RFA # *A347*

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: Monday, October 16, 2017

DEADLINE DATE: Tuesday, November 21, 2017

INQUIRIES and DELIVERY INFORMATION:
Direct all inquiries concerning this RFA to:
Leslie deRosset, MSPH, MPH
Program Manager
Leslie.derosset@dhhs.nc.gov
919-707-5690 (phone)
919-870-4827 (fax)
Applications will be received until *5:00pm* on Tuesday, November 21, 2017

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: Leslie deRosset, 2nd floor
1929 Mail Service Center
Raleigh, NC 27699-1929

Street/Hand Delivery Address:
NC DHHS – Division of Public Health
WCHS, Women's Health Branch
Attn: Leslie deRosset
5601 Six Forks Road, 2nd Floor
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) Initiative 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, Division of Public Health, Women's and Children's Health Section, Women's Health and Children and Youth Branches.

The health of women of childbearing 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[1]

In 2014, North Carolina (NC) had the eighth highest infant mortality rate in the country with a rate of 7.1 per 1,000 live births as compared to the national rate of 5.8 per 1,000 live births in 2014. The NC infant mortality increased slightly in 2015 to 7.3 per 1,000 live births. Significant variance in rates among racial/ethnic groups continues in NC. Non-Hispanic (NH) African American infants had the highest infant mortality rate (12.5 per 1,000 live births) while NH-whites had the lowest (5.7 per 1,000 live births). NH-American Indian and Hispanic infants had a rate had a rate of 4.9 and 5.4 per 1,000 live births, respectfully. The infant mortality rate disparity ratio among NH-African American and NH-White infants was 2.2 in 2015, which is a slight decrease from the 2014 ratio of 2.5**.** Thirty-eight counties had a ratio higher than the state rate.

Child Health Insurance[2]

According to U.S. Census Small Area Health Insurance Estimates, 95.6% of children under the age of 19 had health insurance in 2015, an increase from 92.4% in 2011. However, disparities exist among racial/ethnic groups. In 2015, 94.4% of non-Hispanic American Indian, 90.8% of Hispanic, and 94.4% of Asian children had health insurance compared to 96.3% of non-Hispanic African American and 96.7% of non-Hispanic white children. Overall, 53.1% of all children under the age of 19 in North Carolina are covered by public health insurance, an increase from 47.9% in 2011.

Child Poverty[3,4]

The percent of children under five years of age living in poverty in North Carolina decreased from 29.8% in 2011 to 26.4% in 2015, according to the U.S. Census Small Area Income and Poverty Estimates. North Carolina continues to have higher rates of poverty than the national rate, which decreased from 25.8% in 2011 to 22.8% in 2015. North Carolina ranked eleventh among all states for poverty of children under five years of age. County-level data estimates for the percent of children under the age of five is available from the 2011-2015 American Community Survey. While the state

estimate from this survey is 28.4%, the estimated poverty levels ranged from 15.5% to 56.2% among North Carolina counties.

ELIGIBILITY

Only local health departments/districts are eligible and 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. 1,000 or more births in 2015 in the county(ies)

AND

2. At least ONE of the following:
   - Combined 2013-2015 infant mortality rate 10.7 or higher per 1,000 live births and 20 or more infant deaths;
   - Combined 2013-2015 infant mortality disparity ratio of 2.3 or higher;
   - Based on 2013 data, percent of children <5 years of age must be 42.6% or higher; or
   - Combined 2010-2014 percent of children <19 years of age who are uninsured must be 6.9% or higher.

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 2017. The eligibility tool can be found online: http://whb.publichealth.nc.gov.

FUNDING

Between four (4) and six (6) Improving Community Outcomes for Maternal and Child Health (ICO4MCH) Initiative 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, 2018 and end May 31, 2020.

II. BACKGROUND

Session Law 2017-57, Section 11E.3. (a.- d.) continues funding to the Division of Public Health 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. Funding began with an initial capacity-building focus with implementation funds on June 1, 2016. The law places the following requirements on the Division of Public Health (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 be 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 Initiative 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 three 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	Using a Reproductive Justice Framework to improve the utilization of reproductive life planning (RLP) and access to long-acting reversible contraception (LARC).
	Tobacco Use Screening, Counseling, and Documentation
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
	Clinical Effort Against Secondhand Smoke Exposure (CEASE)

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.

The ICO4MCH project should be implemented using the Collective Impact framework and the principles of implementation science. Each evidence-based strategy (EBS) should address the health inequities that result from health disparities.

COLLECTIVE IMPACT

The complexity and challenges facing communities to improve the health of women of childbearing 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 the principles of Implementation Science 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, clients, consumer and family leaders, and other representatives that should include hospital executives, 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 monthly throughout the funding period. The CAT will provide guidance and expertise during the planning, implementation, and evaluation of the project.

IMPLEMENTATION

Each funded ICO4MCH project will be required to work with an Implementation Coach from the National MCH Workforce Development Center (http://mchwdc.unc.edu/) throughout 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. The program manager at the funded ICO4MCH site will serve as the primary contact for the implementation coach. The Community Action Team (CAT) will participate in implementation capacity building. Each project should expect to work with the implementation coach at a minimum of three to four days per month in the early stages of the project. All applicants should budget $2,000 per month for the implementation coach.

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 risks or status 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.

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 January 5, 2018**.**

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 **October 16, 2017.**
http://www.ncdhhs.gov/about/grant-opportunities/public-health-grant-opportunities and posted on the Women's Health Branch's website http://whb.ncpublichealth.com/.

2. **Distribution of the RFA**
RFAs will be posted on the Women's Health Branch's website http://whb.ncpublichealth.com/ beginning **October 16, 2017.**

3. **Bidder's Conference / Teleconference / Question & Answer Period**
All prospective applicants are **required to attend** a Bidder's Webinar on **Monday, October 23, 2017 at 9:30am.** 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 RFA will be received until 5:00pm on Monday, October 30, 2017. Written questions should be emailed to: leslie.derosset@dhhs.nc.gov at the NC DPH, Women's Health Branch. All questions must be in writing. As an addendum to this RFA, a summary of all questions and answers will be posted on the Women's Health Branch website http://whb.ncpublichealth.com/ by Monday, November 6, 2017

4. Applications

Applicants shall submit **one** (1) **original**, four (4) copies of the application and one electronic version on thumb drive. All copies shall 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. The original application should be clearly marked "original" on the application face sheet. Mechanical, copied, or stamped signatures are not acceptable.

6. Copies of Application

Along with the **original application**, submit **four** (4) **copies** 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 format. An emailed electronic copy will not be accepted.

7. Format

The application must be typed, single spaced, 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.

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, required number of hard copies, and the electronic version. 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 **Tuesday, November 21, 2017.**

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 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. 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.

14. Application Process Summary Dates

10/16/2017: Request for Applications released to eligible applicants.
10/23/2017: **Required** Bidder's Webinar
10/30/2017: End of Q&A period. All questions due in writing by 5pm.
11/06/2017: Answers to questions posted, as an addendum to the RFA.
11/21/2017: Applications due by 5pm.
01/05/2018: Successful applicants will be notified.
06/01/2018: Proposed Agreement Addendum begins

VI. EVALUATION CRITERIA

The application is worth a total of 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)

VII. APPLICATION

Cover Letter (1 point)

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.

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 # *A347* 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

Health Equity (15 points)

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 (3) evidence-based strategies (EBS) will address health disparities in the service area(s) which perpetuate the health inequities. Each program aim 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 two of the three selected EBS. NOTE: If an 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, NC DPH will accept this in lieu of conducting a new assessment. The North Carolina Division of Public Health (NC 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 plan and/or evaluation plan. The Applicant will implement the third EBS using the HEIA within the first quarter of the second year of funding. Appendix D has a HEIA that can be utilized.

Section 1: Needs Assessment (10 points)

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, Applicants must: 1) understand how health inequities contribute to health disparities in North Carolina among the chosen EBS; 2) understand the factors that contribute to high infant mortality rates, particularly among minority populations; 3) understand the factors that contribute to poor maternal and infant birth outcomes; 4) understand the factors that contribute to improving the health status of children ages birth to five; 5) assess which of the factors are most relevant for the population they intend to serve; and 6) determine which EBS and policies 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 must state which three (3) 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 states. 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 women 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/smoking during pregnancy rates;
k. Tobacco/smoking rates among women, men, and adolescents;
l. Breastfeeding initiation rates among women;
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 women;
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 project. 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, Implementation Science, and Community Involvement (15 points)

Applicants should describe their experience utilizing the Collective Impact framework and the principles of Implementation Science 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. 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 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. Letters of commitment must be included in Attachment B.

The CAT must convene at least monthly and more often, if needed. Meeting minutes shall be taken and should include the names of the attendees, 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 Memorandum of Agreement (MOA) 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 MOA should include the specific contribution from the agency to the specific evidence-based strategy. All Memorandums of Agreement must be included in Attachment C.

Section 6: Budget (8 points)

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 evidence-based strategy. Note: Triple P and Family Connects Newborn Home Visiting Program have specific staffing requirements that must followed.

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, 2018 – May 31, 2019) and Year 2 (June 1, 2019 – May 31, 2020)] 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 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 $0.535 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 Division of Public Health 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.osbm.nc.gov/library

Current Rates for Travel and Lodging

Meals	**In State**	**Out of State**
Breakfast	$8.40	$8.40
Lunch	$11.00	$11.00
Dinner	$18.90	$21.40
Total Meals Per Diem Per Day	*$38.30*	*$41.00*
Lodging *(Maximum rate per person, excludes taxes and fees)*	$71.20	$84.10
Total Travel Allowance Per Day	**$109.50**	**$125.10**
Mileage	$0.535 cents 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 should 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. State funds may be used for non-cash incentives such as gift cards, travel vouchers, and healthy meals. If gift cards and/or travel vouchers are provided, Applicants must outline a plan to log them by serial number, maintain them in a locked storage cabinet and obtain the signature of program participants upon receipt of the cards/vouchers.

Implementation Costs
As described in the Scope of Services section of this RFA, each funded ICO4MCH project will be required to budget funds for an Implementation Coach from the National MCH Workforce Development Center throughout the two-year grant period. The monthly cost for the implementation coach is $2,000. This monthly cost must be included in both two-year project budgets (Year 1-2). Each project should expect to work with the implementation coach at a minimum of three to four days per month in the early stages of the project.

Under the Ten Steps for Successful Breastfeeding Scope of Services, all applicants will implement the required Scope of Services and be required to select one additional activity from the list of optional Scope of Services. If the applicant selects the Scope of Service, *Shared Decision Making using Patient Decision Aids*, applicant will need to budget a usage fee of $10 per program participant. Costs should be

budgeted for both budget years' periods. If the applicant selects either, *Making It Work or Breastfeeding Friendly Community Program*, Scope of Services, technical assistance will be supported by the Women's Health Branch. However, if sites determine more technical assistance is needed costs should be budgeted. Applicants should contact the Program Manager of the ICO4MCH project during the application process to discuss relevant budget costs.

Indirect Costs
Indirect costs are not allowed.

Attachment A: Agency Information

This attachment must include each of the following:

1. Organizational chart of the local health department.
    a. If this is a multi-county proposal, include an organizational chart for each local health department.
2. Job descriptions or resumes for all staff positions that are necessary to implement and support the project. Current staff should submit a resume. Future or proposed staff positions should submit a job description. current staff (resume) and job descriptions (future staff).
3. Provide a copy of a letter from the IRS which documents the lead local health department's tax identification number. The organization's name and address on the letter must match your current organization's name and address.

Attachment B: Letters of Commitment

This attachment must include letters of commitment 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: Memorandums of Agreement

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

VIII. APPLICANT'S RESPONSE

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**
4. **Project Budget on Open Windows Budget Form**
   - Include a budget in the format provided.
   - Budget narrative
5. **Attachment A: Agency Ability**
   - Organizational chart
   - Current staff position resumes/future staff job descriptions
   - Include: IRS Letter Documenting Your Organization's Tax Identification Number
6. **Attachment B: Letters of Commitment**
7. **Attachment C: Memorandums of Agreement**

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 Improving Community Outcomes for Maternal and Child Health 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 states. 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 women 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/smoking during pregnancy rates;
k. Tobacco/smoking rates among women, men, and adolescents;
l. Breastfeeding initiation rates among women;
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 women;
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 Local Health Department. (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 evidence-based strategies (EBS) 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 which 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 to 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 NC Division of Public Health. (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 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 she/he 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 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	☐ Job Description ☐ Resume

						☐ New Hire	
						☐ 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 stakeholders from the community) was/were involved in developing the selection of the evidence-based strategies (EBS), the program, implementation, and evaluation plans. Include information on how the CAT (or stakeholders from the community) with other 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, their role, and how long they have been involved with the CAT. Roles include: consumer, 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, child care, programming, training, etc.

Include a Memorandum of Agreement (MOA) from each agency describing the agency's contribution to the specific evidence-based strategy. Include the MOA in Attachment C.

Please insert additional rows if needed. (4 points)

Organization	Services Provided	EBS focus	Sub-Contract?	MOA 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 MOA) is acceptable. Identify in the chart where the LOC or MOA 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 (6/1/18 through 5/31/19) and Year 2 (6/1/19 through 5/31/20). 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 amounts 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 resumes of current staff, including in-kind staff
- Documentation of agency tax identification number from IRS.

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 MOA) is acceptable.

Attachment C
Memorandums of Agreement

This attachment must include each of the following:

- Memorandums of Agreement (MOAs) 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 MOA) is acceptable.

Appendix A: Evidence-based Strategy Scope of Services, Performance Measures, and Report Requirements

PROGRAM AIM 1: Improve Birth Outcomes

I. Using a Reproductive Justice Framework to improve the utilization of reproductive life planning (RLP) and access to long-acting reversible contraception (LARC).

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 men and women of reproductive age to engage in decisions about their reproductive future. Based on this framework all women should 1) have access to LARC if they select this as their contraception method of choice, 2) be able to decline LARC without judgement or pressure and 3) have access to LARC 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://files.nc.gov/ncdma/documents/files/1E7_1.pdf
A. Scope of Services
Offer educational workshops and trainings, within the LHD and at other public/private health care facilities* to educate women and men of childbearing 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.
Involve consumers of service (men and women of childbearing age) in developing and implementing educational materials, protocols, policies, and strategies to increase access to RLP and family planning methods, including LARCs.
Provide education 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.
Educate and train health care providers and staff at the LHD and other public/private health care facilities, using the reproductive justice framework and evidence-informed principles of RLP. This may include utilization of the One Key Question® as well as a tiered approach, and patient centered and culturally sensitive counseling to all patients of childbearing 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 and availability of LARC methods at the LHD and other public/private health facilities. Training should include: insertion and removal of IUDs/implants, tiered counseling, informed consent, potential side effects, and reimbursement and billing (including the Be Smart Family Planning Program).
B. Performance Measures
Conduct education with a minimum of 300 women and men of childbearing age, using a reproductive justice framework, about family planning methods, specifically LARCs, reproductive life planning (RLP), and a tiered approach to contraceptive counseling.
Conduct outreach and education, 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 local health department (LHD) patients who report access to all methods without pressure from providers.

Increase the percent of LHD providers and other public/private health care providers who participate in training. 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.
Increase the percent of LHD providers who utilize the RLP protocol when providing health care services to women in all LHD clinics (family planning, maternal health, etc.).
C. Reporting/Monitoring Requirements The following reporting/monitoring requirements may be tracked by the grantee and/or the grantor.
The number of women and men of childbearing 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 education. Data should include: topics discussed, location, basic demographics, and resources shared.
Conduct chart audits with 10% of client's electronic medical record in the family planning and maternal clinics in the LHD four times per year to assess the documentation: Reproductive Life Planning (#5), Education/Counseling (#12, boxes 1,2,5, and 6), and Client Method Counseling (#13, box 2).
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, billing and reimbursement, tiered contraceptive counseling, motivational interviewing, postpartum IUD/implant insertion.
The number of family planning clients who receive a LARC method on same day of request. Information will be collected through the North Carolina's Health Information System on a quarterly basis by the NC DPH Program Manager.
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. Tobacco Use Screening, Counseling and Documentation
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 women 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 child care 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/

A. Scope of Services

Train at least four key licensed professionals (physicians and non-physicians) to become certified tobacco treatment specialists CTTS). At least 50% of trained CTTS should be from facilities external to the LHD.

Assess 100% of all pregnant and postpartum women 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.

Provide tobacco/smoking cessation counseling to 100% of all applicable pregnant and postpartum women utilizing the 5As (Ask, Advise, Assess, Assist, Arrange) method.

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 100% 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.

Provide second- and third-hand smoke exposure resources to 100% of all applicable pregnant and postpartum women.

Document second- and third-hand smoke exposure in 100% of the client's medical record.
Refer clients to the QuitlineNC (1-800-784-8669) and/or the National Institute of Health's Smoke-Free text line support line (SmokefreeTXT, text QUIT to 47848).
Offer clients a (FDA) approved tobacco treatment pharmacotherapy or Nicotine Replacement Therapy (NRT) when clinically appropriate.
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.
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.
B. Performance Measures
Increase the number of certified tobacco treatment specialists (CTTS) in the county(ies).
Decrease the percentage of pregnant and postpartum women who use tobacco/smoke.
Increase the percentage of pregnant and postpartum who utilize the QuitlineNC services.
Increase the number of health care professionals, internal and external to the LHD, that utilize the 5As smoking cessation a counseling method into their clinical practice.
Increase the number of health care professionals, internal and external to the LHD, who participate and are trained in the 5As smoking cessation counseling method.
Increase the number of public policies for smoke-free or tobacco-free (inclusive of electronic nicotine devices such as e-cigs, vaping, etc.), and other indoor and outdoor public places within the services area.
Increase the awareness of primary, secondary, and tertiary smoke exposure, including environmental and tobacco policies, through paid and earned media opportunities in the service area(s).
C. Reporting/Monitoring Requirements The following reporting/monitoring requirements may be tracked by the grantee and/or the grantor.
Track the number of CTTS trained in the county.
Number of pregnant women who smoke/use tobacco.
Number of registered pregnant and postpartum callers to the QuitlineNC.
Number of 5As trainings and health care providers who participate. Specific data should be provided,

including: type of health care provider and place of employment (LHD, FQHC, hospital, private clinic, other public, etc.).
Number of pregnant and postpartum women who received counseling and cessation services using the 5As method and referrals made, in their electronic medical records.
Number of pregnant and postpartum women 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(s). Data should include qualitative information about workplaces, policies, etc.
Number of primary, secondary, and tertiary smoke exposure, including environmental and tobacco policies through paid earned media opportunities in the service area(s). Data provided should include any additional qualitative information such as examples of paid and earned media.
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 women 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 child care 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/
A. Scope of Services
Train at least four key licensed professionals (physicians and non-physicians) to become certified tobacco treatment specialists CTTS). At least 50% of trained CTTS should be from facilities external to the LHD.
Refer at least 75% of clients who use tobacco or have secondhand smoke exposure from the local health departments 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 (SmokefreeTXT, text QUIT to 47848).
Offer clients a (FDA) approved tobacco treatment pharmacotherapy or Nicotine Replacement Therapy (NRT) when clinically appropriate.
Assess 100% of all men and women, 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 local health department 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 local health department 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 women 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 and secondhand smoke exposure status in the client's electronic medical record 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.
Train at least four key licensed staff (physician and non-physician) to become Certified Tobacco Treatment Specialists (CTTS) within the service area, both internal and external to the Local Health Department (LHD). At least 50% of the CTTS trained should be employed at facilities other than the LHD.
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.
B. Performance Measures
Increase the number of callers to the QuitlineNC by 10% within the service area(s) (6% Medicaid/Medicare/uninsured and 4% other types of insurance).
Decrease the percentage of pregnant women 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 QuitlineNC 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).
C. Reporting/Monitoring Requirements The following reporting/monitoring requirements may be tracked by the grantee and/or the grantor.
Number of registered callers to the QuitlineNC.
Number of pregnant women, who smoke, and have been assisted with quitting tobacco by a licensed health care professional.
Number of health care professionals and health care systems who incorporate the 5A's smoking cessation counseling method into their clinical setting.
Number of tobacco use/smoking and/or secondhand smoke exposure documented in client's medical record.

Number of new smoke-free or tobacco-free worksites.
Number of new smoke-free or tobacco-free indoor public places.
Number of new worksites with a cessation program or contract with QuitlineNC.
Number of key licensed staff that become certified tobacco treatment specialists (CTTS). At least 50% of the trained CTTS should be external licensed professionals from the local health departments.
Use of paid and earned media messages to educate and inform on the impact of tobacco, secondhand smoke exposure and/or environmental policies.
Number of men, women, adolescents, children, and caretakers who receive the 5As smoking cessation counseling from a health care professional.
Number of 5As trainings to internal and external health care professionals and health care systems.
2. Ten Steps for Successful Breastfeeding, with a focus on Steps 3 & 10
Exclusive breastfeeding is considered one of the most effective preventative health measures to reduce child morbidity and mortality in the US and globally.[11] Infants who received any breastmilk were found to have a 60% lower risk of dying from SIDS and an overall lower risk of dying in their first year of life.[12,13,14] North Carolina (NC) has a lower rate of ever breastfeeding (75.3%) compared to the US (81.1%).[14] Breastfeeding at six and 12 months drops dramatically in both the US and in NC. In 2015, the rate of breastfeeding at six and 12 months was 47.5% and 30.0%, respectfully.[14] In the US, the rates were 51.8% and 30.7% in 2016.[14] Although breastfeeding rates have increased in the US and NC, racial/ethnic disparities exist. According to the National Immunization Survey (2013), non-Hispanic (NH) whites had higher rates of breastfeeding at initiation (81.9%), six months (57.9%), and 12 months (36.1%) compared to NH-African Americans who had the lowest rates: (initiation, 66.3%; six months, 39.1%; and 12 months, 19.3%). NH-Asians had the highest overall rates of breastfeeding at initiation (81.9%), six months (64.4%), and 12 months (38.7%).[15] Racial/ethnic disparities in NC mirror those of the US. At discharge, 83.4% of NH-white women reported initiating breastfeeding compared to 66.7% of NH-African Americans, 56.1% of non-Hispanic NA/AI.[16] 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 North Carolina, 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.
A. Scope of Services
Provide culturally and linguistically appropriate education to men and women of childbearing 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, & neighbors) for women 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 policy development and review, staff orientation, and education in the service area(s).
Strengthen partnerships between the local health department 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 the 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 additional Scope of Services:
Making in Work: Empowering Employers and Mothers. Utilize approved resources for the increasing the number of breastfeeding friendly businesses/work sites in the service area. LHDs should provide education, consultation, and information to the businesses/work sites. Resources include the adapted Making It Work Toolkit (URL to be determined) and the Businesses Leading the Way: (http://www.nutritionnc.com/breastfeeding/index.htm) LHDs selecting this strategy will develop and maintain an agreement with the North Carolina Breastfeeding Coalition to receive technical support and implementation support.
Breastfeeding Friendly City Program: Collaborate with communities in the service area(s) to increase the support for the breastfeeding family through the implementation of the Breastfeeding Friendly City

program, which includes implementing 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.

LHDs selecting this strategy will develop and maintain an agreement with the North Carolina Breastfeeding Coalition to receive technical support and implementation support. For more information, http://www.amchp.org/programsandtopics/BestPractices/InnovationStation/ISDocs/CSB.pdf

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 be following with 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

LHDs selecting this strategy will work with other ICO4MCH grantees and Greensboro AHEC to develop content for the web-based decision aids and will need to budget for a laptop/tablet for use in the prenatal clinic exam room.

B. 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 men and women of childbearing 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 women.
Increase the number of collaborations with partner organizations, community-based and faith-based organizations that support breastfeeding women 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:
Increase the number of businesses/worksites that are breastfeeding-friendly for patrons and/or employees.
The number of organizations, businesses, hospitals, day care/child care 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 women 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.
C. Reporting/Monitoring Requirements The following reporting/monitoring requirements may be tracked by the grantee and/or the grantor.
The number of infants who were breastfed at hospital discharge. Data will be provided by the North Carolina Division of Public Health, Women's and Children's Health Section.
The number of WIC-eligible infants who were breastfed at six and 12 months. Data will be provided by the North Carolina Division of Public Health, Women's and Children's Health Section.
Provide a copy of the breastfeeding policy and a copy of the members of the team.
The number and type of training that staff and health care providers in the local health department and at other public/private health care practices* participate in.
Provide the number of community-based and faith-based organizations that support breastfeeding women 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 women who have received one or more of the patient decision aids during their prenatal visit in the local health department and other public/private health care practices.
Local Health Departments that are interested in selecting the VII or VIII scopes of service listed as "options" **must contact the North Carolina Breastfeeding Coalition** in Chapel Hill, North Carolina **before responding to this RFA**. The contact is: Kathy Parry, kathyparry@unc.edu, 919-966-8588, ncbcf.org. Local Health Departments that are interested in selecting the IX scope of services listed as "options" **must contact the ICO4MCH Program Manager for ICO4MCH**: leslie.derosset@dhhs.nc.gov, 919-707-5690 **before responding to this RFA.**
*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 2: 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; and
- To reduce the incidence of child maltreatment and behavioral/emotional problems in childhood and adolescence.

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

A. 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, 2018, 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, PASS, Triple P integration into the child-serving agency, and practitioner service delivery plan;
7. Job descriptions and work plans for key staff; and
8. Only one implementation plan for both Title V and ICO4MCH Triple P activities should.

Maintain a 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 Memoranda of Agreement (MOA) 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 North Carolina 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.

B. 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 child care 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.
C. Reporting/Monitoring Requirements The following reporting/monitoring requirements may be tracked by the grantee and/or the grantor.
The number of families/caregivers with children ages 0 – 5 served.
The number of children, 0–5 served.
Using pre- and post-test satisfaction survey with all families/caregivers, the number of families/caregivers who complete the surveys, and identify satisfaction.
The number of Triple P online users.
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.
Local Health Departments 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.
1. *Clinical Efforts Against Secondhand Smoke Exposure (CEASE)*
The Clinical Effort Against Secondhand Smoke Exposure (CEASE) was developed after extensive research in the adult and child healthcare settings, based on the current best practices for the adult setting. The CEASE Module was developed in 2005 after years of research to help child health care providers adjust

their office setting to address family tobacco use in a routine and effective manner.

To better meet the needs of child healthcare clinicians, the CEASE team is partnered with the American Academy of Pediatrics (AAP) Julius B. Richmond Center of Excellence (Richmond Center). The mission of the Richmond Center is to improve child health by eliminating children's exposure to secondhand smoke and tobacco through changing the clinical practice of pediatrics. The CEASE vision is that all child health care providers will be active participants in the elimination of tobacco use and second- and third-hand smoke exposure of children. With the establishment of the Richmond Center at the AAP, child health providers will be provided with the education, training, and tools needed to effectively intervene to protect children from the harmful effects of tobacco use and second- and third-hand smoke exposure.

There are three steps to the CEASE intervention: 1) Ask – about the tobacco use/smoking status of family members and household smoking rules; 2) Assist – in quitting smoking and establishing a smoke-free home and car, prescribe, or recommend appropriate pharmacotherapy; and 3) Refer – QuitlineNC (1-800-QUIT-NOW) and/or the National Institute of Health's Smoke-Free text line support line (SmokefreeTXT) and develop a follow-up plan. Grantees must implement the CEASE intervention using the implementation guide, clinic forms, and program materials, which can be found at: http://www2.massgeneral.org/ceasetobacco/nc.htm.

Grantees will integrate the CEASE intervention into their child health clinic. Grantees working in multi-county collaborations will be required to implement CEASE in each child health clinic. Single county grantees will be required to implement CEASE in the child health clinic at the LHD and at least two additional external child health clinics that accept Medicaid, Health Choice/Health Check, private insurance, and the uninsured. Grantees will sub-contract with the purveyor for technical assistance throughout the two-year funding cycle.

A. Scope of Services

Participant in trainings, technical assistance calls, webinar, or conferences as offered by the purveyor, as needed.

Use the Peer to Peer Training Protocols to train all key staff (health care providers, nurses, nurse practitioners, physician assistants, clerical and front office staff, volunteers, medical students, etc.) in the CEASE intervention.

Identify a primary and secondary person in each child health clinic to act as the Practice Leader. A Practice Leader is defined as the lead contact for the CEASE intervention who collaborates with the LHD Program Coordinator and the purveyor.

Assess tobacco use (inclusive of electronic nicotine devices such as e-cigs, vaping, etc.) among all parents/caregivers, children, and youth patients in the child health clinic. utilizing the electronic I-Pad survey developed by CEASE.

Document outcomes of the I-Pad survey regarding tobacco use (inclusive of electronic nicotine devices such as e-cigs, vaping, etc.) among all parents/caregivers, children, and youth patients in the child health clinic at every visit.

Document the outcomes of screening, counseling, follow-up, in the electronic medical records of each

health care practice.
Document outcomes of tobacco use (inclusive of electronic nicotine devices such as e-cigs, vaping, etc.) among all parents/caregivers, children, and youth patients in the child health clinic in the client's electronic medical record at every visit.
Refer clients to QuitlineNC (1-800-QUIT-NOW) and/or the National Institute of Health's Smoke-Free text line support line (SmokefreeTXT) as well as other appropriate community resources as needed.
B. Performance Measures
Complete required and necessary trainings, technical assistance calls, webinars, conferences, etc. with the purveyor.
Complete an annual child health care practice assessment forms as required by the purveyor.
Increase training of staff at the child health care clinics to at least 80% of all employees.
Complete documentation of primary, secondary, and tertiary tobacco use/smoking in at least 75% of client records. Documentation should include all variables collected from the I-Pad survey. These variables include: 1. who smokes (mother, father, other); 2. number of households with tobacco users; 3. services requested (NRT, QuitlineNC, Smokefree Txt); 4. staff response to services requested, 5. number of new surveys and repeated surveys; and 6. number of eligible participants and eligible consented participants.
Decrease the percentage of North Carolinians who use tobacco/smoke.
Increase the number of applicable North Carolinians to the QuitlineNC.
Increase the percentage applicable North Carolinians who utilize the QuitlineNC services.
C. 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.
Document the type and number of trainings, technical assistance calls, webinars, conferences, etc. Program Coordinator(s) participates in.
Provide copies of the child health care practice assessment forms to NC DPH.
Document the number of and role of each at each health care clinic trained. Training includes: Office Champion, Peer-to-Peer, maintenance training at six and 12 months.

Documentation of primary, secondary, and tertiary tobacco use/smoking. Documentation should include all variables collected from the I-Pad survey. These variables include:

1. who smokes (mother, father, other);
2. number household with tobacco use identified;
3. services requested (NRT, QuitlineNC, Smokefree Txt);
4. staff response to services requested,
5. number of new surveys and repeated surveys; and
6. number of eligible participants and eligible consented participants.

Number of registered people in the county of service who use the QuitlineNC.

3. 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 and
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.

A. 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; and
- 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*.

B. Performance Measures

Complete home visits in the service area with 60–70% of all births in the service area.

Complete an integrated home visit (IHV) 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 Center for Child and Family Health.
Complete documentation of family demographics on all families participating in the program.
C. 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 newborns 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 (IHV).
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 Center for Child and Family Health (CCFH) and the Local Health Department.
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 Karen O'Donnell at karen.o.donnell@dm.duke.edu or 919-491-9883.

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, 2015 Population Estimates by Age, Race, and Sex

   Pregnancy and Live Births
   - 2011-2015 Pregnancy Rates per 1,000 Population, by Race/Ethnicity for Females 15-17, 15-19, and 15-44
   - 2011-2015 Fertility Rates per 1,000 Population, by Race/Ethnicity for Females 15-17, 15-19, and 15-44
   - 2011-2015 Abortion Rates per 1,000 Population, by Race/Ethnicity for Females 15-17, 15-19, and 15-44
   - Live Birth Rates per 1,000 Population, 2011-2015
   - 2011-2015 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

- 2011-2015 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, 2011-2015
- Births Delivered by Cesarean Section, 2011-2015
- Births Delivered by Gestation, 2011-2015
- Births Where Mothers Smoked During Pregnancy, 2011-2015
- Births to Medicaid and WIC Mothers, 2008-2012

2015 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:
http://www.schs.state.nc.us/data/births/2015.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, 2015 and County, 2013-2015
- Years of Potential Life Lost, Totals and by Sex, 2011-2015

Mortality
- Fetal Death Rates per 1000 Deliveries, 2011-2015
- Neonatal (<28 Days) Death Rates per 1000 Live Births, 2011-2015
- Postneonatal (28 Days - 1 Year) Death Rates per 1000 Live Births, 2011-2015
- Infant Death Rates per 1,000 Live Births by Race/Ethnicity, 2011-2015
- Unadjusted Child Death Rates per 100,000 Population, 2011-2015
- Unadjusted Death Rates per 100,000 Population, 2015 and 2011-2015
- Death Counts and Crude Death Rates per 100,000 Population for Leading Causes of Death, by Age Groups NC 2011-2015
- Unintentional Poisoning Mortality Rates per 100,000, 2011-2015
- 2011-2015 Race-Sex-Specific Age-Adjusted Death Rates by County
- 2011-2015 Race-Specific and Sex-Specific Age-Adjusted Death Rates by County

Morbidity
- 2009-2013 NC Cancer Incidence Rates per 100,000 Population Age-Adjusted to the 2000 US Population
- Projected New Cancer Cases and Deaths by County, 2016

5. Detailed Mortality Statistics

6. Infant Mortality Statistics
   - County-by-county Listing of Final Infant Death Rates for 2015
   - Infant Death Rates by Perinatal Care Regions (PCR) and County of Residence, NC 2014, 2015 and 5-year totals 2011-2015 Table Maps

7. NC Health Statistics Pocket Guide 2015
   - Table 7. Demographic, Economic, and Health Resources Data
     Resident Population - July 1, 2015 (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 1998-2007, and the reporting of means of death is incomplete for deaths which occurred in 2004 and 2005.

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 2015). 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. 2017 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 2017. An example of a data card can be found here: http://www.ncchild.org/wp-content/uploads/2017/05/yancey.pdf.

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.

C. WCHS PROCESS OUTCOME OBJECTIVES (POOs) DATA

1. Family Planning POOs by County 2017-18 or by Objective Topic 2017-182.2.
2. Family planning caseload (unduplicated users as reported to HIS)
3. Adolescent pregnancy rate among females ages 10 to 17.
4. Percentage of repeat pregnancies to teens ages 17 and under.
5. Percentage of women with short birth intervals (<6 months between birth and conception)
6. Percentage of all resident out of wedlock live births.

7. Percentage of unintended pregnancies (as defined by the sum of abortions, births to teens 18 years old or younger, and out-of-wedlock births to women over 18 years of age).

    1. Maternal Health POOs by County 2017-18 or by Objective Topic 2017-18
        1. Percentage of women having live births who had adequate prenatal care as defined by Kessner Index.
        2. Percentage of women with live term singleton births who received WIC Program services during pregnancy and who gained recommended/ excessive/inadequate weight according to the National Academy of Sciences – Institute of Medicine (IOM) Recommended Total Weight Gain Ranges During Pregnancy.
        3. Percentage of women having live births who smoked during pregnancy.
        4. Percentage of Medicaid enrolled pregnant women who receive prenatal WIC services.
        5. Percentage of infants enrolled in WIC who breastfed at 6 weeks postpartum.
        6. Percentage of Medicaid enrolled pregnant women who deliver and receive a postpartum home visit.

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

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 here: http://whb.ncpublichealth.com/docs/rfa320/RFA-320-MCH-InitiativeCitationGuidance.pdf

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 not 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 #XX 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 North Carolina Health Equity Impact Assessment was developed by #impactEQUITYNC, a collaboration between NC Child, the NC Division of Public Health Women's Health Branch, NC Office of Minority Health and Health Disparities, and the Rockingham Health Department. This assessment was informed by the Health Equity Review Planning Tool created by the Washington State Department of Public Health and the City of Seattle Race and Social Justice Initiative Racial Equity Toolkit.

Table of Contents

About This Tool

*North Carolina is at its best when every individual--regardless of race, ethnicity, income, or geography--has the opportunity to attain his or her best health***.** Ensuring health equity for all requires changing policies, systems, and practices to address health inequities and reduce longstanding disparities. The North Carolina Health Equity Impact Assessment (HEIA) provides a structured process to guide the development, implementation, and evaluation of policies, programs, and initiatives in order to reduce disparities and promote health equity.

Why Use This Tool

Use this tool to identify how a program, policy, or practice may impact groups in different ways or potentially cause unintended consequences that increase health disparities. The use of the tool may also raise awareness about health equity.

Who Should Use This Tool

Everyone. The HEIA can be used with local and state stakeholders engaged in public policy or community planning. Examples include community based organizations, elected officials, government staff, health and human services staff, hospitals, and faith-based organizations.

When to Use This Tool

Early. Early and frequent assessment provides a structured framework to achieve your desired policy, program, or practice outcomes.

How to Use This Tool

Be Inclusive. Successful health equity assessments involve members of impacted communities.

Use Data. Data is essential to identify disparities and understand the complex factors that contribute to health inequities across populations

Dig Deeper. When completing this tool think concretely and consider the social, structural, and cultural factors that impact individual and community health.

This assessment is made up of two pre-work activities and six action steps. *Worksheet A* identifies who needs to participate in the HEIA and *Worksheet B* helps you prepare a data profile for your assessment. The remaining steps are sequential, building from beginning to end:

Step 1. *Getting started*: Determine what is being assessed.
Step 2. *Set outcomes*: State your intended outcomes.
Step 3. *Analyze data to determine impact:* Identify impacted populations and communities.
Step 4. *Determine benefit and burden*: Determine positive and negative impacts.
Step 5. *Identify modifications*: Propose changes that enhance your strategy.
Step 6. *Develop an action plan*: Monitor implementation and share findings.

I. Pre-work A: Identify Participants

The success of your health equity assessment is highly dependent on having the correct people at the table throughout the assessment process. To help ensure diverse stakeholder involvement and community representation, the following is a description of potential stakeholder roles that are important to the assessment process. Use this worksheet to identify specific people who will be invited to participate.

- **Content Experts**: People who have a command of research, policy and practice who can speak to the nuances of how each of those things work. The person who knows the issue best.
- **Providers**: People who are on frontlines actually carrying out the day to day realities (e.g., teacher, health care provider, community health care worker, public health program manager/coordinator).
- **Consumers**: People who use the services your policy, program, or intervention seeks to implement or change.
- **Impacted Groups**: People who are disproportionately impacted by the issue.
- **Key Decision Makers**: People who have the influence or power to create change and set policies.
- **Community Leaders**: People who have the trust and respect of the community and can mobilize action.
- **Advocates**: Professionals who advocate in the interest of particular communities or groups.

Role	Participant Name(s)
Content Experts	
Providers	
Consumers	
Impacted Groups	
Key Decision Makers	
Community Leaders	
Advocates	

II. Pre-work B: Compile Your Data Profile

Collecting and analyzing data by race, ethnicity, and other key demographic factors (such as literacy, language preference, nativity, etc.) is critical in identifying disparities and understanding the complex factors that contribute to health inequities across populations. Your analysis in Step 2 should include the following types of information:

- Quantitative data refers to surveillance, administrative, or survey statistics that capture dimensions that can be measured.
- Qualitative data refers to descriptive characteristics that can be observed, but not measured. These data are often generated through focus groups, surveys, and key informant interviews and include stories collected from your target population and community.

Pre-Step 1: Describe the problem your policy, program, or intervention seeks to address.

_____

_____

_____

Pre-Step 2: List the top questions your group needs to answer in order to understand the root causes of this problem. This helps focus data collection on information you need to get, rather than what is easiest to collect.

Question 1: _____

Question 2: _____

Question 3: _____

Pre-Step 3: Compile data related to the questions above**.** See **[insert link to a webpage here]** for a list of North Carolina data sources.

Pre-Step 4: Use the prompts below to construct a data profile. Develop charts, tables, or graphs to visualize your data. You will use this profile in Step 2 of the assessment.

Prompts	Data-based Insights
● What subgroups make up your target population or community?	
● Which members of your target population experience the best related health outcomes? Which experience the worst?	
● Are there geographic locations or clusters of disparities? If so, where?	
● What other relevant disparities do you observe in the data? *(Ex. differences by age, gender, nativity, etc.)*	
● Identify three assets or strengths available among your target population that you should leverage.	
● Identify three challenges impacting your target population.	

Pre-Step 5: Identify what data are missing that would be helpful to understand the experiences of the community or groups impacted by your policy, program, or intervention. What strategies might you use to collect this information, or to support the development of data collection efforts?

Step 1 Getting Started: Determine What is Being Assessed

Select the category that best describes the item you are assessing:

☐ Policy ☐ Program ☐ Intervention ☐ Budget Issue ☐ Other: _____

Briefly describe what is being assessed:

List the specific communities, populations, or audiences intended to be served:

Step 2 Set Outcomes: State Your Intended Outcomes

2a. What problem does this policy, program, or intervention seek to address?

2b. What change do you expect to see as a result of this policy, program, or intervention?

2c. Which factor(s) will the policy, program, or intervention impact? *(Check all that apply.)*

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

2d. What are the consequences of not implementing your policy, program or intervention?

2e. Who is already working on the issues identified above (for example, churches, civic groups, community leaders, community organizations, etc.)? List individuals or organizations and indicate whether they should be included in this health equity impact review process.

2f. Who else needs to be at this health equity assessment table? (Ex. Who needs a voice or an advocate?)

Step 3

Analyze Data to Determine Impact: Identify Impacted Populations and Communities

Use the data profile completed in Worksheet B to answer the following questions:

3a. Which geographic areas will be impacted? *(Check all that apply and name.)*

☐ Statewide

☐ County: _____

☐ Region: _____

☐ City: _____

☐ Neighborhood: _____

☐ Zip code(s): _____

☐ Other: _____

3b. What is the racial/ethnic breakdown of those living in the impacted area(s)?

Population	**Data**
White	
Black or African American	
American Indian or Alaska Native	
Asian	
Native Hawaiian or Pacific Islander	
Two or More Races	
Hispanic or Latinx	

3c. Who may be affected by the issue more than others? *(Check all that apply.)*

- ☐ Poor or low-income individuals or families
- ☐ Racial or ethnic groups. Please list:
- ☐ Individuals/Families with limited English proficiency
- ☐ Individuals/Families with physical or behavioral disabilities
- ☐ Children
- ☐ Adolescents
- ☐ Elderly
- ☐ LGBTQ
- ☐ Rural
- ☐ Immigrants or Refugees
- ☐ Other: _____

3d. List community members you have consulted to interpret the data and determine impacts.

3e. Summarize the priority issues and needs community members indicated were most important to them. How does your initiative fit with these priorities?

3f. What does the data and your conversations with stakeholders tell you about existing racial and other inequities that influence people's lives and should be taken into consideration?

3g. What root causes or factors may be creating these racial and other inequities?

3h. Which of these root causes does your policy, program, or intervention address?

Step 4

Determine Benefit and Burden: Determine Positive and Negative Impacts

Given what you have learned from the data and stakeholder involvement, please answer the following questions.

4a. How will the policy, program, intervention improve health equity (including racial and ethnic equity) for each of the groups identified in question 3c? What benefits may result?

4b. How will your proposed policy, program, or intervention have a negative impact on health equity for those groups identified in question 3c? What inequities may result?

4c. What are potential unintended consequences? (*List both positive and negative*)

4d. Are the impacts identified here aligned with the outcomes that you defined in Step 2?

Step 5

Identify Modifications: Propose Changes that Enhance Your Strategy

Based on the findings of this assessment, summarize the modifications needed to reduce inequities and promote health equity in your policy, program, or intervention.

5a. List the modifications you will make as a result of this assessment process. *(If not applicable, skip to question 5c.)*

Modification 1: _____

Modification 2: _____

Modification 3: _____

Modification 4: _____

Modification 5: _____

5b. Use the space below to provide specific and detailed notes regarding your rationale for proposing the above modifications to the policy, program, or intervention. If no modifications are necessary, please give the reasons why.

Step 6

Develop an Action Plan: Monitor Implementation and Share Findings

To ensure there are no disparate impacts on the communities identified in this assessment, monitoring implementation of your policy, program, or intervention is essential.

6a. Create an action plan to monitor how well the policy, program, or intervention is working. A sample table is offered here, but adapt as necessary, making sure to include the who/what/where/when.

Action	Date to Be Completed	Who is responsible	Result

6b. If disparate impacts arise, how will they be addressed?

6c. A Health Equity Impact Assessment is not a document that "sits on the shelf." This is a continual process that should be re-evaluated and assessed on a regular basis. How will you communicate information regarding the implementation and evaluation of your policy, program, or intervention with the members of impacted groups and other stakeholders?

6d. List all HEIA participants below.

Participant Name	Role and Affiliation	Date(s) of participation

Lead Facilitator: _____ Date Completed: _____

Glossary

Advocates: Professionals who advocate in the interest of particular communities or groups.

Beneficence**:** Action that is done for the benefit of others. Actions can be taken to help prevent or remove harms or to simply improve the situation of the population.

Community Leaders: People who have the trust and respect of the community and can mobilize action.

Community Outcomes: The specific result you are seeking to achieve that advances racial equity.

Consumers: People using services your policy, program, or intervention seeks to implement or change.

Content Experts: People who have a command of research, policy and practice that can speak to the nuances of how each of those things work. The person who knows the issue best.

Evaluation: Making a judgement as to how successful (or otherwise) a project has been, with success commonly being measured as the extent to which the project has met its original objectives or intended outcomes.

Health Disparity: Preventable differences in health status or outcomes between groups.

Health Equity**:** Refers to the attainment of the highest level of health for all people.

Health Inequities: Preventable differences in health risk or status between different population groups. Inequities refer to differences in the root causes of health that are avoidable, unnecessary, and unjust.

Impacted Population: A group of people or community that is identified as the intended recipient of a policy, program, or intervention.

Inclusive Outreach: The process of including all people of diverse races, cultures, gender identities, sexual orientation, and socio-economic status.

Intervention: Programs intended to improve health and quality of life through prevention or treatment.

Key Decision Makers: People who have the influence or power to create change and set policies.

Program: A defined set of activities implemented in response to needs within a community or target population.

Providers: People who are on the frontlines actually carrying out the day to day realities (e.g., teacher, health care provider, community health care worker, public health program manager/coordinator).

Public Policy: Rules, laws, or regulations that define government response to the needs of its citizens. Public policy may be legislative or administrative.

Quantitative Data: Surveillance, administrative, or survey statistics that capture dimensions that can be measured.

Qualitative Data: Descriptive characteristics that can be observed but not measured. These data are often generated through focus groups, surveys, and key informant interviews and include stories collected from your target population and community.

Racial Equity: When social, economic, and political opportunities are not predicted based on a person's race.

Racial Inequity**:** When a person's race can predict their social, economic, and political opportunities and outcomes.

Root Causes: A root cause is one of many factors that contributes or creates an undesired outcome, and if eliminated would have prevented the undesired outcome. In other words, root causes are specific underlying causes or sources of a problem.

Unintended Consequences: Unforeseen outcomes that are not intended by a purposeful action.

Social Determinants of Health: The conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at national, state, and local levels.

Stakeholders: Those impacted by proposed policy, program, or intervention, who may have concerns or provide key information. Examples include: Specific racial/ethnic groups, housing authority, schools, community-based organizations etc.

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

Appendix E

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

The table below indicates which 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
Improving the utilization of Reproductive Life Counseling (RLP) to increase access to long-acting reversible contraception (LARC).	-Unique monthly users of long-acting reversible contraception (LARC) services in the LHDs	-DPH will provide the HIS data quarterly to the LHDs.
Tobacco Use Screening, Counseling, and Documentation	-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, Crossroads data system, annually
Positive Parenting Program (Triple P)	-Triple P online data	-DPH will provide data quarterly to the LHDs
Clinical Effort Against Secondhand Smoke Exposure (CEASE)	-QuitlineNC data (includes all demographic and county specific data on registered callers).	-DPH will provide data quarterly to the LHDs

	-Pregnant women who smoke/ use tobacco	-NC State Birth Certificate data, annually.
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

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