 1,000 Live Births by Race/Ethnicity, 2013-2017](#)
- [Unadjusted Child Death Rates per 100,000 Population, 2013-2017](#)
- [Unadjusted Death Rates per 100,000 Population, 2017 and 2013-2017](#)
- [Death Counts and Crude Death Rates per 100,000 Population for Leading Causes of Death, by Age Groups NC 2013-2017](#)
- [Unintentional Poisoning Mortality Rates per 100,000, 2013-2017](#)
- [2013-2017 Race-Sex-Specific Age-Adjusted Death Rates by County](#)
- [2013-2017 Race-Specific and Sex-Specific Age-Adjusted Death Rates by County](#)

Morbidity

- 2013-2017 NC Cancer Incidence Rates per 100,000 Population Age-Adjusted to the 2000 US Population
- Projected New Cancer Cases and Deaths by County, 2017

5. Detailed Mortality Statistics

6. Infant Mortality Statistics
   - County-by-county Listing of Final Infant Death Rates for 2017
   - Infant Death Rates by Perinatal Care Regions (PCR) and County of Residence, NC 2016, 2017 and 5-year totals 2013-2017 Table   Maps

7. NC Health Statistics Pocket Guide 2017
   - Table 7. Demographic, Economic, and Health Resources Data
     Resident Population - July 1, 2017 (and available in Excel here)
     Economic and Health Resources Data (and available in Excel here)
     Birth and Medicaid Statistics (and available in Excel here)
   - Table 8. Selected Health Indicators
     Pregnancy Statistics Total and Females, 15-19 (and available in Excel here)
     Mortality and Morbidity Statistics (and available in Excel here)

8. NC Reported Pregnancies

9. NC Vital Statistics, Volume I

10. NC Vital Statistics, Volume 2

11. Selected Data from the NC Office of the Chief Medical Examiner (OCME) - Data are for 2007-2017, and the reporting of means of death is incomplete for deaths which occurred in 2014 and 2015.

12. NC Statewide and County Trends in Key Health Indicators
    For each county in NC, the SCHS has produced 24 graphs representing trends in key health indicators at both the county and state levels over approximately the past 15 years (latest data is for 2017). In order to ensure a fair degree of stability in rates and trends when annual numbers for a county may be relatively small, several years of data have been grouped together and averaged out for each indicator, resulting in three data points for each indicator. Example of a county data report can be found at here: http://www.schs.state.nc.us/data/keyindicators/reports/Alamance.pdf.

    LIST OF INDICATORS
    1. Percentage of Resident Live Births Classified as Low Birthweight
    2. Percentage of Resident Live Births Classified as Very Low
    3. Percentage of Resident Live Births that were Premature
    4. Percentage of Resident Live Births Delivered by Cesarean Section
    5. Teen Pregnancies (Ages 15-19) per 1,000 Female Residents
    6. Percentage of Resident Teen Pregnancies (Ages 15-19) that Were Repeat

7. Infant Deaths per 1,000 Live Births
8. Child Deaths per 100,000 Residents Ages 0-17
9. Age-Adjusted Cardiovascular Disease Death Rates
10. Age-Adjusted Heart Disease Death Rates
11. Age-Adjusted Stoke Death Rates
12. Age-Adjusted Diabetes Death Rates
13. Age-adjusted Colorectal Cancer Death Rates
14. Age-Adjusted Trachea, Bronchus, & Lung Cancer Death Rates
15. Age-Adjusted Female Breast Cancer Incidence Rates
16. Age-Adjusted Prostate Cancer Incidence Rates
17. Age-Adjusted Unintentional Motor Vehicle Death Rates
18. Age-Adjusted Other Unintentional Injury (excluding MVA) Injury Death Rates
19. Age-Adjusted Homicide Rates
20. Age-Adjusted Suicide Death Rates
21. Number of Primary Care Physicians per 10,000 Residents
22. Number of Dentists per 10,000 Residents
23. Number of Registered Nurses per 10,000 Residents
24. Number of Physician Assistants per 10,000 Residents

13. Life Expectancy - State & County Estimates

B. DATA AVAILABLE ON NC CHILD WEBSITE/KIDS COUNT NC

1. 2019 Child Health Report Card County Data Cards
   Data are provided on a variety of social, economic, and health outcomes for each county as a
   supplement to the NC Child Health Report Card 2019. An example of a data card can be
   found here: https://www.ncchild.org/publication/2019-county-data-cards/
2. KIDS COUNT Data Center
   NC county-level data are available for a variety of demographic, economic well-being,
   education, health, and safety and risky behaviors indicators.

<u>Appendix C: Documentation of previous questions and answers from Improving Community Outcomes for Maternal and Child Health project FY16-19, Bidder's Webinar and Open-time for Questions and Answers</u>

1. **Question: Letters of Commitment and Memorandums of Agreement, should these be by year or for both years of the grant?**
   Answer: Those that are submitting Letters of Commitment and/or Memorandums of Agreement should write a letter covering the entire period of the grant (2 years).

2. **Question: If the agency is on the Collective Action Team (CAT) and providing services for some of the interventions, can they write one letter, or does it need to be two separate letters?**
   Answer: One letter for both is sufficient. The MOA should state the CAT involvement and role along with the details of services the agency is providing.

3. **Question: In the RFA, it says not to delete the question headers. Does this refer to the actual question or the number?**
   Answer: Keep the question headers, keep the numbers of the question. Type your answer under each header.

4. **Question: Do you have a preferred citation style for the endnotes of the needs assessment? Would links be sufficient?**
   Answer: Links are not sufficient. Please follow the Citation Guide listed under the RFA#XXX heading, entitled" Guidance for Citing Sources in the Needs Assessment." The guide can be found on the Women's Health Branch website.

5. **Question: Regarding the budget, please define what administrative costs are? Do administrative costs include salary and fringe?**
   Answer: Administrative costs or "overhead" are the things that keep your organization operating smoothly and efficiently but are not necessarily tied to any one direct service. They can include such things as: Administrative staff salary and fringe for the Executive Director, Finance Director, Human Resources, the receptionist, and clerical staff not dedicated to specific programs; Office space used by administrative staff, including costs of rent and utilities; Equipment and services used by everyone such as copiers, phone systems, janitorial service, and IT support; Board expenses; Fundraising & marketing expenses; Liability insurance; Staff training, etc.

6. **Question: Can the money be used to purchase the long-acting reversible contraceptives (LARC) for providers, including health department providers and private providers?**
   Answer: Yes, the funding can be used to purchase LARCs for the health departments and providers to cover the cost for women who do not have an insurance payer source. You must ensure that only local health departments and federally qualified health care centers receive the reduced 340B pricing; private health care providers must be charged the normal rate.

7. **Question: Do the local health directors of the multi-county area who are applying for the grant need to provide a Letter of Commitment to be included in the RFA packet?**

Answer: If counties are only serving on the Collective Action Team (CAT) and are <u>not</u> part of a multi-county application, then the local health director of those counties should write a Letter of Commitment (LOC) to be included in Attachment B of the RFA packet. The LOC should explain:

- *The multi-county group;*
- *Their role in the multi-county group; and*
- *Past/current collaborations.*

If multiple counties are working together and are submitting a multi-county application then a Memorandum of Agreement (MOA) between the lead health department and <u>each</u> of the local health departments in the multi-county application must be included in Attachment C. A separate Letter of Commitment from the non-lead counties is not required however, the MOA should include the specific contribution from the agency to the specific evidence-based strategy and should detail:

- *Participation in the Collective Action Team (CAT);*
- *Commitment to implementation of the program; and*
- *Services to be provided (including referrals).*

The application cover letter should explain the relationship between the health departments in the multi-county group and, if they are the lead county, explain how other counties will work with them or, if not the lead county, explain how they will work with the lead county. The cover letter should be on the letterhead of the lead agency.

Please note that the health districts Martin-Tyrell-Washington Health District, Toe River Health District, Appalachian Health District, and Albemarle Regional Health Services are considered to be one entity representing all the counties in their district. An MOA would only be required if the health district was partnering with a county outside of their district.

8. **Question: Who can be a sub-contractor and how does it work if you have a multi-county or health district?**
   Answer: Based on your county guidelines, potentially nonprofit community-based organization or local government agency may be a sub-contractor if they are going to be assisting in the implementation of the project. Multi-counties and health districts can sub-contract to other health departments in their group. The lead health department can sub-contract to a community-based organization or other agency to implement the work. Please refer to the Consolidated Agreement for specific subcontracting provisions and restrictions, including but not limited to, Section C, "Fiscal Control" 1.b. – d.

   If the health department is sub-contracting services, the budget should specify exactly what the sub-contracted amount will be paying for. Do not list only a grand total for the sub-contractor, you must be specific.

9. **Question: What if I am a county that already has Triple P and/or Family Connects Home Visiting?**
   Answer: Any county applying for the RFA that currently receives funding for Triple P or Family Connects Home Visiting should include a current copy of their contract or agreement

addendum that identifies the scope of work and deliverables. This should be included as an addendum in the application packet, and you should clearly describe how you are expanding your current program.

10. **Question: Do health departments who already receive Triple P funding need to contact Triple P America too? We plan to partner with multiple counties, and we are the only district with Triple P funding, would we need to contact TPA to give them a heads up about this regional approach?**
Answer: Yes, if any county is considering implementing Triple P or currently has Triple P and wants to expand under this RFA, contact Sara van Driel at Triple P America, 803-719-1110 or sara@triplep.net.

11. **Question: For counties currently receiving Triple P funds-can these funds be used for sustaining services?**
Answer: No, this is a new RFA and the money for this program cannot be used to sustain existing programs. It must be used, in the example of Triple P, to expand and enhance what is currently in your contract or agreement addendum. If, because of the upcoming reorganization of Triple P funding anything beyond what that funding can support will be considered an expansion of services.

12. **Question: Please clarify that in a multi-county application all county health agencies should include their information in Section 4, Agency Ability and include each of the attachments in Attachment A, Agency Information.**
Answer: Section 4, Agency Ability should explain each of the counties in the multi-county group. Answer each of the questions for each of the counties. In Attachment A, each local health department should provide the organizational chart. The lead local health department is the only LHD that should provide a Tax ID number. The job descriptions and Collective Action Team (CAT) information should be a collaborative document for the multi-county or health district.

Appendix D: Health Equity Impact Assessment Tool Kit

#impactEQUITYNC

North Carolina Health Equity Impact Assessment

The Health Equity Impact Assessment Tool: Overview

Health inequities are complex and typically longstanding problems that affect our communities. These unjust outcomes are further impacted by policies and programs created with the intention of improving quality of life. By acknowledging the factors that contribute to health disparities and health inequities, we can be inclusive and systematic in our approach to address the inequities that negatively impact the health of certain populations. **The Health Equity Impact Assessment (HEIA) encourages focus on a particular policy/program and its impact on health disparities and health inequities.** The tool allows a team to think outside the box and consider all factors that could potentially impact the health of populations at risk.

The HEIA helps facilitate conversations about factors that support or weaken health, including the root causes of disparities and inequities. Information gathered throughout this process will provide community perspective and guide your team in strategic planning to modify an existing or proposed policy/program. The HEIA will help to develop concrete methods and action steps aimed at improving policies/programs in the hope of reducing health disparities and inequities within the impacted population(s). In addition, the HEIA will:

- **Analyze Data** to determine potential impact of policies/programs.
- **Involve Stakeholders and Impacted Populations.** Effective health equity assessments require early and continued involvement of members of impacted populations. It is important to have knowledge of the community (resources, contacts, and partners) and to gain their perspective on current policies and programs as well as understand the potential impacts on the community, both positive and negative.
- **Identify** ways to modify current or proposed policies or programs to ensure they reduce health disparities and inequities; **NOT** make them worse.
- **Provide information** on uneven impacts on various populations or communities.
- **Recommend** modifications to policies or programs that promote equity and ease negative impacts.

The HEIA consists of three Pre-Work steps, team-building activities, four implementation steps, a glossary, and worksheets.

The Pre-Work

A small leadership team will complete two of the Pre-Work activities prior to the implementation of the HEIA.

Pre-Work A: Identify the Program/Policy and Implementation Team
During Pre-Work A, the leadership team will identify both the policy/program to be reviewed using the HEIA and the participants who are needed to implement the assessment (implementation team). Identifying the necessary participants and getting them onboard can take time. Recruitment and engagement of the identified participants is very dependent on relationships and having the right people reach out to potential team members.

Pre-Work B: Self-Assessment/Preparing your Team
Pre-Work B provides online resources and opportunities for both the leadership and implementation team members to assess and enhance their knowledge and skills associated with health equity, health disparities, and implicit biases. Pre-Work B resources should be shared with the implementation team at least two weeks prior to the assessment. The leadership team can copy and paste the information from Pre-Work B into an email or letter for the participants. Both the leadership and implementation teams will complete Pre-Work B. Appendix B has additional resources that can be shared with your implementation team.

Pre-Work C: Prepare your Data Profile
The leadership team will use Pre-Work C to prepare a data profile to be used as part of the assessment. The profile is used to highlight inequities and provide some description of the current state of disparities for a given community. Depending on the data needs, the time to complete this work will vary, but allow at a minimum two weeks to prepare the data profile.

Team-Building Activities
These activities provide opportunities to get to know each other better, form group norms, gain trust, and understand key terms and definitions. **The implementation team will need to be on the same page to discuss complicated and sensitive information, so these activities are important**. Take ample time either the day of the implementation or, if the team is available, at a prior time to engage the team in these activities.

Handouts

Each member of the implementation team should receive a copy of the *North Carolina Health Equity Impact Assessment Handouts for Day of Assessment* document. This document contains the worksheets for each of the four steps which will be completed as part of the assessment.

The Steps of the HEIA

- Step 1: Describe the current policy or program
- Step 2: Analyze and interpret the data profile
- Step 3: Identify modifications
- Step 4: Develop a monitoring plan

The four steps of the HEIA will be completed jointly by the leadership team and the implementation team on the day of the assessment. It is strongly encouraged to implement steps 1 – 4 of the HEIA at the **same time** with the **same group** of people. Based on experiences piloting the HEIA, it will take approximately five hours to implement all four steps of the HEIA, including break time.

The HEIA was implemented by five lead health departments and the NC Division of Public Health, Women's Health Branch in the summer and fall of 2018. The implementing agencies found there was insufficient time to complete step 4. Therefore, rather than rushing through each of the steps, the local leadership teams at each agency, in agreement with the implementation team, decided to use their allotted time to complete through step 3 and then complete step 4 at a

later date. Some of the agencies completed step 4 as a leadership team, while others reconvened the implementation team. Both processes worked for the agencies. After completing step 4, the leadership team sent out the monitoring plan to the implementation team for feedback as well as accountability.

Prior to implementing the HEIA with your implementation team, the leadership team should develop a contingency plan for completing the HEIA and what they would suggest to the implementation team if they cannot get through step 4.

In addition, if the leadership team decides to conduct the HEIA implementation on multiple days, make sure time is set aside each day to review and summarize the previous days' material. It is advisable to complete a full step before ending an implementation day. Failure to complete a full step may lead to confusion at the next implementation day.

Appendix E: Outline of data provided by DPH and the funded local health department

Appendix E

Outline of data provided by DPH to the funded local health department

The table below indicates additional data elements will be provided to the funded Local Health Department (LHD) by DPH. Data will be provided on a quarterly, bi-annual, or annual basis, depending on the evidence-based strategy (EBS). Data not listed will be provided by the funded LHD. This rubric is subject to change.

Evidence-based strategy	Data element	Procedure
Using a Reproductive Justice Framework to improve the utilization of reproductive life planning (RLP).	-Unique monthly users of long-acting reversible contraception (LARC) services in the LHDs	-DPH will provide the LHD-HSA data quarterly to the LHDs.
Preconception Health	-QuitlineNC data (includes all demographic and county specific data on registered callers)	-DPH will provide data quarterly to the LHDs
Tobacco Cessation and Prevention	-QuitlineNC data (includes all demographic and county specific data on registered callers) -Pregnant women who smoke/ use tobacco	-DPH will provide data quarterly to the LHDs -NC State Birth Certificate data, annually.
Ten Steps for Successful Breastfeeding	-Breastfeeding initiation rates -Breastfeeding duration at 6 and 12 months	-NC State Birth Certificate data, annually. -Nutrition Services Branch, Crossroad's data system, annually
Positive Parenting Program (Triple P)	-Triple P online data	-DPH will provide data quarterly to the LHDs
Collective Impact	-Focus group/key informant interview data.	-Evaluators, contracted with DPH, will provide site specific summaries to DPH and each LHD.

Appendix F: Citations

1. North Carolina State Center for Health Statistics

2. Small Area Health Insurance Estimates

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17. US Department of Agriculture; US Department of Health and Human Services. Dietary guidelines for Americans, 2020–2025. 9th ed. Washington, DC: US Department of Agriculture, US Department of Health and Human Services; 2020.

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