U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration

Maternal and Child Health Bureau
Division of Maternal and Child Health Workforce Development

Maternal and Child Health (MCH) Interdisciplinary Education in Pediatric Pulmonary Centers (PPCs)

Announcement Type: Initial: New and Competing Continuation
Funding Opportunity Number: HRSA-15-074

Catalog of Federal Domestic Assistance (CFDA) No. 93.110

FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2015

Application Due Date: March 23, 2015

MODIFIED on February 3, 2015:
language clarified on page 15 regarding ...1.c.v. Family Leadership in Section IV.

Ensure your SAM.gov and Grants.gov registrations and passwords are current immediately!
Deadline extensions are not granted for lack of registration.
Registration in all systems, including SAM.gov and Grants.gov,
may take up to one month to complete.

Release Date: January 15, 2015
Issuance Date: January 20, 2015

Claudia Brown, MSN
Division of Maternal and Child Health Workforce Development
Maternal and Child Health Bureau
5600 Fishers Lane, Mailstop 18SWH03
Rockville, MD 20857
E-Mail: cbrown4@hrsa.gov
Telephone: (301) 443-0869
Fax: (301) 443-4842

Authority: Social Security Act, Title V, Section 501(a)(2), (42 U.S.C. 701(a)(2)) as amended

EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB), Division of Maternal and Child Health Workforce Development is accepting applications for fiscal year (FY) 2015 for the Maternal and Child Health (MCH) Interdisciplinary Education in Pediatric Pulmonary Centers (PPCs). The purpose of this grant program is to: improve the health status of infants, children, and youth with chronic respiratory conditions by supporting interdisciplinary training of health professionals that incorporates family-centered care, a public health approach, diversity, and cultural and linguistic competence to address health disparities related to chronic respiratory conditions.

Funding Opportunity Title:	Maternal and Child Health (MCH) Interdisciplinary Education in Pediatric Pulmonary Centers (PPCs)
Funding Opportunity Number:	HRSA-15-074
Due Date for Applications:	March 23, 2015
Anticipated Total Annual Available Funding:	$2,040,000
Estimated Number and Type of Award(s):	Up to six (6) grants
Estimated Award Amount:	Up to $340,000 per year
Cost Sharing/Match Required:	No
Project Period:	July 1, 2015 through June 30, 2020 (Five (5) years)
Eligible Applicants:	As cited in 42 CFR Part 51a.3(b), only public or nonprofit private institutions of higher learning may apply for training grants. [See Section III-1 of this funding opportunity announcement (FOA) for complete eligibility information.]

All applicants are responsible for reading and complying with the instructions included in HRSA's *SF-424 R&R Application Guide,* available online at http://www.hrsa.gov/grants/apply/applicationguide/sf424rrguide.pdf, except where instructed in this funding opportunity announcement to do otherwise. A short video for applicants explaining the new *Application Guide* is available at http://www.hrsa.gov/grants/apply/applicationguide/.

Technical Assistance Call:
A technical assistance call will tentatively be held on Wednesday, February 4, 2015 from 1:00 P.M. until 2:00 P.M. Eastern Time. The Program Staff will provide an overview of the FOA and answer questions during the call.

Call information is as follows: Conference Call Number: 1-888-603-9226 | Participant Code: 1269212#.

The following meeting web link will be used: https://hrsa.connectsolutions.com/fy15pedpul/.

Table of Contents

I. Funding Opportunity Description

1. Purpose

This announcement solicits applications for the Maternal and Child Health (MCH) Interdisciplinary Education in Pediatric Pulmonary Centers (PPCs).

The purpose of the PPC program is to improve the health status of infants, children, and youth with chronic respiratory conditions. PPCs achieve this objective by addressing four (4) aims:

1) Providing interdisciplinary leadership training at the graduate and post-graduate levels in five (5) core disciplines of *pediatric pulmonary medicine, nursing, social work, nutrition, and family leadership*. PPCs serve as models of excellence in interdisciplinary training, systems integration, and research related to chronic respiratory conditions in infants, children, and youth;
2) Engaging with families as full partners to support family-centered practice, policies, and research;
3) Impacting policies and practices at the regional and national levels, including working with state and local health agencies and providers through a public health/population-based approach. PPCs provide a critical link in assuring that the next generation of health care providers contribute to MCHB's mission to assure access to care for Children and Youth with Special Health Care Needs (CYSHCNs) through systems improvement; and
4) Supporting diverse trainees and faculty, and cultural and linguistic competence approaches, to address health disparities related to chronic respiratory conditions.

2. Background

This program is authorized by the Social Security Act, Title V, Section 501(a)(2), (42 U.S.C. 701(a)(2)), as amended.

PPC programs have long worked to enhance system and service integration through the foundation of Special Projects of Regional and National Significance (SPRANS) within Title V. The PPC program supports MCHB's mission to provide national leadership, and to work in partnership with states, communities, public-private partners, and families to strengthen the maternal and child health infrastructure; assure the availability of medical homes; and build the knowledge and human resources, in order to assure continued improvement in the health, safety, and well-being of the MCH population, which includes all America's women, infants, children, youth and their families, including fathers and children/youth with special health care needs (CYSHCN).

Division of Maternal and Child Health Workforce Development (DMCHWD) 2012-2020 National Goals

The DMCHWD works collaboratively with national, state, and local MCH organizations to develop and sustain MCH professionals prepared to provide leadership within Title V and other MCH programs. DMCHWD's vision for the 21st century is that all children, youth, and families will live and thrive in healthy communities served by a quality workforce that helps assure their health and well-being. Additional information about the vision and strategic plan for 2012-2020 is available at: http://mchb.hrsa.gov/training/about-national-goals.asp.

The Pediatric Pulmonary Centers (PPCs)

The need for providers and leaders trained in pediatric pulmonary care and prevention is a major health issue in the United States. Due to the complexity and prevalence of pediatric pulmonary issues, they need to be addressed by the health care community in an interdisciplinary, family-centered, culturally competent manner. The rigorous interdisciplinary training provided by the PPCs enables professionals in the disciplines of pediatric pulmonary medicine, nursing, social work, nutrition, and family-centered care to meet this critical need for children with respiratory diseases such as asthma and cystic fibrosis.

The need for interdisciplinary health professional leaders trained in the respiratory care of children is critical, especially in light of possible decreases in the number of those entering the field. According to the 2013 Pediatrician Workforce Policy Statement from the American Academy of Pediatrics (AAP), the prevalence of chronic conditions, including asthma in the pediatric population, has increased the need for pediatric physicians and specialists. Additionally, the racial and ethnic diversity of the pediatric population points to a need for culturally effective care and increased racial and ethnic diversity in the pediatric workforce. The increasing number of children who are insured through health care reform efforts, only adds to the need for pediatric specialists.[1]

Asthma

The most common respiratory disease among children is asthma. The current asthma population estimate for children under age 18 is 6,834,000.[2] According to parent-reported data from the 2011/2012 National Survey of Children's Health (NSCH),[3] 8.8% of children up through age 17 currently have asthma. The percentage of children with asthma is rising more rapidly in preschool-age children than in any other age group. Asthma is a leading cause of school absenteeism due to a chronic condition, accounting for nearly 13 million missed school days per year.[4] In 2007, 6.7 million children visited private physician offices for asthma while 800,000 visited pediatric outpatient departments for the same respiratory condition. During this time, asthma accounted for 640,000 visits to emergency department; 157,000 hospital stays; and 185 deaths among children aged 0–17.[5] Asthma symptoms that are not severe enough to require a visit to an emergency room, or to a physician, can still be serious enough to prevent a child with asthma from living a fully active life.

---

[1] Pediatrician Workforce Policy Statement. (2013). *Pediatrics, 132*(2), 390-397. doi:10.1542/peds.2013-1517.
[2] 2012 National Health Interview Survey (NHIS) Data, CDC: http://www.cdc.gov/asthma/nhis/2012/data.htm.
[3] 2011/2012 National Survey of Children's Health (NSCH), HRSA, Maternal and Child Health Bureau: http://www.childhealthdata.org/learn/NSCH.
[4] Managing Asthma in the School Environment. (2010). Environmental Protection Agency (EPA). EPA 402-K-10-004. Retrieved September 15, 2014 from http://www.epa.gov/iaq.
[5] Akinbami, L.J., Moorman, J.E., M.S., Liu, X.. (2011). Asthma Prevalence, Health Care Use, and Mortality: United States, 2005–2009. National Center for Health Statistics, No. 32. Retrieved September 15, 2014 from http://www.cdc.gov/nchs/data/nhsr/nhsr032.pdf.

There are significant racial and ethnic health disparities associated with asthma with 16.8% of black non-Hispanic children having asthma, as compared to 6.8% of Hispanic children and 7.6% of white non-Hispanic children. Racial and ethnic disparities in asthma prevalence, as well as access to care, have persisted over time.[6] Additionally, disparities in access to preventive and primary care services result in differences in asthma hospitalizations based on income levels, as well as racial/ethnic disparities on the prevalence of asthma. Over 26% of non-Hispanic White children and non-Hispanic children of other races lived in households with a smoker, as did 25% of non-Hispanic Black children. The time and expenses associated with caring for children who have asthma can be significant for families.

Current asthma prevalence is highest among males, African-Americans, and multi-race children under age 18. Non-Hispanic black children, under age 15, had the highest percentage of having an asthma episode in the past 12 months, as compared with the other race/ethnicity and age groups. Children up to 100% of the federal poverty level (FPL) have a greater current asthma prevalence, as compared to children at 450% FPL or greater. Children with a poverty threshold of 0 to 0.99 have a current asthma prevalence of 13.0, as compared to a prevalence of 6.9 for children with poverty threshold of 4.50 and above.

Cystic Fibrosis

In the United States, approximately 30,000 people are living with cystic fibrosis, a life-threatening genetic disease that primarily affects the lungs and digestive system.[7] Data from the Cystic Fibrosis Foundation's 2012 Patient Registry Report shows that most people are diagnosed before age two, and newborn screenings have increased the number of people with cystic fibrosis identified at birth. Earlier diagnosis is associated with better health outcomes.[8] Pediatric patients with cystic fibrosis can suffer from a variety of health complications, including impaired kidney functioning,[9] cystic fibrosis liver disease, losses in bone density and mineral content due to factors that include poor nutrition;[10] poor growth due to poor nutrition;[11] and cystic fibrosis-related diabetes. In addition to physical complications, pediatric patients with cystic fibrosis can also suffer from behavioral and mental health complications. These include, moderate to severe sleep problems, problematic mealtime behaviors, and a difficulty adhering to prescribed physiotherapy.

Due to advances in treatment, the life spans of those with cystic fibrosis have been increased and most live well into adulthood.[12] [13] A well-managed transition from pediatric to adult care is important for adolescents with cystic fibrosis given the many different organs affected and the need for care by multiple specialists. A recent study found that transitional care should be

---

[6] Flores, G., & Lin, H. (2013). Trends in racial/ethnic disparities in medical and oral health, access to care, and use of services in US children: has anything changed over the years?. *International Journal For Equity In Health*, *12*(1), 1-16. doi:10.1186/1475-9276-12-10.

[7] Cystic Fibrosis Foundation. (n.d.). About Cystic Fibrosis. Bethesda, MD: Cystic Fibrosis Foundation. Retrieved March 28, 2014 from http://www.cff.org/AboutCF/.

[8] Cystic Fibrosis Foundation. (2013). Patient Registry Annual Data Report 2012. Bethesda, MD: Cystic Fibrosis Foundation. Retrieved March 27, 2014 from http://www.cff.org/UploadedFiles/research/ClinicalResearch/PatientRegistryReport/2012-CFF-Patient-Registry.pdf.

[9] Prestidge, C., Chilvers, M., Davidson, A. A., Cho, E., McMahon, V., & White, C. (2011). Renal function in pediatric cystic fibrosis patients in the first decade of life. *Pediatric Nephrology*, *26*(4), 605-612. doi:10.1007/s00467-010-1737-1.

[10] Reix, P., Bellon, G., & Braillon, P. (2010). Bone mineral and body composition alterations in paediatric cystic fibrosis patients. *Pediatric Radiology*, *40*(3), 301-308. doi:10.1007/s00247-009-1446-8.

[11] Cystic Fibrosis Foundation. (2013). Patient Registry Annual Data Report 2012. Bethesda, MD: Cystic Fibrosis Foundation. Retrieved March 27, 2014 from http://www.cff.org/UploadedFiles/research/ClinicalResearch/PatientRegistryReport/2012-CFF-Patient-Registry.pdf.

[12] Reix, P., Bellon, G., & Braillon, P. (2010). Bone mineral and body composition alterations in paediatric cystic fibrosis patients. *Pediatric Radiology*, *40*(3), 301-308. doi:10.1007/s00247-009-1446-8.

[13] Cystic Fibrosis Foundation. (2012). Patient Registry Annual Data Report 2012. Bethesda, MD: Cystic Fibrosis Foundation. Retrieved March 27, 2014 from http://www.cff.org/UploadedFiles/research/ClinicalResearch/PatientRegistryReport/2012-CFF-Patient-Registry.pdf.

approached systematically, with individualized transitional planning and specific training on transitional care for health care providers.[14]

Sleep Health

The importance of sleep health is underscored by a growing literature that links sleep problems with other morbidities. Sleep problems, some of which are preventable, are associated with chronic diseases, mental disorders, health-risk behaviors, limitations of daily functioning, injury, and mortality.[15] For instance, from a life course perspective, cardiovascular morbidity and metabolic syndrome have been linked with obstructive sleep apnea (OSA). Impairments in daytime functioning and decreased quality of life, in affected children, are also associated with sleep problems. Additionally, secondary effects on families, such as disrupted parent sleep; marital discord; and maternal stress, may occur as a result of childhood sleep problems.[16]

Although the clinical practice of sleep medicine has concentrated mainly on the identification and treatment of sleep apnea in adults, there are now more than 80 recognized sleep-related disorders. The majority of these disorders are experienced both by adults and children, but the clinical manifestations; evaluation methods; diagnostic criteria; and treatments differ greatly across the two populations.[17]

The PPCs have also demonstrated expertise in issues related to overall pediatric health, such as sleep health and sleep disorders that affect the respiratory health of children and adolescents. There are several sleep disorders that affect the respiratory health of children and adolescents, including sleep-disordered breathing and obstructive sleep apnea, which have a greater negative consequence on children/youth with existing respiratory conditions.

Alignment with Title V

Title V envisions a nation where all mothers, children and youth, including children with special health care needs (CSHCN), and their families are healthy and thriving. State Title V programs are facing unprecedented changes in the health care and public health systems, from implementation of the Patient Protection and Affordable Care Act (Affordable Care Act) of 2010 to severe budget and staffing cuts due to budget austerity measures. With the implementation of the Affordable Care Act, there is an increased emphasis on prevention and health promotion, as well as increased coverage for those previously uninsured. As a result, maternal and child health outcomes will change.

The MCH workforce needs to be prepared to develop new systems of care that better incorporate ongoing quality improvement; integrate primary care, specialty care, and public health; develop an interdisciplinary approach to health care; and work across multiple sectors to improve the health of the nation's women, children, and families – at the individual, organizational and service system levels. In order to achieve appropriate community-based systems of services for CSHCNs, PPC programs support the six core system components, outlined by MCHB, which must be in place to assure comprehensive systems of services for CSHCNs and their families:

---

[14] Al-Yateem, N. (2013). Guidelines for the transition from child to adult cystic fibrosis care. *Nursing Children & Young People*, *25*(5), 29-34.
[15] Morbidity and Mortality Weekly Review (2011). Unhealthy Sleep-Related Behaviors — 12 States, 2009. *Centers for Disease Control and Prevention.*
[16] Byars, K.C., Yolton, K., Rausch, J., Lanphear, B, & Beebe, D.W. (2011). Prevalence, Patterns, and Persistence of Sleep Problems in the First 3 Years of Life. *Pediatrics* 2012;129;e276; originally published online January 4, 2012.
[17] Ievers-Landis, C. E. & Kuhn, B. R. (2012). Commentary: Introduction to the Special Issue on Pediatric Behavioral Sleep Medicine. Children's Health Care. 41:183-18.

- Family/professional partnership at all levels of decision-making.
- Access to comprehensive health and related services through the medical home.
- Early and continuous screening, evaluation and diagnosis, and intervention.
- Adequate public and/or private financing of needed services.
- Organization of community services so that families can use them easily.
- Successful transition to all aspects of adult health care, work, and independence.

According to data from the 2010 Needs Assessment Cycle in the Title V Information System (TVIS), also funded by MCHB, and available at https://mchdata.hrsa.gov/tvisreports/MeasurementData/MeasurementDataMenu.aspx, States identified priority needs in the following areas related to pediatric pulmonary care:

- Reduce morbidity due to asthma among children and youth.
- Improve access to preventive, primary, specialty, mental health and oral health care, as well as, health insurance coverage for all children, including those with asthma and other special health care needs.
- Address environmental issues (asthma, lead, second-hand smoke) affecting children, youth, and pregnant women.
- Reduce exposure to lead hazards, asthma triggers, and other environmental hazards to assure safe and healthy home environments.
- Decrease asthma hospitalizations.
- Improve diagnosis and treatment of asthma in the maternal and child health population.
- Decrease unnecessary health care utilization associated with asthma.[18]

II. Award Information

1. Type of Application and Award

Types of applications sought: New, Competing Continuation.

Funding will be provided in the form of a grant.

2. Summary of Funding

This program will provide funding during Federal fiscal years 2015 – 2019. Approximately $2,040,000 is expected to be available annually to fund six (6) awardees. Applicants may apply for a ceiling amount of up to $340,000 per year. The project period is five (5) years. Funding beyond the first year is dependent on the availability of appropriated funds for the PPC program in subsequent fiscal years, satisfactory awardee performance, and a decision that continued funding is in the best interest of the Federal Government.

Effective December 26, 2014, all administrative and audit requirements and the cost principles that govern Federal monies associated with this award are superseded by the Uniform Guidance 2 CFR 200 as codified by HHS at 45 CFR 75.

[18] Title V Information System (TVIS) 2010 - 2015 Needs Assessment Cycle data, Maternal and Child Health Bureau: https://mchdata.hrsa.gov/tvisreports/MeasurementData/MeasurementDataMenu.aspx

III. Eligibility Information

1. Eligible Applicants

As cited in 42 CFR Part 51a.3(b), only public or nonprofit private institutions of higher learning may apply for training grants. "Institution of higher learning" is defined as any college or university accredited by a regionalized body or bodies approved for such purpose by the Secretary of Education and any teaching hospital which has higher learning among its purposes and functions and which has a formal affiliation with an accredited school of medicine and a full-time academic medical staff holding faculty status in such school of medicine.

2. Cost Sharing/Matching

Cost sharing/matching is not required for this program.

3. Dun and Bradstreet Universal Numbering System Number and System for Award Management (formerly, Central Contractor Registration)

Applicant organizations must obtain a valid DUNS number and provide that number in their application. Applicant must also register with the System for Award Management (SAM) and continue to maintain active SAM registration with current information at all times during which it has an active Federal award or an application or plan under consideration by an agency (unless the applicant is an individual or Federal agency that is exempted from those requirements under 2 CFR 25.110(b) or (c), or has an exception approved by the agency under 2 CFR 25.110(d))**.**

HRSA may not make an award to an applicant until the applicant has complied with all applicable DUNS and SAM requirements and, if an applicant has not fully complied with the requirements by the time HRSA is ready to make an award, HRSA may determine that the applicant is not qualified to receive an award and use that determination as the basis for making an award to another applicant.

If an applicant/awardee organization has already completed Grants.gov registration for HRSA or another Federal agency, confirm that it is still active and that the Authorized Organization Representative (AOR) has been approved.

The Grants.gov registration process requires information in three separate systems:

- Dun and Bradstreet (http://fedgov.dnb.com/webform/pages/CCRSearch.jsp)
- System for Award Management (SAM) (https://www.sam.gov)
- Grants.gov (http://www.grants.gov/)

For further details, see Section 3.1 of HRSA's *SF-424 Application Guide*.

Applicants that fail to allow ample time to complete registration with SAM or Grants.gov will not be eligible for a deadline extension or waiver of the electronic submission requirement.

4. Other
Applications that exceed the ceiling amount will be considered non-responsive and will not be considered for funding under this announcement.

Any application that fails to satisfy the deadline requirements referenced in *Section IV.3* will be considered non-responsive and will not be considered for funding under this announcement.

Students/trainees receiving support from grant funds must be a citizen of the United States, a non-citizen national, or a foreign national having in his/her possession a visa permitting permanent residence in the United States.

NOTE: Multiple applications from an organization are not allowable.

IV. Application and Submission Information

1. Address to Request Application Package

HRSA ***requires*** applicants for this funding opportunity announcement to apply electronically through Grants.gov. Applicants must download the SF-424 Research and Related (R&R) application package associated with this funding opportunity following the directions provided at Grants.gov.

2. Content and Form of Application Submission

Section 4 of HRSA's *SF-424 R&R Application Guide* provides instructions for the budget, budget justification, staffing plan and personnel requirements, assurances, certifications, and abstract. You must submit the information outlined in the Application Guide in addition to the program specific information below. All applicants are responsible for reading and complying with the instructions included in HRSA's *SF-424 R&R Application Guide* except where instructed in the funding opportunity announcement to do otherwise.

See Section 8.5 of the *SF-424 R&R Application Guide* for the Application Completeness Checklist.

Application Page Limit
The total size of all uploaded files may not exceed the equivalent of 80 pages when printed by HRSA. The page limit includes the abstract, project and budget narratives, attachments, and letters of commitment and support required in the *Application Guide* and this FOA. Standard OMB-approved forms that are included in the application package are NOT included in the page limit. Indirect Cost Rate Agreement and proof of non-profit status (if applicable) will not be counted in the page limit. **We strongly urge you to print your application to ensure it does not exceed the specified page limit.**

Applications must be complete, within the specified page limit, and validated by Grants.gov under the correct funding opportunity number prior to the deadline to be considered under the announcement.

Program-Specific Instructions
In addition to application requirements and instructions in Section 4 of HRSA's *SF-424 R&R Application Guide* (including the budget, budget justification, staffing plan and personnel requirements, assurances, certifications, and abstract), please include the following:

i. *Project Abstract*
See Section 4.1.ix of HRSA's *SF-424 R&R Application Guide*.

ii. *Project Narrative*
This section provides a comprehensive framework and description of all aspects of the proposed project. It should be succinct, self-explanatory and well organized so that reviewers can understand the proposed project.

Use the following section headers for the Narrative:

- *INTRODUCTION -- Corresponds to Section V's Review Criterion 1 (Need)*
  This section should briefly describe the purpose of the proposed project.

- *NEEDS ASSESSMENT -- Corresponds to Section V's Review Criterion 1 (Need)*
  This section should outline the need for pediatric respiratory health as an important public health issue to be addressed. It should highlight the need for service delivery systems to be leveraged through policies and practices as venues for promoting respiratory health and driving impact at the national, regional, local, and family levels. A critical evaluation of the need/demand for interdisciplinary training, specifically identifying problems to be addressed and gaps which the PPC project is intended to fill, should be included.

  The importance of the PPC project, by relating the specific objectives to the potential of the project to meet the stated goals and purposes of the MCHB training program, should be described. An assessment of the target population of children and youth with respiratory and sleep issues and their unmet health needs, including socio-cultural determinants of health and existing health disparities, should be included. Demographic data should be used and cited whenever possible to support the information provided. Other available and relevant data that further demonstrates the need for the training/interventions/activities proposed in the application should also be included. References should be provided for all data sources; and if available, a summary of needs assessment findings should be included.

- *METHODOLOGY -- Corresponds to Section V's Review Criterion 2 (Response)*
  This section should include proposed methods that will be used to meet each of the program requirements and expectations in this grant announcement. The description of the project methodology should extend across the proposed five years of the project effort. The project methodology should include and describe the goals and objectives of the project and the proposed methods that will be used to accomplish each goal and objective. The proposed methods should include required curriculum, including didactic, clinical and public health components; training strategies, including the expected leadership and interdisciplinary/interprofessional competencies the project graduates are to achieve; and research activities to identify/clarify best practices in pulmonary and sleep health.

1. *GOALS AND OBJECTIVES*

The applicant must develop clear, measurable educational goals and objectives for a didactic, clinical, and evidence-based program. These educational goals and objectives must incorporate: the acquisition of knowledge of all aspects of chronic pulmonary conditions including social adaptation, genomics, and primary, secondary and tertiary aspects of prevention and health promotion; knowledge of the social environment and social determinants of health (the family, community, school, etc.); and, acquisition of skills including interviewing, counseling, teaching, and use of current technology for educational purposes, communication, and information acquisition and processing.

The applicant must state the overall goals of the project as they respond to the four (4) overarching program aims of: 1) Interdisciplinary Training/Practice; 2) Family-Centered Care; 3) Public Health/Population-Based Approach; and, 4) Diversity / Cultural and Linguistic Competence), as delineated below. The application should also outline the observable objectives that respond to the stated goals/need/purpose for the project.

The objectives must be "SMART":

- **S**pecific –simplistically written and clearly define what you are going to do
- **M**easurable – produce tangible evidence demonstrating that you have reached/met the objective
- **A**chievable –stretch you slightly so you feel challenged, but defined well enough so that you can accomplish them within your knowledge, skills, and abilities
- **R**esults-focused – contain specific outcomes, for each project year, which serve as criteria for evaluation of the program.
- **T**ime-Focused - attainable in the stated time frame.

These four (4) aims *should be present and infused throughout the entire application*; however, ***at least one (1) goal and one (1) objective must be clearly delineated and directly connect to each of the four (4) overarching program aims*** describing: a) interdisciplinary nature of the training program; b) partnership with a focus on family-centered care; c) integration of specialty and primary care through public health and population-based approaches; and, d) addressing diversity, cultural linguistic competence, and health equity, in order to align with the purpose of the PPC Program.

A. Interdisciplinary Training And Practice

MCHB supports the PPC programs to educate and train health professional personnel to practice in an interdisciplinary collaborative manner and setting for leadership roles in maternal and child health. *Interdisciplinary training* is defined as an integrated education program involving the interdependent contributions of the knowledge, skills, attitudes, values, and methods of the collaborating disciplines.[19]

In December 2007, the Interdisciplinary Training and Practice Workgroup provided recommendations for outcomes and indicators to assess the extent to which trainees who complete an MCH Training Program have awareness, knowledge, and skills in areas considered to be "core" to interdisciplinary practice.

[19] *Interdisciplinary Training Guide*, National Training Directors Council, AUCD, November 2001. http://www.mchb.hrsa.gov/training/goal_interpractice.asp.

- The Interdisciplinary Training outcomes and indicators were developed based on definitions of interdisciplinary training used by the MCH Training Programs; the definition of interdisciplinary practice and description of its application in the MCH context developed by the workgroup; and, elements of indicators currently used by individual Training Programs.
- These recommendations, as well as the contributing definitions of interdisciplinary training and practice, can be found at: ftp://ftp.hrsa.gov/mchb/training/documents/all_grantee_meeting/2008/06_interdisciplinarytrainingindicators02.pdf.

1) Interdisciplinary Core Disciplines
   - Central to the PPCs is the interdisciplinary nature of the program, which requires that there be a core of experiential, didactic, and research components, which bring together all faculty and long-term trainees in such a manner and for such periods of time as are necessary for the interdisciplinary process to be effectively demonstrated and practiced.
   - *At a minimum*, PPC programs are expected to demonstrate interdisciplinary leadership development in the five (5) core disciplines of: ***1) pediatric pulmonary medicine; 2) nursing; 3) social work; 4) nutrition***; and ***5) family leadership.***
   - PPC projects must include, but are not limited to these five disciplines. The project must define the content and process which will assure that this interdisciplinary requirement is satisfied within the context of the program.

2) The interprofessional domains and competencies for interdisciplinary education and practice[20], which can be found at http://www.aacn.nche.edu/education-resources/ipecreport.pdf , and the Interdisciplinary Training and Practice Workgroup recommendations are suggested resources for applicants to reference in conceptualizing and developing competencies for the proposed PPC project.

3) Applicants must describe the interdisciplinary competencies that project graduates are expected to achieve as a result of participation in the PPC program. NOTE: It is expected and understood that the leadership requirement and the interdisciplinary requirement may be reflected within the same competency.

B. Family-Centered Care

Evidence supporting a family-centered approach in the PPC program includes National Survey studies, a multi-site study, Institute of Medicine Reports, the National Quality Forum, the Joint Commission, and the Agency for Healthcare Research and Quality (AHRQ).[21] Research shows associations of family participation and patient-centered care with improved transition, fewer unmet needs, better community-based systems, fewer problems with specialty referrals, lower costs, improved patient (physical and behavioral) function, increased adoption of a medical home/access to preventive health care, and

[20] *Core Competencies for Interprofessional Collaborative Practice: Report of an Expert Panel.* Interprofessional Education Collaborative (IPEC). May 2011. Retrieved July 3, 2014 from http://www.aacn.nche.edu/education-resources/ipecreport.pdf

[21] National Strategy for Quality Improvement in Health Care: Report to Congress. March 2011. Department of Health & Human Services. Retrieved July 5, 2014 from http://www.ahrq.gov/workingforquality/nqs/nqs2011annlrpt.pdf.

improved quality of care.[22] [23] The evidence also establishes family/professional partnership, shared decision making, and patient/family-centered care as a national quality indicator. Moreover, AHRQ endorses the need to help families navigate the health care system; recognize high-quality health care; become informed health care consumers; and develop skills in selecting a hospital, doctor, and health plan (highlighted also as a priority within the National Quality Strategy). [24]

Family-Centered Care is the standard of practice that results in high quality services. The foundation of family-centered care is the partnership between families and professionals. MCH Training Programs have expanded this partnership to include family members, youth, and community members as critical partners. Within MCH Training Programs, family, youth and community members, are faculty members, consultants, partners, advisors, staff, and students.

The key to this partnership are the following principles:

1) Families and professionals work together in the best interest of the child and the family. As the child grows, she assumes a partnership role.
2) Everyone respects the skills and expertise brought to the relationship.
3) Trust is acknowledged as fundamental.
4) Communication and information sharing are open and objective.
5) Participants make decisions together.
6) There is a willingness to negotiate.

Based on this partnership, family-centered care:

1) Acknowledges the family as the constant in a child's life.
2) Builds on family strengths.
3) Supports the child in learning about and participating in his/her care and decision-making.
4) Honors cultural diversity and family traditions.
5) Recognizes the importance of community-based services.
6) Promotes an individual and developmental approach.
7) Encourages family-to-family and peer support.
8) Supports youth as they transition to adulthood.
9) Develops policies, practices, and systems that are family-friendly and family-centered in all settings.
10) Celebrates successes.

For more information about family-centered care, please visit http://www.mchb.hrsa.gov/training/goal_workforce_diversity.asp.

[22]Report on the Current "State of the Art" for Medical / Health Care Home. December 2008. Institute for Clinical Systems Improvement. Retrieved July 5, 2014 from http://www.health.state.mn.us/healthreform/homes/background/icsireport.pdf.
[23]Kuo, D., Bird, T., & Tillford, J. (2011). Associations of Family-Centered Care with Health Care Outcomes for Children with Special Health Care Needs. Maternal and Child Health Journal. 15(6):794-805.
[24]National Strategy for Quality Improvement in Health Care: Report to Congress. March 2011. Department of Health & Human Services. Retrieved July 5, 2014 from http://www.ahrq.gov/workingforquality/nqs/nqs2011annlrpt.pdf.

C. Public Health /Population-Based Approach

The integration of public health, primary care, and specialty care is key to the implementation of the Affordable Care Act. This is particularly important for children and young adults, for whom social institutions (e.g., child care, schools, extra scholastic recreation activities) provide opportunities for health promotion. Within the context of the Affordable Care Act, there are new opportunities for PPC and Title V programs to integrate systems to better improve the health and well-being of women, children, and families. Implementation of the Affordable Care Act has accelerated such opportunities through emerging delivery system mechanisms. One of the challenges of health care reform continues to be how to critically assess the ways in which primary care, specialty care, and public health can be better integrated.

The 2012 Institute of Medicine Report highlights the need for the development of training and teaching tools to prepare the workforce, both primary and specialty care clinicians, and public health professionals, for shared practice. Successful integration will address social and environmental determinants of health, engage communities, align leadership, develop the healthcare workforce, sustain systems, and share and collaborate on the use of data and analysis—all with an eye toward achieving a shared goal of population health improvement.[25]

The applicant should document ways in which the PPC training program might influence integrated care for children with chronic respiratory condition, special health care needs, and their families through new delivery system mechanisms, such as Accountable Care Organizations (ACOs); Patient-Centered Medical Homes, including those supported by Title V MCH programs; Home Visiting programs; Healthy Start sites; Medicaid Health Homes for persons with chronic conditions; Health Center programs; and, "Look-Alike" programs.

D. Diversity / Cultural Linguistic Competence / Health Equity

MCHB strives to develop an MCH workforce that is reflective of the diversity of the nation. This strategy requires a focus on increasing the diversity of MCH faculty and students. By addressing faculty and trainee diversity, and incorporating cultural competence and family-centered care into training programs, the DMCHWD aims to improve the quality of care for the MCH population. Over time, DMCHWD must evaluate whether the emphases on diversity, cultural competence, and family-centered care might also help to reduce health disparities.

"Cultural competence" is defined as the knowledge, interpersonal skills, and behaviors that enable a system, organization, program, or individual to work effectively cross-culturally by understanding, appreciating, honoring, and respecting cultural differences and similarities within, and between, cultures. Cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time.

"Culture" refers to language; thoughts; communications; actions; customs; beliefs; values; and institutions of racial, ethnic, religious, social group, or self-identified community. "Competence" implies having the capacity to function effectively as an individual and/or

[25] National Research Council. *Primary Care and Public Health: Exploring Integration to Improve Population Health*. Washington, DC: The National Academies Press, 2012.

organization, within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. Cultural competence requires that systems, organizations, programs, and individuals have the ability to:

- Appreciate diversity and similarities in customs, values, beliefs, and communication patterns among all peoples.
- Understand and effectively respond to cultural differences.
- Engage in cultural self-assessment at the individual and organizational levels.
- Make adaptations to the delivery of services and enabling supports through policy making, infrastructure building, program administration, and evaluation.
- Institutionalize cultural knowledge and practices.
- Communicate effectively with persons of limited English proficiency, reading and comprehension skills.

The complexity, prevalence, and continued health disparities of pediatric pulmonary issues require that children and youth with these conditions be served by PPC health professionals practicing in an interdisciplinary, family-centered, culturally competent manner.

The applicant must document how their PPC project will address diversity and health equity and promote cultural and linguistic competence through their training and practice environments, such as faculty recruitment, training, and professional development; and through recruitment of diverse trainees and family leaders from underserved populations and community organizations serving hardest-to-reach populations and communities, for participation in the project.

The applicant should emphasize, either as discrete topics or as topics integrated in other components, appropriate didactic, experiential, and research components relative to the development, implementation and evaluation of systems that address diversity, cultural and linguistic competence, disparities, and inequalities in health care. The applicant description should address how health equity strategies will be incorporated within didactic methods, curricula, research, leadership development, and clinical activities including references to emerging theories in public health such as the life course, social determinants of health, and health equity models.

For more information about cultural competence, please visit: http://www.mchb.hrsa.gov/training/goal_workforce_diversity.asp.

2. Methods—Training, Curriculum, Collaboration, Research, and Activities

The applicant should describe the activities, methods, and techniques to be used to accomplish the project goals and objectives of the project by YEAR. Interdisciplinary approaches to care, training, curriculum development, and research activities should be emphasized.

A. Training

Training should not be limited to didactic strategies to achieve educational objectives and competencies. The PPC programs should offer long-term, medium-term, and short-term trainees a balance of learning experiences. These learning experiences are interdisciplinary/interprofessional in nature, including didactic, skills-based, seminar,

mentoring, community service projects, research skills, and peer leadership in addition to required oral and written presentation experiences.

1. Trainees
   a. Trainees may be supported in each of the professions represented on the required core faculty and by the family leader. Support for trainees is limited to those whose career goals are aligned with the priorities outlined in this program guidance.
   b. The primary purpose of PPC is for the training of graduate and post-graduate health professionals in an interdisciplinary/interprofessional MCH setting. The Project Narrative should include criteria for and a **detailed** description of:
      i. Methods of recruitment, including the geographic area and types of trainees to be targeted by the project.
      ii. Methods for selecting trainees whose career goals are consonant with PPC program objectives.
      iii. Special efforts directed toward recruitment of qualified trainees that are culturally, racially, and ethnically diverse. The MCH Training Program focuses on recruiting culturally, racially, and ethnically diverse trainees because studies have documented that diverse providers are more likely to serve underserved populations, thus increasing the likelihood that health care disparities will be addressed.
      iv. Estimate of the number and types of trainees who will benefit from the program.
      v. Any special efforts to retain trainees once they have entered the program.
      vi. Sources of support for trainees, please review guidance in the **Appendix : "Guidelines for Trainees/Fellows"** for specific information about qualifications, restrictions, allowable and non-allowable trainee costs and stipend levels. MCH training support (tuition, stipends, travel, etc.) must be limited to students whose background, career goals, and leadership potential are consonant with the intent of the PPC training grant. Trainee support varies, by discipline, in accordance with standards of the profession, availability of other support, nature of training required to meet program goals, and other factors. *IMPORTANT NOTE: As used in this section, fellowships refer to non-degree related training and traineeships refer to degree-related training.*

   c. Fellows and trainees should be representative of the health professions required to serve as core faculty; however, programs have flexibility to consider outstanding trainee candidates in other health professions (i.e. pharmacy) that would contribute to the MCH field. The following is intended as a guide for the types of trainees/fellows generally supportable in each profession:

      i. Pediatric Pulmonary Medicine – *Three-year, non-degree conveying, post-residency fellowships in pediatric pulmonary medicine*. The fellowship program must comply with the recommendations of the Accreditation Council for Graduate Medical Education Residency Review Committee.

ii. Nursing – *Master's or Doctoral candidates*. Consideration may be given to post-master's clinical fellowships of not more than one year in duration.
iii. Social Work – *Master's or Doctoral candidates*. Consideration may be given to post-master's clinical fellowships of not more than one year in duration.
iv. Nutrition – *Registered Dietitian, Master's or Doctoral candidates*. Consideration may be given to R.D.s for post-master's clinical fellowships of not more than one year in duration.
v. Family Leadership –*An Adult Family Member* (Parent, Sibling, etc.) or *Caregiver* of a child with chronic respiratory issues or special health care needs or a *Young Adult Consumer Representative* with chronic respiratory issues. Family traineeship may not be more than one year in duration.

d. Conditions of Support: Trainees must be:
i. At least a master's candidate.
ii. Long-Term (minimum of 300 hours**)** and/or Medium-Term (40-299 hours).
iii. Enrolled in programs providing a minimum of 50% of the total training experience for which support is requested as a part of the clinical program, or in programs directly under the control and supervision of training faculty.

e. Other Trainees
i. PPC programs are expected to develop exemplary models of education and training that may include, for example, elective experiences for short-term and medium-term trainees, such as health care professionals not supported by the training grant. For example, health centers might be utilized as an experiential training site with center providers/staff participating as short-term/medium term "other" trainees.
ii. Short-term trainees are defined as trainees receiving less than 40 contact hours in a program, and do not include continuing education (CE) recipients.
iii. Medium-term trainees are defined as trainees receiving equal to or more than 40 and less than 300 contact hours in a program. *IMPORTANT NOTE: Stipend support for medium-term trainees must be approved by HRSA since the program priority is the training of long-term trainees.*
iv. Fellows and long-term trainees are expected to participate in these teaching activities, and to serve as role models for students, residents, and other short-term and medium-term trainees.

f. Eligibility Qualifications of Trainees/Fellows:
- See **Appendix: "Guidelines for Trainees/Fellows"**

2. Clinical Preparation/Service

Training should be based on comprehensive, exemplary, interdisciplinary/ interprofessional, clinical services which are family-centered, and culturally and linguistically competent. Training should focus on prevention, early detection,

assessment, care coordination, and treatment, including home care and follow up of children who have, or are at risk for development of, chronic pulmonary conditions, including asthma, cystic fibrosis, and bronchopulmonary dysplasia (BPD); sleep issues; and/or who are technology dependent. Training must occur, in both institutional (inpatient and outpatient) and remote site community-based settings, with a client population representative of the cultural, social, and ethnic diversity of the community.

It is expected that the clinical component of the training will occur, both within the primary program setting and in diverse community settings. The training settings must provide sufficient and appropriate space for core faculty and trainees for clinical and teaching activities. The training plan must be structured to assure sufficient formal interaction, and informal association, to accomplish and enhance the interdisciplinary experience on which the program is based. Community settings will seldom approximate the interdisciplinary staffing, or practice of the primary setting, and thus provide important, contrasting models of care. This might be an opportunity for applicants to build upon existing interdisciplinary, diversity, and team-based strategies and approaches within health centers. Applicants are encouraged to coordinate clinical training opportunities with MCHB-funded research sites and Title V programs, if possible.

Clinical and community service sites should provide exemplary, comprehensive, community-based services in a variety of institutional, and rural/urban community-based settings, focused on children with respiratory health care needs and other special health care needs representative of the cultural, social, and ethnic diversity of the community. Selection, of clinical sites in underserved communities, is especially recommended. To the extent possible, clinical services at community service sites should include community engagement activities and educational efforts. For instance, the project might provide a community in-service on the asthma exacerbating effects of in-home/ environmental irritants, such as tobacco, or wood smoke; perfumes; aerosol sprays; cleaning products; and fumes from paint, or cooking gas.

3. Community-Based Preparation

Programs must involve their trainees in a variety of settings that help to foster achievement of community-based, coordinated care. Community-based experiential settings might include primary care, primary care with specialist consultation, and specialist/dedicated practices. Sites should include outpatient and inpatient programs in tertiary care centers, as well as community-based sites that are off-campus from the academic medical center. Examples might include Health Center and Look-Alike program grantees supported by the Bureau of Primary Health Care, free clinics, public health departments, rural outreach clinics, and telemedicine services.

B. Curriculum

Content and philosophy must address the four aims of the PPC program and be geared to preparation of graduates to assume leadership roles in the development, and improvement and integration of systems of care; especially in programs providing maternal and child health services, including those for children with special health care

needs, with special emphasis on care of chronic respiratory conditions, in community-based, family-centered settings. Attention to the needs of children living in underserved communities is strongly encouraged. The curriculum must include content about family-centered care that assures the health and well-being of children and their families through a respectful family-interprofessional partnership.

The curriculum should also emphasize content relating to science-based judgment, evidenced-based practice, and documentation of quality outcomes and performance within an established plan of care; expansion of the direct service roles to include interdisciplinary/interprofessional consultation, collaboration, and supervision; and various service delivery models and approaches.

Applicants must develop clear, measurable educational project objectives for an interdisciplinary core curriculum (didactic and practicum); clinical/service experiences; and research opportunities for project trainees, which incorporate the acquisition of knowledge of:

- Knowledge of public health, including the social environment (the family, community, school, etc).
- Cultural competency and family-centered services.
- Life course and social determinants of health.
- Interdisciplinary team skills (team building, shared leadership, mutual accountability, etc).
- Communication skills (verbal, written, conflict resolution, etc).
- Leadership skills (refer to MCH Leadership Competencies and Version 3.0—see information below for details).
- Acquiring of skills, including interviewing, counseling, teaching, and use of current technology for educational purposes, communication, and information acquisition and processing.

Content/Competency Preparation

Attachment 9 should contain a ***brief syllabus,*** *or* ***curriculum summary,*** *differentiating between required and elective components, and include:*

- *Descriptions of courses;*
- *Clinical experiences;*
- *Community/public health opportunities;*
- *Competency preparation; and*
- *Research activities.*

This brief syllabus/curriculum summary, in **Attachment 9**, should also:

- *Infuse the topical areas described below; and*
- *Include a "snapshot" description of trainee experiences over the course of the project*

1) Leadership

The MCH Training Program places a particular emphasis on leadership education. The curriculum must include content and experiences to foster development of

leadership attributes. Leadership training prepares MCH health care professionals to move beyond excellent clinical or health administration practice to leadership, through practice, research, teaching, administration, and advocacy. The PPC project must indicate how MCH Leadership Competencies will be incorporated into the training program. A complete description of the competencies, including definitions, knowledge areas, and basic and advanced skills for that competency is included at: http://leadership.mchtraining.net.

2) Public Health

The project must address a broad public health perspective. At a minimum, a broad public health perspective includes, but is not limited to; analysis of core public health functions applied to pediatric pulmonary care issues, community needs assessment, advocacy, public policy formulation and implementation, legislation/rule making, financing, budgeting, communication, program administration, consultation, and program planning and evaluation. It should emphasize, either as discrete topics or as topics integrated into other elements, appropriate didactic, experiential, and research components relative to MCH/Title V and related legislation. The project should also address emerging public health issues relevant to respiratory and sleep health and provide opportunities for trainees to interact with MCH personnel, and other public health professionals. Project faculty should provide consultation and technical assistance to develop or improve community-based services, and such technical assistance should be utilized to enhance trainee exposure to and understanding of such services.

MCHB encourages organizations to develop proposals that incorporate and build upon the goals, objectives, guidelines and materials of emerging theories in public health with initiatives that aim to improve the overall quality of health promotion and preventive services in the context of family and community. Hence, PPC projects should include references to emerging issues and theories in public health such as the Life Course, Social Determinants of Health, and Health Equity Models; MCHB Performance Measures; priorities outlined by State Public Health Agencies through the Title V Information System (https://perfdata.hrsa.gov/mchb/mchreports/Search/search.asp); health reform issues; and *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents.*

3) Family-Centered Care

Family-centered care honors the strengths, cultures, traditions, and expertise that everyone brings to the relationship. Family-centered care is the standard of practice that results in high quality services. The PPC curriculum must also include content about family-centered care that assures the health and well-being of children and their families through a respectful family-professional partnership.

4) Cultural/Linguistic Competence (CLC)

The applicant must demonstrate how the training program will address issues of cultural competence, such as including cultural/linguistic competence training in the curriculum, clinical and community experiences, administrative procedures, faculty and staff development, and recruiting culturally, racially and ethnically diverse faculty and students. Training must be structured on a broad range of

exemplary, interdisciplinary, comprehensive services which provide family-centered, coordinated care that is responsive to the cultural, social, linguistic, and ethnic diversity of the community.

For more information about the Curricula Enhancement Module Series created by the National Center for Cultural Competence, please visit http://www.nccccurricula.info/.

5) Distance Learning Methodologies/Technology
The project must incorporate the use of current technology for communication, training, and education, including distance learning techniques and methodologies for remote, off-site, and/or online learning, collaboration, consultation, continuing education and technical assistance. Programs should use principles of adult and youth/child/developmentally-appropriate learning and proven education models utilizing available technologies such as multimedia networking, teleconferencing, satellite broadcasting, webcasting, blogging, social networking sites, and other innovative and interactive technologies.

6) CYSHCNs (Children and Youth with Special Health Care Needs)
CYSHCNs are defined as "those children and youth who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally" (American Academy of Pediatrics, 1998).

The PPC project should emphasize, either as discrete topics or as topics integrated in other components, appropriate didactic, experiential, and research components relative to the development, implementation and evaluation of systems of health care for CYSHCNs, most specifically as issues relate to respiratory and sleep health.

7) MCH/Title V and Related Legislation
The project must provide for a comprehensive historical, legislative, and public health knowledge base regarding Title V and related programs. The project must include theoretical, experiential, and research-related components which provide students with working knowledge of Title V and related legislation.

8) Healthy People 2020
The project must reflect awareness of emerging health problems and practice issues, such as those outlined in Healthy People 2020 National Health Promotion and Disease Prevention Objectives, which can be found at: http://www.healthypeople.gov/).

C. Regional Training, Regional Consultation/Collaboration, and National Interchange

The applicant should document and describe plans to address the following three (3) areas around training, consultation, collaboration, and interchange as a SPRANS-funded grantee: 1) a collective regional training approach; 2) a distinct PPC project-specific approach to regional consultation and collaboration; and, 3) a plan for program collaboration and national interchange.

1) Collective Regional Training Approach

The applicant must document and describe a ***potential*** collective regional approach to training, consultation, and/or collaboration ***that can be further developed, formalized, and implemented collectively*** by each of the funded PPC programs, within a region of determination, during the five-year project period. In this description, the applicant must:

A) *Define one proposed region*. This description of the defined region must include several states and/or U.S. territories (i.e. Puerto Rico) that will be impacted by the proposed regional approach.

B) *Define one proposed regional strategy to be implemented.* This regional strategy must be implementable by Year 2 of the project period and able to produce the demonstrated outcome/impact in each state within the defined region by Year 4 of the project period.

C) *Define one proposed outcome/impact of the regional strategy*. This outcome/impact must be directly attributable to the proposed regional strategy and be measureable within all of the states/territories within the defined region.

D) *Define one proposed evaluative measure of the regional strategy.* This evaluative measure must be able to definitively demonstrate that the outcome/impact has occurred in all states within the defined region.

E) *Include written assurance of PPC program's participation in collective approach.* The applicant must include a statement of assurance that the PPC program will participate in the planning, finalization, implementation, evaluation, revision, and reporting of the collective regional approach to training, consultation, and/or collaboration during the entire five-year project period. Additionally, this assurance must include a willingness to host (as applicable); participate in the meeting planning process (as applicable); and attend the collective regional approach collaborative meeting (which will also serve as the Year 1 annual PPC meeting within this project period) to be held no later than the Spring of 2016.

2) Distinct PPC Project-Specific Regional Consultation/Collaboration with State Title V/MCH Agencies/Other Related Programs.

A) The applicant must describe the project-specific coordination planned with appropriate national, regional, State and/or local health agencies and/or organizations in the area(s) served by the project.

B) The applicant must work to improve access to pediatric pulmonary care in rural, urban underserved, tribal communities, and/or other hardest-to-reach populations (populations with medical service access barriers, which might be socio-economic, physical, cognitive/developmental, cultural, and/or linguistic) within the applicant's state and/or region by providing clinical consultation through a variety of mechanisms such as telehealth, phone consultation, and some in-person consultation to align with other HRSA investments (i.e. Health Center program grantees and Look-Alikes, Health Center Controlled Networks [HCCNs], Primary Care Associations, [PCAs], National Cooperative Agreements [NCAs], the National Health Service Corps [NHSC], etc.). Examples of consultative services include, but are not limited to:

- Consultation and support to monitor children with complex asthma to avoid emergency room visits and hospital admissions.
- Consultation and support for the follow up of premature babies with bronchopulmonary dysplasia.
- Consultation and support of sleep apnea issues in obese adolescents.
- Access to an interdisciplinary team that can offer support on multiple issues, navigation of needed services, and parent support.

C) The applicant must document active and effective relationships with State Title V MCH Programs and other related programs, e.g., XIX (Medicaid/EPSDT), and XXI (State Children's Health Insurance Program), as well as with providers in under-resourced areas including consultation, in-service education, and continuing education geared to the needs of several States and/or a HRSA region.

- As an example, the applicant might document ways in which the PPC training program might initiate and maintain partnerships with primary care, public health, and other providers such as Health Center program grantees and Look-Alikes, WIC providers and others, across the country and engage in prevention of chronic respiratory conditions and other diseases at the very earliest opportunities.

PPC faculty should engage fellows and trainees in consulting with and providing technical assistance and/or continuing education to Community Health Center program grantees and Look Alikes, State Title V / MCH agencies / other related programs in the development of new health programs and in the application of innovative techniques affecting the health care system. Consultation, technical assistance, and/or continuing education, to develop or improve community-based services, should be provided by program staff and should be utilized to enhance trainee exposure to and understanding of such services.

Collaboration with agencies or programs providing educational, legal, social, recreational, rehabilitative or similar services; or service on boards, commissions, advisory groups or similar entities which set standards, help define public policy or otherwise influence service on a multi-state, regional, or national basis should also be documented.

- As an example, the applicant might incorporate population-based social determinants of health strategies, such as increasing the public knowledge and educating community partners (i.e. local health departments) about diesel air pollution from ports, trains, buses, and truck and its link as a primary trigger and source of exacerbating asthma. In this way, the approach is not just on managing individuals with a health condition, but on increasing the health equity of the people who live in the neighborhoods that are most subject to these conditions, and the health problems that emerge from them.
- Collaboration must be documented in the application, i.e., descriptions of committees, copies of agreements/contracts, etc.
- Programs must provide for periodic meetings/workshops/conferences for the purpose of furthering the development of pediatric pulmonary health

and related services at the national level. The general plan for the conduct of such activities should be defined in the project narrative.

- Title V national and state performance measures are changing in order to adapt to the evolving MCH landscape. Of particular relevance to PPC program applicants will be new child health performance structural and process measures that state Title V programs will develop in support of national outcomes and performance outcome measures.

3) Program Collaboration Across All MCHB-Funded PPC Programs

National collaboration/linkage with all funded PPC programs is required. The annual grantee meeting and quarterly call are designed to promote productive interchange and assist in the development of national PPC collaborative activities.

A) Annual Meeting.

- It is recommended that each PPC grantee provide an outline of a plan to conduct the PPC annual meeting, on a rotating basis, at least one (1) time during the five (5) year project cycle.
- It is recommended that the PPC annual meeting plan outline include proposed expenses, not to exceed $25,000, to cover the costs of planning and conducting the annual meeting.
- It is suggested that the host PPC grantee coordinate with the MCHB Program Staff in selecting both the date and location of the PPC annual meeting to facilitate coordination with other available meetings.
- Each PPC grantee/program should send at least two (2) faculty members to the annual PPC grantee meeting. It is also *recommended* that each program consider bringing one (1) to two (2) fellows/long-term/level II medium-term trainees (with at least 150 contact hours) to the annual PPC meeting.
- The meeting host PPC grantee should consider incorporating a session/activity, within the annual meeting, geared towards fellows/long-term/level II medium-term trainees, in which some aspect of trainee work can be showcased (i.e. poster presentation of leadership, community-service, research-specific, policy-based project, etc).
- IMPORTANT NOTES:
  a. *No later than Spring of 2016, the designated annual meeting host PPC grantee is required to hold the first annual meeting, within this project period, in the Washington, D.C. area to facilitate the collective regional approach to training collaboration session (see Project Narrative). MCHB Program Staff/Consultants will support host grantee in the facilitation of this collaboration session.*
  b. *This annual meeting requirement may be waived during Year 5 of the project period.*

B) Quarterly Calls

- It is recommended that each PPC grantee provide an outline of a plan to host PPC program quarterly calls, on a rotating basis, during at least one (1) budget year of the five-year project period.
- It is recommended that the PPC grantee, hosting the call, organize calls, on a quarterly basis (or every three [3] months) with the Project Director or at

least one (1) faculty representative from each of the six (6) PPC programs attending the calls. The call host grantee should take meeting minutes for each call.

- Once funded, the six (6) PPC programs may jointly determine an alternative process (i.e. at least quarterly *Steering Committee* calls) for meeting this quarterly call requirement.

D. Research Activities

Programs must provide for the conduct of collaborative research by the faculty and by trainees under their supervision (e.g., contributing new knowledge, validating effective intervention strategies, assessing quality, or linking intervention to functional outcomes and quality of life).

1) Trainee Research

All trainees are expected to receive exposure to and achieve basic understanding of research principles, methodology, and application. This may be achieved through formal course work, lectures/presentations, participation in a research activity, or combinations of these and/or other methods. The nature and degree of research exposure/involvement should be commensurate with the level (prior training) of the trainee and length of PPC training involvement. Master's level students are expected to gain knowledge and skills in research methodology and dissemination of research findings into practice. Long-term doctoral and post-doctoral trainees are required to conduct a specific research activity, either as an individual investigator with appropriate faculty advice and mentorship, or collaboratively with other trainees and/or faculty. Doctoral students are to prepare and present findings in peer-reviewed journals and meetings.

2) Faculty Research

Faculty are expected to engage in research relevant to the purposes of the program. PPC training funds may not be utilized for support of faculty research; however, reasonable commitments of faculty time to research activities, *when such activities contribute to PPC training purposes*, will be construed as falling within the required faculty time commitments to the training program.

- *WORK PLAN – Corresponds to Section V's Review Criteria) 2 (Response) and 4 (Impact)*

The application should describe the activities or steps that will be used to achieve each of the activities proposed during the entire project period in the Methodology section. The project work plan should describe the roles and responsibilities of key project personnel. As appropriate, identify meaningful support and collaboration with key stakeholders in planning, designing and implementing all activities, including development of the application and, further, the extent to which these contributors reflect the cultural, racial, linguistic and geographic diversity of the populations and communities served. Provide a timeline and identify responsible persons for implementation of the activities that will support the objectives.

Please include the proposed project's Work Plan in **Attachment 1**.

Include copies of agreements, letters of understanding/commitment or similar documents from key organizations/individuals of their willingness to perform in accordance with the

work plan presented in the application. Letters of agreement or similar documents defining the relationships between the proposed program and collaborating departments/ institutions, organizations, or agencies, and the responsibilities of each should be included.

Include only letters of support which specifically indicate a commitment to the project/program (in-kind services, dollars, staff, space, equipment, etc.). Letters of agreement and support must be dated. List all other support letters on one page

Please include *Letters of Agreement / Support / Commitment* in **Attachment 5**.

IMPACT

Applications should demonstrate the impact of PPC programs on children and youth with chronic respiratory conditions and their families; health professionals; Title V partners; and, community partners through key activities. Proposed impact of the training program around the four program aims should be outlined in the program logic model (Attachment 2).

PPC program impact might be evident through: 1) an increase in pediatric pulmonary clinicians (physicians, nurses, nutritionists, and social workers) who practice in an interdisciplinary manner and become excellent teachers, researchers, administrators, and policymakers to improve health outcomes for children with chronic respiratory conditions; and 2) an increase in knowledge supporting evidence-based practices, interventions, preventive measures, and informed policy in family-centered respiratory care. 3) recruitment of trainees from racially, ethnically and culturally and linguistically diverse backgrounds and other hardest-to-reach communities; and, 4) impact of a collaborative, regional approach to improving systems of care and health outcomes for children with chronic respiratory conditions.

DISSEMINATION

b. As PPC training programs revise and develop new curricular materials, technical models, and other educational resources and references in response to new research findings and developments in the field of MCH, they should disseminate information about these and make them available to other public health programs, professional associations, and/or other pediatric pulmonary training programs in order to enhance attention to programs without this emphasis.
c. The application should document the extent and effectiveness of plans for dissemination of project results; the extent to which project results may be national in scope; and the degree to which the project activities are collaboratively shared with other HRSA stakeholders through venues, such as the HRSA TRAIN (https://hrsa.train.org) and/or the MCH Navigator (http://www.mchnavigator.org/).

- *RESOLUTION OF CHALLENGES -- Corresponds to Section V's Review Criterion 2 (Response)*

  Discuss challenges that are likely to be encountered in designing and implementing the activities described in the Work Plan, and approaches that will be used to resolve such challenges.

- *EVALUATION AND TECHNICAL SUPPORT CAPACITY -- Corresponds to Section V's Review Criteria) 3 (Evaluative Measures) and 5 (Resources/Capabilities)*
  Evaluation and self-assessment are critically important for program improvement and assessing the value-added contribution of Title V investments. Consequently, discretionary grant projects, including training projects, are expected to incorporate a carefully designed and well-planned evaluation protocol capable of demonstrating and documenting measurable progress toward achieving the stated goals.

  The measurements of progress toward goals should include both process and outcome measures. Process evaluation is a type of evaluation that examines what goes on while a program is in progress. It assesses what the program is and how it is being implemented or carried out. Outcome evaluation is a type of evaluation that attempts to determine a program's results. Outcome evaluation is often used to determine the extent to which a program achieves its outcome-oriented objectives.

  Applicants must describe the plan for the program performance evaluation that will contribute to continuous quality improvement. The program performance evaluation should monitor ongoing processes and the progress towards the goals and objectives of the project. The measurement of progress toward goals should focus on systems, health and performance outcome indicators, rather than solely on intermediate process measures.

  The protocol should be based on a clear rationale relating to the identified needs of the target population with project goals, grant activities, and evaluation measures. A project lacking a complete and well-conceived evaluation protocol may not be funded. A formal plan for evaluating the PPC program must address how the major goals and objectives of the project will be achieved.

  Monitoring and evaluation activities must be ongoing and, to the extent feasible, must be structured to gain information that is quantifiable and permits objective, rather than subjective, judgments. The applicant should explain how required performance data will be collected, the methods for collection, and the manner in which data will be analyzed and reported. The specific outcomes for the objectives in each project year, which were included with your goals, represent the criteria for evaluation of the program. Therefore, data analysis and reporting must facilitate evaluation of the project outcomes.

  Applicants must describe the systems and processes that will support the project's performance management requirements through effective tracking of performance outcomes, including a description of how the program will collect and manage data (e.g. assigned skilled staff, data management software) in a way that allows for accurate and timely reporting of performance outcomes. The applicant should describe who on the project will be responsible for refining, collecting, and analyzing data for the evaluation, and how the applicant will make data-driven changes to the project, based on evaluation findings, as part of a continuous quality improvement effort. The applicant should describe the current experience, skills, and knowledge, including individuals on staff, materials published, and previous work of this nature. As appropriate, describe the data collection strategy to collect, analyze and track data to measure process and impact/outcomes, with different cultural groups (e.g., race, ethnicity, language), and explain how the data will be used to inform program development and service delivery. Applicants must describe any potential obstacles for implementing the program performance evaluation protocol and how

those obstacles will be addressed.

The applicant must present a plan for collecting the data elements described in the MCHB Administrative Forms and Performance Measures, which can be found at: https://perf-data.hrsa.gov/mchb/DgisApp/FormAssignmentList/T72_2.HTML.

If there is any possibility that an applicant's evaluation may involve human subjects research as described in 45 CFR part 46, the applicant must comply with the regulations for the protection of human subjects, as applicable.

The evaluation protocol should include descriptions of the inputs (e.g., organizational profile, collaborative partners, key staff, budget, and other resources), key processes, and expected outcomes of the funded activities. To facilitate this evaluative aspect, applicants must include a *logic model* (**Attachment 2**) for designing, managing, and evaluating the outcomes of their project in the evaluation plan. A logic model is a one-page diagram that presents the conceptual framework for a proposed project and explains the links among program elements. While there are many versions of logic models, for the purposes of this announcement the logic model should summarize the connections between the:

- Goals of the project (e.g., objectives, reasons for proposing the intervention, if applicable);
- Assumptions (e.g., beliefs about how the program will work and is supporting resources. Assumptions should be based on research, best practices, and experience);
- Inputs (e.g., organizational profile, collaborative partners, key staff, budget, other resources);
- Target population (e.g., the individuals to be served);
- Activities (e.g., approach, listing key intervention, if applicable);
- Outputs (i.e., the direct products or deliverables of program activities); and
- Outcomes (i.e., the results of a program, typically describing a change in people or systems).

Please include the proposed project's Logic Model in **Attachment 2**.

- *ORGANIZATIONAL INFORMATION -- Corresponds to Section V's Review Criterion 5 (Resources/Capabilities)*
  Applicant organizations are expected to have sound systems, policies, and procedures in place for managing funds, equipment, and personnel to receive grant support. Applicants who propose subcontracting these administrative or fiduciary responsibilities for the project will not be approved for funding. All successful applicants must perform a substantive role in carrying out project activities and not merely serve as a conduit for an award to another party or to provide funds to an ineligible party.

  The applicant should provide information on the applicant organization's current mission and structure, scope of current activities, and an organizational chart, and describe how these all contribute to the ability of the organization to conduct the program requirements and meet program expectations. The organizational chart should include how the administration and the fiscal management of the proposed project will be integrated into the current administration. The applicant should provide information on the program's resources and capabilities to support provision of culturally and linguistically competent

and health literate services. The applicant should describe how the unique needs of target populations of the communities served are routinely assessed and improved.

Please include the proposed project's Organizational Chart in **Attachment 6**.

PPC Faculty Specifics:

A. PPC Project Director and Core Faculty Composition

The highly sophisticated nature and complexity associated with interdisciplinary/ interprofessional education demands a special type of faculty commitment and dedication. Programs must document a staffing plan that includes appropriately qualified core faculty with adequate time commitment to participate fully in all components of the training program.

1) PPC Project Director

The PPC Project Director (PD) shall be a board-certified pediatrician, with sub-specialty certification in pediatric pulmonology, at the assistant professor-level or higher who has experience in programs serving children with special health care needs, post-graduate level teaching and the conduct of scholarly research related to pediatric pulmonology. The PD must be the person having direct, functional responsibility for the program for which support is directed. *IMPORTANT NOTE: The Project Director for the MCH training grant is administratively responsible in all cases.* **The Project Director must commit a minimum of 20% time/effort, either grant-supported or in combination with in-kind support, to the PPC Program.** Please note that while Co-Project Directors may be designated, they are not formally recognized by HRSA/MCHB.

2) Core Faculty

The minimal complement of other core faculty must include the following five (5) disciplines:

A) one additional pediatric pulmonologist;
B) a pediatric pulmonary nurse;
C) a social worker;
D) a nutritionist; and
E) a family leader

It is highly desirable that additional disciplines be included in the core faculty. Therefore, participation of faculty from other relevant disciplines is strongly encouraged, but not required.

B. PPC Faculty Qualifications

1) Core Discipline Faculty

It shall be the responsibility of the appointing academic school, or department, to determine the basic faculty qualifications, and the responsibility of the employing program, to determine and document the additional specialized pediatric training and clinical experience necessary to serve as faculty in the PPC program; however, core discipline faculty must meet at least the minimum standards of education, experience, and certification/licensure generally accepted by their respective professions.

In addition, each core faculty must demonstrate leadership, and have teaching and clinical experience in pediatrics and in providing health and related services to the special health care needs of the population on which the program is focused, and relevant to the purposes of the PPC. Core faculty must also be able to document cultural competency, and knowledge and experience in family-centered care, and the project must provide appropriate continuing education for faculty to maintain, and expand, these competencies.

Each core faculty must be accorded recognition, in the form of an academic appointment, in an appropriate degree-granting school, or department, of his/her profession in the grantee and/or an affiliated institution of higher learning. These requirements constitute the minimum qualifications section of the job description for each faculty position. Appointment as core faculty shall constitute the primary professional appointment and role for such individuals. Those faculty who are at an organizational level superior to that of the Project Director, or who are not subject to the Project Director's administrative direction, such as academic deans, department chairs, and others in similar positions, while highly valued faculty, *may not serve as core faculty, or receive payment from project funds unless special permission is obtained from DMCHWD.*

Core faculty may be functionally, programmatically, or academically responsible to such positions, as may be specified in the approved plan and position descriptions, but must be responsible to the PPC Project Director for the time allocated to the PPC project. Core faculty members are the chief representatives of their respective professions in the program. As such, they have primary responsibility for:

- Individually, for planning, designing, implementing, supervising, coordinating, and evaluating all training and service elements of their discipline components, with special emphasis on respiratory health, for the overall PPC program.
- Collectively, for the interdisciplinary core curriculum of the overall interprofessional leadership training program for all trainees;
- Defining the appropriate criteria for recruitment of trainees for their respective disciplines, and jointly selecting such trainees with the appropriate academic school/ department, and/or PPC training director/committee;
- Serving as the primary liaison between the program and their professional associates, academic affiliates, clinical departments, and discipline counterparts in state and community programs;
- Representing their discipline on internal program, policy, or governance committees;
- Engaging in scholarship directed toward the areas of integrated systems of quality care, capacity building, partnership, interdisciplinary training and practice, performance measurement, quality assurance and improvement, policy analysis, medical home implementation, and other important areas established by MCHB;
- Providing supervision and professional leadership for others of their discipline in the program; and
- Planning and implementing the overall interdisciplinary PPC program.

Functional and program responsibilities should be specified in the narrative and position descriptions. These standards must be met by each core faculty member whether or not students of his/her profession are being trained in the program. .

2) Family Leader

Trainees in PPC programs should receive an appropriate balance of academic, clinical, and community opportunities; work towards being culturally competent; and demonstrate a capacity to provide interdisciplinary care for chronic respiratory conditions using a family-centered approach. Therefore, adult family members (parents, siblings, etc.)/caregivers of children with chronic respiratory issues/young adult consumer representatives must be paid faculty, paid staff, paid partners, paid consultants, or paid advisors to the PPC project.

C. Faculty and Staff Support

Priority must be given to maintenance of the required complement of core faculty, as defined herein and as necessary to accomplish project plan objectives. However, to the extent required to meet the primary training mission, including provision of necessary clinical services, additional staffing can be supported. *IMPORTANT NOTE: Support cannot be provided for staff who is at an organizational level superior to that of the Project Director, or who are not subject to his/her administrative direction.*

Grant support for faculty is to assure dedicated time for meeting the explicit objectives of the training program. All projects must support faculty in the (4) core disciplines (medicine, nursing, nutrition, and social work) and support one (1) family leader. Along with the Project Director, core faculty members and family leader should have experience in providing academic, clinical and/or community-based training in respiratory health, as an interdisciplinary focus is the essential driver of this PPC training program.

Parents or caregivers of children with chronic respiratory health issues and young adult consumer representatives with chronic respiratory health issues must be paid faculty, staff, advisors, consultants, or partners of this PPC training program.

In some instances, not all academic disciplines of the core faculty members or family leaders, listed above, may be regionally located or proximal to the home institution. Since an interdisciplinary focus is the hallmark of the PPC program, flexibility is permitted to the extent that alternative arrangements are academically and educationally acceptable and appropriate, and patient care is acceptable and uncompromised.

IMPORTANT NOTE: These distance-learning arrangements must be thoroughly developed; part of a process that is already well established within the institution; and clearly specified in the application. There should not be an indication that a distance-learning process is to be developed after application is accepted for funding.

D. PPC Staffing Plan and Job Descriptions for Key Personnel

The applicant should describe the staffing plan (excluding contractor staff) which identifies positions that will provide personnel for essential programmatic, fiscal, and evaluation activities. Key personnel should have adequate qualifications, appropriate experience and allocated time (% FTE) to fulfill their proposed responsibilities.

The staffing plan should include adequate justification for the proposed staff that includes education and experience qualifications and rationale for the amount of time being requested for each staff position. Position descriptions should include the roles, responsibilities and qualifications of proposed project staff.

- Please include the proposed project's Staffing Plan and Job Descriptions for Key Personnel in **Attachment 3**.

E. PPC Biographical Sketches of Key Personnel

That applicant must provide a biographical sketch for key professional contributing to the PPC project. The information must be current, indicating the position which the individual fills and including sufficient detail to assess the individual's qualifications for the position as specified in the program announcement and position description.

Each biographical sketch must be limited to one (1) page or less, including recent selected publications. Include all degrees and certificates. When listing publications under Professional Experience, list authors in the same order as they appear on the paper, the full title of the article, and the complete reference as it is usually cited in a journal. The biographical sketches should be arranged in alphabetical order, after the project director's sketch and must include:

Name (Last, first, middle initial),
Title on Training Grant,
Education, and,
Professional Experience, beginning with the current position, then in reverse chronological order, a list of relevant previous employment and experience. Also, a list, in reverse chronological order, of relevant publications, or most representative, must be provided. Please provide information on one (1) page or less.

- Please include the proposed project's Biographical Sketches of Key Personnel in **Attachment 4**.

iii. *Budget*

Reminder: The Total Project or Program Costs are the total allowable costs (inclusive of direct **and** indirect costs) incurred by the recipient to carry out a grant-supported project or activity. Total project or program costs include costs charged to the award and costs borne by the recipient to satisfy a matching or cost-sharing requirement.

See Section 4.1.iv of HRSA's *SF-424 R&R Application Guide*. In addition, the PPC program requires the following:

The applicant must use SF-424 R&R budget forms. Please complete the entire budget form for each of the five (5) budget periods. Provide a line item budget justification (for the Budget Justification Narrative in the next section) using the budget categories in the SF-424 R&R.

The level of support available is intended to build upon existing resources. It is assumed that applicant institutions will already have basic elements necessary for a training

program and that support from this grant will provide additional funds to enable formal implementation of the PPC program.

Awards are subject to adjustment after program and peer review. If this occurs, program components and/or activities will be negotiated to reflect the final award.

The Consolidated and Further Continuing Appropriations Act, 2015, Division G, § 203, (P.L. 113-235) states, "None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II." Please see Section 4.1.iv Budget – Salary Limitation of HRSA's *SF-424 R&R Application Guide* for additional information. Note that these or other salary limitations will apply in FY 2016, as required by law.

iv. *Budget Justification Narrative*

See Section 4.1.v of HRSA's *SF-424 R&R Application Guide*. In addition, the PPC program requires the following:

The applicant must provide a narrative that explains the amounts requested for each line in the budget. The budget justification should specifically describe how each item will support the achievement of proposed objectives. The budget period is for ONE year; however, the applicant must submit one-year budgets for each of the subsequent project period years (up to five years) at the time of application. Line item information must be provided to explain the costs entered on the SF-424 R&R. **The budget justification must clearly describe each cost element and explain how each cost contributes to meeting the project's objectives/ goals.** Please pay particular attention in showing how each item in the "other" category is justified. For subsequent budget years, the justification narrative should highlight the changes from year one or clearly indicate that there are no substantive budget changes during the project period.
The budget justification MUST be concise, and must NOT be used to expand the project narrative.

In accordance with the review criteria, reviewers will deduct points from applications for which budgets are not thoroughly justified.

Budget for Multi-Year Grant Award

This announcement is inviting applications for project periods up to five (5) years. Awards, on a competitive basis, will be for a one-year budget period, although project periods may be for up to five (5) years. Applications for continuation grants funded under these awards beyond the one-year budget period but within the five-year project period will be entertained in subsequent years on a noncompetitive basis, subject to availability of funds, satisfactory progress of the grantee, and a determination that continued funding would be in the best interest of the Government.

Caps on Expenses

Indirect Costs: Indirect costs are those costs incurred for common or joint objectives which cannot be readily identified but are necessary to the operations of the organization, e.g., the cost of operating and maintaining facilities, depreciation, and administrative salaries. For some institutions, the term "facilities and administration" is used to denote indirect costs. Note: 45 CFR 75, which can be found at: http://www.ecfr.gov/cgi-

bin/retrieveECFR?gp=1&SID=63acc1d895c7c7c6cab27a2b6af8fb50&ty=HTML&h=L&r=PART&n=pt45.1.75, establishes principles for determining costs applicable to grants, contracts, and other agreements with educational institutions.

Indirect costs under training grants to organizations other than State, local or Indian tribal governments will be budgeted and reimbursed at eight percent (8%) of the modified total direct costs (MTDCs) rather than on the basis of a negotiated rate agreement, and are not subject to upward or downward adjustment. MTDCs exclude amounts of equipment, capital expenditures, charges for patient care, tuition and fees (including tuition remission), rental costs of off-site facilities, scholarships, and fellowships as well as the portion of each sub-grant and sub-award in excess of $25,000 from the actual direct cost base for purposes of this calculation.

The applicant must include the following cost category explanations in the **Budget Justification Narrative**:

- *Personnel Costs (as listed in Sections A & B on the R&R Budget Form)*:
Explain personnel costs by listing each staff member who will be supported through award funds, including name (if possible), position title, calendar months devoted to project, annual base salary, and the exact amount requested for each project year. *The Project Director must commit 20% time/effort, either grant-supported or in combination with in-kind support, to the PPC program*.

- *Fringe Benefits (as listed in Sections A & B on the R&R Budget Form)*:
List the components that comprise the fringe benefit rate (i.e. health insurance, taxes, unemployment insurance, life insurance, retirement plan, tuition reimbursement). The fringe benefits should be directly proportional to that portion of personnel costs that are allocated for the project.

- *Equipment (as listed in Section C on the R&R Budget Form)*:
List equipment costs and provide justification for the need of the equipment to carry out the program's goals. Extensive justification and a detailed status of current equipment must be provided when requesting funds for the purchase of computers and furniture items that meet the definition of equipment. *Equipment is defined as an article of tangible nonexpendable personal property that has a useful life of more than one (1) year and an acquisition cost of $5,000 or more per unit.*

- *Travel (as listed in Section D on the R&R Budget Form)*:
List all travel costs distinguishing between local travel and long distance travel. For local travel, the mileage rate, number of miles, reason for travel and staff member/consumers completing the travel should be outlined. The budget should also reflect the travel expenses associated with participating in meetings and other proposed trainings or workshops. *Foreign travel is not an allowable expense for MCH training programs.*

- *Trainee / Participant Support Costs*:
    1. **Trainee Tuition and Fees:** Tuition and related fees include changes by an institution of higher education for a regularly offered course taught by an employee of that institution performing his/her normal duties. *Include the total amount of funds requested for trainee/participant tuition and related fees.*

2. **Stipends:** Stipends include payments made to an individual under a fellowship or training grant in accordance with pre-established levels to provide for the individual's living expenses during the period of training. Additional guidance on "Stipends, Tuition/Fees and Other Budgetary Levels Effective for Fiscal Year 2015" may be found at: http://grants.nih.gov/grants/guide/notice-files/NOT-OD-15-048.html. *Include the total amount of funds requested for trainee/participant stipends.*

3. **Travel:** When estimating travel, 1) proposed per diem or subsistence allowances must be reasonable and limited to the days of attendance at the event plus the actual travel time required to reach the event location by the most direct route available. 2) Per diem or expenses, other than local mileage, for local participants in an event are not allowable. 3) Where meals and/or lodgings are furnished at the event, without charge or at a nominal cost (i.e. as part of the registration fee), the proposed per diem or subsistence allowance must take this into consideration and be adjusted accordingly to avoid overpayment. 4) Transportation costs for attendees and participants at the event may not exceed coach class fares; and in all cases, U.S. flag carriers must be used where possible. *Include and justify the total funds requested for trainee/participant travel associated with this PPC program.*

4. **Subsistence/Health Insurance:** Include the total funds requested for participant/trainee subsistence (if applicable). This may also include health insurance (if applicable).

5. **Other Trainee Costs:** *Describe, in detail, and enter the total funds requested for any other participant/trainee costs/institutional allowances, scholarships etc. Please identify in the space provided.*

6. **Number of Participants:** Enter the total number of proposed participants/trainees (those receiving stipends, scholarships, etc.).

7. **Total Trainee Costs:** Estimate the total associated trainee costs in the above categories. If applying electronically, this total will be calculated for you.

- *Other Direct Costs*:
  - **Materials & Supplies:** List the items that the project PPC will use as materials and supplies. In this category, separate office supplies from medical and educational purchases. Office supplies could include paper, pencils, and the like. Educational supplies may include pamphlets and educational videotapes. Medical supplies should be listed, described, and justified for use within the PPC training program. *Remember, office supplies, educational materials, and medical purchases (as applicable) must be listed separately.*
  - **Consultant Costs**: Provide the name, institutional affiliation, and qualifications of each consultant and indicate the nature and extent of the consultant service to be performed. Include expected rate of compensation and total fees, travel, per diem, or other related costs for each consultant, as applicable.

- **Sub-awards/Consortium/Contractual Costs:** Applicants and/or grantees are responsible for ensuring that their organization and/or institution has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring all contracts. Applicants and/or grantees must include and provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables.

Please include *Description(s) of Proposed/Existing Contracts (project specific)* in **Attachment 5**.

- *Other Costs:* Put all costs that do not fit into any other category into this category and provide an explanation of each cost in this category. In some cases, grantee rent, utilities and insurance fall under this category if they are not included in an approved indirect cost rate.

- *Indirect Costs*:
  Indirect costs are those costs incurred for common or joint objectives which cannot be readily identified but are necessary to the operations of the organization, e.g., the cost of operating and maintaining facilities, depreciation, and administrative salaries. For some institutions, the term "facilities and administration" is used to denote indirect costs. Indirect costs under training grants to organizations other than State, local or Indian tribal governments will be budgeted and reimbursed at 8 percent (8%) of modified total direct costs (MTDCs) rather than on the basis of a negotiated rate agreement, and are not subject to upward or downward adjustment. MTDCs exclude equipment (capital expenditures), tuition and fees, and sub-grants and subcontracts in excess of $25,000 from the actual direct cost base for purposes of this calculation.

v. ***Program-Specific Forms***

1) Performance Standards for Special Projects of Regional or National Significance (SPRANS) and Other MCHB Discretionary Projects

The Health Resources and Services Administration (HRSA) has modified its reporting requirements for SPRANS projects, CISS projects, and other grant programs administered by the Maternal and Child Health Bureau (MCHB) to include national performance measures that were developed in accordance with the requirements of the Government Performance and Results Act (GPRA) of 1993 (Public Law 103-62). This Act requires the establishment of measurable goals for Federal programs that can be reported as part of the budgetary process, thus linking funding decisions with performance. Performance measures for States have also been established under the Block Grant provisions of Title V of the Social Security Act, the MCHB's authorizing legislation. Performance measures for other MCHB-funded grant programs have been approved by the Office of Management and Budget and are primarily based on existing or administrative data that projects should easily be able to access or collect. An electronic system for reporting these data elements has been developed and is now available.

2) Performance Measures for the PPC Program and Submission of Administrative Data

To inform successful applicants of their reporting requirements the listing of MCHB administrative forms and performance measures for this program can be found at: https://perf-data.hrsa.gov/mchb/DgisApp/FormAssignmentList/T72_2.HTML.

NOTE: The performance measures and data collection information is for your PLANNING USE ONLY. These forms are not to be included as part of this application. However, this information would be due to HRSA within 120 days after the Notice of Award.

vi. *Attachments*

Please provide the following items in the order specified below to complete the content of the application. Unless otherwise noted, attachments count toward the application page limit. Indirect cost rate agreements and proof of non-profit status (if applicable) will not count toward the page limit. **Each attachment must be clearly labeled**.

Attachment 1: Work Plan

Attach the Work Plan for the project that includes all information detailed in Section IV. ii. Project Narrative.

Attachment 2: Logic Model

Attach the required logic model for the project that includes all information detailed in Section IV. ii. Project Narrative.

Attachment 3: Staffing Plan and Job Descriptions for Key Personnel (see section 4.1. of the HRSA's *SF-424 R&R Application Guide*

Keep each job description to one page in length as much as is possible. Include the role, responsibilities, and qualifications of proposed project staff.

Attachment 4: Biographical Sketches of Key Personnel

Include biographical sketches for persons occupying the key positions described in Attachment 3, not to exceed two pages in length. In the event that a biographical sketch is included for an identified individual who is not yet hired, please include a letter of commitment from that person with the biographical sketch. As applicable, biographical sketches should include training, language fluency and experience working with the cultural and linguistically diverse populations that are served by their programs.

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

Provide any documents that describe working relationships between the applicant organization and collaborating departments, institutions, organizations, agencies, and other entities and programs cited in the proposal. Documents that confirm actual or pending contractual agreements should clearly describe the roles of the contractors and any deliverable. Letters of agreement or similar documents defining the relationships between the proposed program and collaborating departments/ institutions, organizations, or agencies, and the responsibilities of each should be included. Letters of agreement must be dated and should provide the following information: Institution,

Person as appropriate, Responsibilities/Activities agreed to be provided, and Type of Commitment (e.g., in-kind, dollars, staff, equipment).

Attachment 6: Project Organizational Chart

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

Attachment 7: Maps, Tables, Charts, etc.

Provide a map which indicates the location(s) and settings of primary training activities. To give further details about the proposal, tables, charts, (e.g., Gantt or PERT charts, flow charts, etc.) may also be included, as applicable.

Attachment 8: For Multi-Year Budgets--Fifth Year Budget

After using columns (1) through (4) of the SF-424A Section B for a five-year project period, the applicant will need to submit the budgets for year 5 as an attachment. They should use the SF-424A Section B.

Attachment 9: Syllabus / Curriculum Description

Provide a syllabus or other curriculum summary, which includes a description of trainee experiences as appropriate for the PPC Program.

Attachment 10: Accomplishment Summary

A well planned accomplishment summary can be of great value by providing a record of accomplishments. It is an important source of material for HRSA in preparing annual reports, planning programs, and communicating program specific accomplishments.

Competing Continuation Applicants

The accomplishments of competing continuation applicants are carefully considered during the review process; therefore, an accomplishments summary, covering the entire previous project period (five years) from July 1, 2010 and projected through June 30, 2015 should be provided for competing continuation applications. The detailed description of the previous PPC project may be less than, but must not exceed **20 pages, including the narrative and all attachments**. This attachment is included in the total page count for the application.

The Accomplishment Summary should include:

(1) The period covered (dates).

(2) Specific Goals and Objectives - Briefly summarize the specific goals and objectives of the project, as actually funded. Applicants are advised to include previously stated goals and objectives in their application and emphasize the progress made in attaining these goals and objectives.

(3) Results - Describe the program activities conducted for each objective. Include both positive and negative results or technical problems that may be important. Include summary performance measure data and total number of trainees trained as a result of the grant.

(4) Evaluation - Enumerate the quantitative and qualitative measures used to evaluate the activities and objectives. Specify project outcomes and the degree to which stated objectives were achieved. Include any important modifications to your original plans. Identify, in tabular form by year, the length of training, numbers, disciplines, and levels of trainees in the program. Each MCH-supported trainee,

who completed training during the approved project period, should be listed along with his/her racial/ethnic identity and current employment. Separate identification should be made of continuing education attendees, as these attendees should not be counted as short-term trainees.

(5) Title V Program Relationship: Describe the activities related to, or resulting from, established relationships of the program and faculty with state and local Title V agencies and programs in the community, state, and region.

(6) Regional and National Significance: Describe significant contributions of the program beyond the state in which it is located.

(7) Value Added: Explain how this training grant has made a difference in the over PPC program, department, university, and beyond. Include accomplishments and benefits that may not have been possible without this training grant support.

New Applicants

New applicants *have the option* of submitting an Accomplishments Summary covering the preceding five years for activities that are *related to* the program for which support is being requested. If applicable, new applicants should submit the Accomplishment Summary with the application, in **Attachment 10**. It should be a brief presentation of the accomplishments for the previous five years, in relation to the proposed goals and objectives of the training program.

Attachments 11 – 15: Other Relevant Documents

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

Applicants for PPC grants are strongly encouraged to include letters of support from their State Title V MCH program /MCH Agencies / Other Related Programs and Regional Organizations.

3. Submission Dates and Times

Application Due Date

The due date for applications under this funding opportunity announcement is *March 23, 2015 at 11:59 P.M. Eastern Time*.

See Section 8.2.5 – Summary of e-mails from Grants.gov of HRSA's *SF-424 R&R Application Guide* for additional information.

4. Intergovernmental Review

The PPC program is not a program subject to the provisions of Executive Order 12372, as implemented by 45 CFR 100.

See Section 4.1 ii of HRSA's *SF-424 R&R Application Guide* for additional information.

5. Funding Restrictions

Applicants responding to this announcement may request funding for a project period of up to five (5) years, at no more than $340,000 per year. Awards to support projects beyond the first budget year will be contingent upon Congressional appropriation, satisfactory progress in meeting the project's objectives, and a determination that continued funding would be in the best interest of the Federal Government.

Indirect costs under training grants to organizations other than State, local or Indian tribal governments will be budgeted and reimbursed at 8 percent (8%) of modified total direct costs rather than on the basis of a negotiated rate agreement, and are not subject to upward or downward adjustment.

Funds under this announcement may not be used for foreign travel.

The General Provisions in Division G, of the Consolidated and Further Continuing Appropriations Act, 2015 (P.L. 113-235), apply to this program. Please see Section 4.1 of HRSA's *SF-424 R&R Application Guide* for additional information. Note that these or other restrictions will apply in FY 2016, as required by law.

All program income generated as a result of awarded grant funds must be used for approved project-related activities.

V. Application Review Information

1. Review Criteria

Procedures for assessing the technical merit of applications have been instituted to provide for an objective review of applications and to assist the applicant in understanding the standards against which each application will be judged. Critical indicators have been developed for each review criterion to assist the applicant in presenting pertinent information related to that criterion and to provide the reviewer with a standard for evaluation. Review criteria are outlined below with specific detail and scoring points.

These criteria are the basis upon which the reviewers will evaluate the application. The entire proposal will be considered during objective review.

Review Criteria are used to review and rank applications. The *PPC* program has seven (7) review criteria:

Applicants should pay strict attention to addressing all seven review criteria, as they are the basis upon which the reviewers will evaluate their application. All PPC Program applications will be reviewed and ranked according to the following seven criteria:

Criterion 1.	Need	10 points
Criterion 2.	Response	35 points
Criterion 3.	Evaluative Measures	10 points
Criterion 4.	Impact	10 points

Criterion 5.	Resources/Capabilities	20 points
Criterion 6.	Support Requested	10 points
Criterion 7.	Specific Program Criteria	5 points
Total		**100 points**

Criterion 1: NEED (10 points) – Corresponds to Section IV's Introduction and Needs Assessment

1) The extent to which the application demonstrates the problem and associated contributing factors to the problem.
2) The extent to which the application demonstrates the critical MCH Training needs that the PPC program will address.
3) The extent to which application demonstrates knowledge of the health and related issues for individuals with pediatric pulmonary conditions.
4) Quality of the data sources provided to demonstrate need.

Criterion 2: RESPONSE (35 points) – Corresponds to Section IV's Methodology, Work Plan, and Resolution of Challenges

A. Goals and Objectives

1) At least one (1) goal and one (1) objective must directly connect to ***each*** of the four (4) overarching program aims: a) interdisciplinary nature of the training program; b) partnership with a focus on family-centered care; c) integrating specialty and primary care through public health and population-based approaches; and, d) addressing diversity, cultural linguistic competence, and health equity.
2) The statement and strength, of the overall goals and specific objectives for the proposed project.
3) The extent to which objectives are specific, measurable, attainable/achievable, relevant, and time-framed with the purpose and requirements of the proposed project.
4) The extent to which the activities, described in the application, are capable of addressing the problem and attaining the project objectives.
5) The extent to which the activities, described in the application, are appropriate and flow logically from the goals and objectives.
6) The extent to which the application provides specific information about the intervention activities/strategies, expected outcomes and potential barriers for all anticipated years of the grant.
7) The extent to which the overall proposed approach to training is thoughtful, logical, and innovative and responds to the "Purpose" included in the program description.

B. Training, Curriculum and Research Activities

1) The extent to which the curriculum addresses program requirements of particular interest to MCHB (interdisciplinary training, leadership training, cultural competency, family-centered care, emerging issues in MCH, improving public health practice, collaboration/linkages with state MCH agencies and other appropriate State offices).
2) The extent to which the clinical, community-based and research requirements are appropriate for the training needs of trainees and fellows.
3) The extent to which the application describes how trainees will be exposed to the MCHB indicators of a system of care for effectively serving children with chronic respiratory issues and special health care needs.

4) The extent to which the clinical rotations are diverse, including inpatient, outpatient, community-based programs, community service settings and regular interactions with interdisciplinary staff.
5) The extent to which the activities demonstrate how distance/remote learning techniques, methodologies, and technology will be incorporated to advertise and advance programs and services; provide training, consultation, collaboration, continuing education, and/or technical assistance; and disseminate information and products.

C. Faculty/Trainees

1) The extent to which the specified disciplines and family leader, as required in the guidance, are reflected in the faculty.
2) The extent to which the application describes a comprehensive plan for recruitment of trainees from racially, ethnically and culturally and linguistically diverse backgrounds and other hardest-to-reach communities.
3) The extent to which the application identifies the competencies expected of graduates.
4) The extent to which faculty and trainees provide continuing education, consultation and technical assistance to those practicing in the field.

D. Regional Consultation/Collaboration

1) The extent to which the applicant documents and describe plans to address regional training, consultation, collaboration and interchange through the following:
   - a collective regional training approach;
   - a distinct PPC project-specific approach to regional consultation and collaboration; and,
   - a plan for program collaboration and national interchange.
2) The extent to which the applicant identifies and describes potential activities to improve access to pediatric pulmonary services in the applicant's state and/or region through clinical consultation to health center programs and look-alikes, national health service corps, and other HRSA investments.
3) The extent to which the applicant documents a data collection and evaluative strategy to capture the outputs/outcomes of regional consultative activities and services.

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

1) The strength, feasibility, and effectiveness of the evaluation plan to measure project objectives and proposed performance measures, including the logic model demonstrating the relationship among resources, activities, outputs, target population, short and long-term outcomes.
2) The extent to which the evidence demonstrates that the evaluative measures will be able to assess: 1) to what extent the program objectives have been met and achieved; and, 2) to what extent these can be attributed to the project.
3) The extent to which the application outlines how the trainee competencies will be measured.
4) The extent to which the application has presented a plan for tracking and reporting on the accomplishments of current and former trainees.
5) The extent to which that applicant describes the data to be collected, the methods for collection, the manner in which data will be analyzed and reported, and assures data collection quality.

6) The extent to which the application articulates who on the project will be responsible for refining, collecting, and analyzing data for the program evaluation.
7) The extent to which the applicant describes a plan to assess, where feasible, the impact of the program on enhancing academic-practice partnerships.
8) The extent to which data and evaluation informs evidence-based changes to the project, as a result of evaluation findings, and feedback from evaluation findings will be incorporated into the program for continuous quality improvement.
9) The extent to which the application presents an evaluation plan for collecting the data elements described in the MCHB Administrative Forms and Performance Measures, which can be found at: https://perf-data.hrsa.gov/mchb/DgisApp/FormAssignmentList/T72_2.HTML.

Criterion 4: IMPACT (10 points) – Corresponds to Work Plan and Logic Model

1) The feasibility and effectiveness of plans for dissemination of project results, and the extent to which project results may be national in scope, and the degree to which the project activities are replicable and generalizable to similar populations.
2) The extent to which the applicant presents a detailed and targeted plan to disseminate the project's methodologies and outcomes, including the extent to which the project results and products are regional and national in scope.
3) The extent to which the applicant describes a targeted plan for the development and dissemination of educational resources for its target audience and the impact of the program on the MCH workforce.
4) The extent to which the application describes the degree to which the project activities and products are replicable.
5) The extent to which the application presents an effective dissemination plan to share project results, including penetration within and possibly beyond the identified target population, with respect to both dissemination of project results, and engagement with the families and communities served.
6) The extent to which the application describes how program activities will be shared with other MCH stakeholders.

Criterion 5: RESOURCES/CAPABILITIES (20 points) – Corresponds to Section IV's Evaluation and Technical Support Capacity and Organizational Information

Organizational:

1) The extent to which the applicant describes the existing resources to support the types of educational methods that are described in the proposal.
2) The extent to which the applicant describes the administrative and organizational structure within which the project will function, including a project organizational chart (**Attachment 6**).
3) The organizational and administrative structures are available and adequate to address the outlined training program.
4) The setting of the project is appropriate to achieve project objectives.
5) The listing, of formal affiliation agreements, is included if multiple institutions or programs are contributing to the training program.
6) The overall extent to which the capabilities of the applicant organization and the quality and availability personnel to fulfill the needs and requirements of the proposed project.

Staffing/Personnel:

1) The specified core disciplines (pediatric pulmonology medicine; nursing; nutrition; social work; and family leadership), are reflected in the faculty.
2) The Project Director is a practiced pediatric pulmonologist and the faculty are well-qualified by training, experience, and expertise to conduct the training, mentor students, and serve as leaders in the field.
3) The faculty has a strong track record of teaching, collaborating, mentoring, providing clinical services, and conducting research.
4) The applicant documents that the Project Director will spend at least 20% effort on this PPC project.
5) The overall extent to which project personnel are qualified by training and/or experience to implement and carry out the project.

Overall:

1) The extent to which the project demonstrates collaboration with key stakeholders in all activities.
2) The extent to which contributors reflect the cultural, racial, linguistic and geographic diversity of the populations and communities served.
3) The extent to which the accomplishment summary progress report: 1) provides a record of accomplishments, which serves as a basis for support of a project; and 2) indicates that this applicant can successfully implement an interdisciplinary leadership training program in pediatric pulmonary care. For competing continuations, past performance will also be considered.
4) The extent to which the applicant demonstrates experience and success in academic-practice partnerships with Title V programs, including letters of support that document such relationships (**Attachment 5**).
5) The quality of approaches proposed to be used to resolve challenges that are likely to be encountered during the project.

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

1) The proposed budget and budget justification, for each year of the project period, is included and budget line items are well described and justified in the budget justification.
2) The proposed budget and budget justification, for each year of the project period, is reasonable according to the scope of work to be accomplished, and links to the statement of activities, evaluation plan, and anticipated results; and, 2) provides explicit qualitative and quantitative documentation of required resources, productivity, and expected outcomes.
3) Key personnel have adequate time devoted to the project to achieve project objectives.
4) The number of trainees and the number of faculty, supported by the program, is adequately explained and are reasonable in comparison to the budget request.
5) The number of doctoral and post-doctoral trainee stipends is reasonably described in the budget in comparison to masters-level trainee stipends.
6) The applicant includes written acknowledgement of willingness and capability to develop and manage the annual PPC Program Meeting for one (1) year during the five-year project period.

Criterion 7: SPECIFIC PROGRAM CRITERIA (5 points) – Corresponds to Section IV's Organizational Information

The applicant has documented a working knowledge of and intent to address areas of special concern to the Maternal and Child Health Bureau, including:

1) Underserved populations: The extent to which the applicant describes how the PPC training program will address the needs of underserved populations.
2) The MCH Block Grant and other relevant health agencies locally and in the State: The extent to which the applicant demonstrates a commitment to collaborate with State Title V agencies and other relevant agencies in the local community, state, and region.
3) Geography/Population Density: The extent to which the PPC program provides training to a State not currently receiving MCH training grant funds. (See http://www.mchb.hrsa.gov/training)
4) Coordination: The extent to which the program describes plans to collaborate/link with other PPC programs and other MCHB-supported training programs.
5) Collective Regional Impact: The extent to which the applicant demonstrates capacity and provides written assurance to participate in the collaborative planning, implementation, evaluation, and quality improvement efforts of the collective regional strategy. (Note: One regional strategy and one resultant outcome will be determined collectively, by the awarded PPC programs, post-award during the Year 1 annual PPC program meeting).

2. Review and Selection Process

Please see Section 5.3 of HRSA's *SF-424 R&R Application Guide*.

This program does not have any funding priorities, preferences or special considerations.

3. Anticipated Announcement and Award Dates

It is anticipated that awards will be announced prior to the start date of July 1, 2015.

VI. Award Administration Information

1. Award Notices

The Notice of Award will be sent prior to the start date of July 1, 2015. See Section 5.4 of HRSA's *SF-424 R&R Application Guide* for additional information.

2. Administrative and National Policy Requirements

See Section 2 of HRSA's *SF-424 R&R Application Guide*.

3. Reporting

The successful applicant under this funding opportunity announcement must comply with Section 6 of HRSA's *SF-424 R&R Application Guide* **and** the following reporting and review activities:

1) **Progress Report**(s). The awardee must submit a progress report to HRSA on an **annual** basis. Further information will be provided in the award notice.

2) **Performance Report(s).**
The Health Resources and Services Administration (HRSA) has modified its reporting requirements for SPRANS projects, CISS projects, and other grant programs administered by the Maternal and Child Health Bureau (MCHB) to include national performance measures that were developed in accordance with the requirements of the Government Performance and Results Act (GPRA) of 1993 (Public Law 103-62). This Act requires the establishment of measurable goals for Federal programs that can be reported as part of the budgetary process, thus linking funding decisions with performance. Performance measures for States have also been established under the Block Grant provisions of Title V of the Social Security Act, the MCHB's authorizing legislation. Performance measures for other MCHB-funded grant programs have been approved by the Office of Management and Budget and are primarily based on existing or administrative data that projects should easily be able to access or collect.

i. Performance Measures and Program Data
To prepare successful applicants for their reporting requirements, the listing of MCHB administrative forms and performance measures for this program can be found at: https://perf-data.hrsa.gov/mchb/DgisApp/FormAssignmentList/T72_2.HTML.

ii. Performance Reporting

Successful applicants receiving grant funds will be required, within 120 days of the Notice of Award (NoA), to register in HRSA's Electronic Handbooks (EHBs) and electronically complete the program specific data forms that appear for this program at: https://perf-data.hrsa.gov/mchb/DgisApp/FormAssignmentList/T72_2.HTML.

This requirement entails the provision of budget breakdowns in the financial forms based on the grant award amount, the project abstract and other grant summary data as well as providing objectives for the performance measures.

Performance reporting is conducted for each grant year of the project period. Grantees will be required, within 120 days of the NoA, to enter HRSA's EHBs and complete the program specific forms. This requirement includes providing expenditure data, finalizing the abstract and grant summary data as well as finalizing indicators/scores for the performance measures.

a) Project Period End Performance Reporting

Successful applicants receiving grant funding will be required, within 90 days from the end of the project period, to electronically complete the program specific data forms that appear for this program at: https://perf-data.hrsa.gov/mchb/DgisApp/FormAssignmentList/T72_2.HTML.

The requirement includes providing expenditure data for the final year of the project period, the project abstract and grant summary data as well as final indicators/scores for the performance measures.

b) Final Reporting**

Successful applicants receiving grant funding, *****who do not receive competitive continuation funding for a subsequent project period after the current project period***, will be required, within 90 days from the end of the project period, to electronically complete a ***final narrative progress report***. The requirement includes providing program-specific goals and progress on strategies; core performance measurement data; impact of the overall project; the degree to which the mission was achieved, goals and strategies outlined in the program; objectives and accomplishments; barriers encountered; and responses to summary questions regarding overall experiences during the entire project period.

3) Audit Reporting Requirements

Comply with audit requirements of 45 CFR 75, Subpart F. Information on audits can be found on the Internet at http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=4d52364ec83fab994c665943dadf9cf7&ty=HTML&h=L&r=PART&n=pt45.1.75#sp45.1.75.f.

4) Payment Management System Reporting Requirements

Submit a quarterly electronic Federal Financial Report (FFR) Cash Transaction Report via the Payment Management System. The report identifies cash expenditures against the authorized funds for the grant or cooperative agreement. The FFR Cash Transaction Reports must be filed within 30 days of the end of each calendar quarter. Failure to submit the report may result in the inability to access award funds. Go to http://www.dpm.psc.gov for additional information.

3) Federal Financial Report. The Federal Financial Report (SF-425) is required according to the following schedule: http://www.hrsa.gov/grants/manage/technicalassistance/federalfinancialreport/ffrschedule.pdf. The report is an accounting of expenditures under the project that year. Financial reports must be submitted electronically through EHB. More specific information will be included in the NoA.

- Budget Period ends May – July: FFR due October 30

VII. Agency Contacts

Applicants may obtain additional information regarding business, administrative, or fiscal issues related to this funding opportunity announcement by contacting:

Denise Boyer
Grants Management Specialist
HRSA Division of Grants Management Operations, OFAM
Maternal Child and Health Systems Branch
Parklawn Building, 10W05D
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 594-4256
Fax: (301) 594-4073
E-mail: DBoyer@hrsa.gov

Additional information related to the overall program issues and/or technical assistance regarding this funding announcement may be obtained by contacting:

Claudia Brown
Senior Public Health Analyst
Attn: PPC Interdisciplinary Training Program
MailStop Code: 18SWH03
Maternal and Child Health Bureau, HRSA
Division of Maternal Child Health Workforce Development
Parklawn Building
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 443-0869
Fax: (301) 443-4842
E-mail: CBrown4@hrsa.gov

Applicants may need assistance when working online to submit their application forms electronically. Applicants should always obtain a case number when calling for support. For assistance with submitting the application in Grants.gov, contact Grants.gov 24 hours a day, seven days a week, excluding Federal holidays at:

Grants.gov Contact Center
Telephone: 1-800-518-4726 (International Callers, please dial 606-545-5035)
E-mail: support@grants.gov
iPortal: https://grants-portal.psc.gov/Welcome.aspx?pt=Grants

Successful applicants/awardees may need assistance when working online to submit information and reports electronically through HRSA's Electronic Handbooks (EHBs). For assistance with submitting information in HRSA's EHBs, contact the HRSA Call Center, Monday-Friday, 8:00 a.m. to 8:00 p.m. ET:

HRSA Contact Center
Telephone: (877) 464-4772
TTY: (877) 897-9910
Web: http://www.hrsa.gov/about/contact/ehbhelp.aspx

VIII. Other Information

Helpful Resources:

DMCHWD Web Site
http://www.mchb.hrsa.gov/training

Healthy People 2020
http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx

HHS Health Workforce Priorities, A 21st Century Health Care Workforce for the Nation
http://aspe.hhs.gov/health/reports/2014/HealthCare_Workforce/rpt_healthcareworkforce.cfm

HRSA Strategic Plan, FY 2010 - 2015
http://www.hrsa.gov/about/strategicplan.html

MCH Leadership Competencies
http://leadership.mchtraining.net/

MCH Navigator
http://navigator.mchtraining.net

MCH Navigator Quality Improvement
http://www.mchnavigator.org/trainings/quality-improvement-spotlight.php

MCHB Administrative Forms and Performance Measures for the MCH Workforce Development Centers Program
https://perf-data.hrsa.gov/mchb/DgisApp/FormAssignmentList/UE7_1.HTML

NACCHO 2013 National Profile of Local Health Departments
http://nacchoprofilestudy.org/reports-publications/

National Academies Press (NAP)
http://www.nap.edu

National Center for Cultural Competence (NCCC)
http://nccc.georgetown.edu/

National Center for Medical Home Implementation
http://www.medicalhomeinfo.org/

National Plan for Maternal and Child Health Training 2012-2020
http://mchb.hrsa.gov/training/about-national-goals.asp

Reconfiguring Health Workforce Policy So That Education, Training, and Actual Delivery of Care Are Closely Connected
http://content.healthaffairs.org/content/32/11/1874.full

Stipends, Tuition/Fees and Other Budgetary Levels Effective for Fiscal Year 2015
http://grants.nih.gov/grants/guide/notice-files/NOT-OD-15-048.html

Surgeon General's Health Reports and Publications
http://www.surgeongeneral.gov/library/

10 Essential Public Health Services
http://www.cdc.gov/nphpsp/essentialservices.html

HRSA's Title V Information System (TVIS)
https://mchdata.hrsa.gov/tvisreports/

2010 State Title V Needs Assessment
https://mchdata.hrsa.gov/tvisreports/NeedsAssessment.aspx

Logic Model Resources:

Additional information on developing logic models can be found at the following website: http://www.cdc.gov/nccdphp/dnpao/hwi/programdesign/logic_model.htm.

Although there are similarities, *a logic model is not a work plan*. A work plan is an "action" guide with a timeline used during program implementation; the work plan provides the "how to" steps. Information on how to distinguish between a logic model and work plan can be found at the following website: http://www.cdc.gov/healthyyouth/evaluation/pdf/brief5.pdf.

Technical Assistance Call:
A technical assistance call will tentatively be held on Wednesday, February 4, 2015 from 1:00 P.M. until 2:00 P.M. Eastern Time. The Program Staff will provide an overview of the FOA and answer questions during the call.

Call information is as follows: Conference Call Number: 1-888-603-9226 | Participant Code: 1269212#.

The following meeting web link will be used: https://hrsa.connectsolutions.com/fy15pedpul/.

IX. Tips for Writing a Strong Application

See Section 4.7 of HRSA's *SF-424 R&R Application Guide*.

Appendix: Guidelines for Trainees/Fellows

A. Definitions

1. A trainee is an individual whose activities within the training program are directed primarily toward achieving an advanced degree.

2. A fellow is an individual who has met at least the minimum standards of education and experience accepted by his/her respective profession and whose activities within the training program are for the primary purpose of obtaining or enhancing particular skills or knowledge.

B. Qualifications

1. A trainee must have at least a baccalaureate degree and be enrolled in a graduate program.

2. A fellow must have achieved the academic degree and completed requisite training which constitutes the basic professional level training for his/her field.

3. A post-doctoral fellow must have an earned doctorate and must have completed any required internship.

4. A post-residency fellow must have an earned medical degree and must have satisfied requirements for certification in a specialty relevant to the purpose of the proposed training.

5. A special trainee or fellow may be approved, upon request to the MCHB, only in those unusual circumstances where particular needs cannot be met within the categories described above.

6. Citizenship – A fellow or trainee must be a United States citizen, or, as an alien, must have been admitted to the United States with a permanent resident visa.

7. Licensure – For any profession for which licensure is a prerequisite, the applicant must also be licensed by one of the states, or, in the case of foreign graduates, meet other requirements which legally qualify him/her to practice his/her profession in the United States.

C. Restrictions

1. Concurrent Income

   It is expected that most trainees/fellows will be full time. In most instances stipends may not be granted to persons receiving a concurrent salary, fellowship or traineeship stipend, or other financial support related to his/her training or employment. In the case of part-time trainees/fellows, exceptions may be requested and will be considered on an individual basis. Tuition support may be provided to full-time or part-time trainees.

2. Non-Related Duties

   The training institution shall not require trainees or fellows to perform any duties which are not directly related to the purpose of the training for which the grant was awarded.

3. Field Training

   Training institutions may not utilize grant funds to support field training, except when such training is part of the specified requirements of a degree program, or is authorized in the approved application.

4. Other Grant funds may not be used:

   a) for the support of any trainee who would not, in the judgment of the institution, be able to use the training or meet the minimum qualifications specified in the approved plan for the training;

   b) to continue the support of a trainee who has failed to demonstrate satisfactory participation; or

   c) for support of candidates for undergraduate or pre-professional degrees, or the basic professional degree.

D. Trainee Costs

1. Allowable Costs

   a) Stipends
   b) Tuition and fees, including medical insurance
   c) Travel related to training and field placements
   d) For a few institutions it is beneficial to support trainees through tuition remission and wages. Tuition remission and other forms of compensation paid as, or in lieu of, wages to students (including fellows and trainees) performing necessary work are allowable provided that there is a bona fide employer-employee relationship between the student and the institution for the work performed, the tuition or other payments are reasonable compensation for the work performed and are conditioned explicitly upon the performance of necessary work, and it is the institution's practice to similarly compensate students in non-sponsored as well as sponsored activities.

2. Non-Allowable Costs

   a) Dependency allowances
   b) Travel between home and training site, unless specifically authorized
   c) Fringe benefits or deductions which normally apply only to persons with the status of an employee

3. Stipend Levels

   All stipends indicated are for a full calendar year, and must be *prorated for an academic year or other training period of less than twelve months*. The stipend levels may, for the Maternal and Child Health Training Program, be treated as ceilings rather than mandatory amounts, i.e., stipends may be less than *but may not exceed the amounts indicated*. However, where lesser amounts are awarded the awarding institution must

have established, written policy which identifies the basis or bases for such variation and which ensures equitable treatment for all eligible trainees/fellows. These stipend levels apply to the National Institutes of Health, the Agency for Healthcare Research and Quality, and the Health Resources and Services Administration training grantees and were updated on December 30, 2014, see http://grants.nih.gov/grants/guide/notice-files/NOT-OD-15-048.html.

a) Pre-Doctoral

One stipend level is used for all pre-doctoral candidates, regardless of the level of experience.

Career Level	Years of Experience	Stipend for FY 2015	Monthly Stipend
Predoctoral	All	$22,920	$1,910

b) Post-Doctoral

The stipend level for the entire first year of support is determined by the number of full years of relevant post-doctoral experience** when the award is issued. Relevant experience may include research experience (including industrial), teaching assistantship, internship, residency, clinical duties, or other time spent in a health-related field beyond that of the qualifying doctoral degree. Once the appropriate stipend level has been determined, the fellow must be paid at that level for the entire grant year. *The stipend for each additional year of support is the next level in the stipend structure and does not change mid-year*.

Career Level	Years of Experience	Stipend for FY 2015	Monthly Stipend
Postdoctoral	0	$42,840	$3,570
	1	$44,556	$3,713
	2	$46,344	$3,862
	3	$48,192	$4,016
	4	$50,112	$4,176
	5	$52,116	$4,343
	6	$54,216	$4,518
	7 or More	$56,376	$4,698

**Determination of the “years of relevant experience” shall be made in accordance with program guidelines and will give credit to experience gained prior to entry into the grant-supported program as well as to prior years of participation in the grant-supported program. The appropriate number of “years” (of relevant experience) at the time of entry into the program will be determined as of the date on which the individual trainee begins his/her training rather than on the budget period beginning date of the training grant. Stipends for subsequent years of support are at the next level on the stipend chart.

4. Supplements to Stipends

Stipends specified above may be supplemented by an institution from non-federal funds. *No Federal funds may be used for stipend supplementation unless specifically authorized under the terms of the program from which the supplemental funds are derived.*