STATE OF TENNESSEE
DEPARTMENT OF HEALTH

REQUEST FOR APPLICATION

MATERNAL MORTALITY ACTION PROJECT

RFS # 34347-74322

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I. Introduction:

Maternal Mortality Review (MMR) is the state mandated review process, established in 2017, in which a multidisciplinary team reviews all deaths that occur during pregnancy or within a year of pregnancy. The goals of Tennessee's MMR program are to identify and address factors contributing to poor pregnancy outcomes for women and facilitate state systems changes to improve the health of women before, during, and after pregnancy. The central objectives of the MMR process are to:

1. Obtain details of events and issues leading up to the death;
2. Perform a multidisciplinary review of cases to gain a holistic understanding of the issues;
3. Determine the annual number of maternal deaths related and not-related to pregnancy;
4. Identify trends and risk factors among pregnancy-related and not-related deaths;
5. Recommend improvements to care at the individual, provider, and system levels;
6. Recommend strategies for prevention and intervention; and
7. Disseminate the findings and recommendations to a broad array of individuals and organizations.

The death of a woman during pregnancy, childbirth, or within the first year postpartum has immediate adverse impacts on a woman's family and community. Nationally, it is estimated that each year approximately 700 women in the United States die from pregnancy or pregnancy-related complications.[1] Racial disparities persist in these statistics as non-Hispanic Black women are three to four times more likely to die from a pregnancy-related complication than non-Hispanic White women.[2] Reducing maternal mortality and improving maternal health are national priorities.[3]

In Tennessee, 62 women died while pregnant or within one year of pregnancy in 2019 from both pregnancy-related and non-related causes. A majority of these deaths occurred between the 43 and 365 day postpartum period. More than a quarter were pregnancy related, meaning her death would not have occurred had she not been pregnant, and 79% were determined to be preventable.

[1] Nicole L. Davis, M. P., Ashley N. Smoots, M., & David A. Goodman, M. P. (2019). Pregnancy-Related Deaths: Data from 14 U.S. Maternal Mortality Review Committees, 2008-2017. National Center for Chronic Disease Prevention and Health Promotion Division of Reproductive Health.

[2] Pregnancy Mortality Surveillance System. Centers for Disease Control and Prevention. Available at: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html

3 Healthy People 2020 [Internet]. Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion [cited [015 January 2020]]. Available from: https://www.healthypeople.gov/node/4897/data_details.

Throughout the review of 2019 deaths, the multidisciplinary team identified key recommendations with actions that could have possibly prevented these deaths. These recommendations are broken down into four main stakeholder categories: community and statewide agencies, clinic and hospital systems, healthcare providers, and women and families.

The Tennessee Department of Health is seeking innovative projects that will reduce the number of maternal deaths. The State intends to award funds for projects that draw upon the prevention recommendations identified in the 2021 *Tennessee Maternal Mortality Report, Review of 2017-2019 Maternal Deaths.* Funding priorities for this cycle will focus on the recommendations below. Proposals should align with one or more of these recommendations.

Community and Statewide Agencies:

1a. Healthcare payors should assure insurance coverage for women of childbearing age to include the first trimester of pregnancy up to one year postpartum at a minimum. In addition, healthcare payors should educate providers about case management resources available to patients and implement policies to cover all home health visits for high-risk women during pregnancy and the postpartum period.

2a. Community and statewide agencies should implement suicide prevention strategies, increase mental health providers who facilitate approaches to disrupt partner violence pathways, and combat stigma associated with mental health issues.

3a. TDH and the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) should continue to educate the public about the importance of SUD treatment, including sharing resources. TDMHSAS should seek funding to expand access to treatment for women with SUD.

4a. Juvenile and family courts should put policies in place to protect individuals and families from domestic violence. These policies should include language about restricting access to guns for felony offenders, maximizing sentencing for repeat offenders, and providing intimate partner violence resources.

5a. TDH and TDMHSAS should continue to provide education, treatment, support services, and referrals regarding the long-term effects of trauma to women experiencing domestic violence and substance use throughout pregnancy and the postpartum period

6a. TDH and Department of Safety should increase social media messages, webinars and educational materials to reduce driving under the influence, discourage riding with a driver under the influence of drugs or alcohol, and increase seatbelt use. These materials should be available for clinics and hospitals to utilize for patient education.

Clinics and Hospital Systems:

1b. Facilities should establish substance use policies and protocols to include: substance use screening upon admission, pain management in the postpartum period for those with substance use disorder and referrals to case management to determine follow up needs during and after pregnancy. Facilities should increase communication, education, and referral to substance use resources.

2b. Hospitals, behavioral health facilities and addiction treatment centers should work together with providers to ensure adequate communication, care

coordination, routine screening, assessments and follow-up occurs throughout pregnancy and the postpartum period for those who have significant substance misuse and mental health issues. Additionally, these systems should improve access to drug and alcohol treatment programs for both inpatient and outpatient settings for pregnant and postpartum women.

3b. Facilities should offer treatment for patients, significant others or family to assist them to abstain from substance use. Facilities should educate and supply naloxone upon discharge.

4b. Hospitals should establish primary and secondary transfer facilities based on needed levels of care for high-risk patients, bed availability, and specialties. Hospitals should implement protocols for improved communication between facilities for bed capacity and transfer.

5b. Facilities should implement national cardiovascular standards of care for women in pregnancy and the postpartum period. Providers should receive education on the physiologic changes in pregnancy that may affect cardiovascular disease and provide thorough education to patients and their families regarding warning signs for acute cardiac decompensation.

6b. Facilities should implement protocols to ensure appropriate follow-up care for patients during the postpartum period. Protocols should include standardized instructions for postpartum patients admission.

7b. Facilities should implement diversity training to prevent interpersonal racism and bias in their health system. Training should address prevention of racism and bias while conducting one-on-one patient care, communicating with colleagues and charting patient records.

8b. Clinics and hospital systems should post automobile safety tips on websites and via social media platforms with particular focus on dangers of driving under the influence, risks of riding with a driver under the influence of drugs or alcohol, and benefits to increase seatbelt use.

Healthcare Providers:

1c. All medical providers should obtain a full patient history to utilize trauma-informed interventions during and after pregnancy to ensure proper treatment and intervention. Providers should integrate a full assessment of medical, psychiatric and social determinants of health when providing care to include an ACE screening and the Edinburgh Postnatal Depression Scale (EPDS). Providers should continue to decrease stigma and biases of substance use and mental health disorder at every opportunity.

2c. Providers should ensure that high-risk patients have management with a multidisciplinary team including a case coordinator, medical navigator, obstetrician, and maternal fetal medicine specialist to ensure appropriate patient follow up and communication between facilities, clinicians and patients during and after pregnancy.

3c. Providers should communicate with each other to determine if patients should continue their mental health medications during and after pregnancy. Clinicians should provide education on accessing help and support for postpartum depression.

4c. Providers should post automobile safety tips in their offices specifically on topics such as dangers of driving under the influence, dangers of riding with a driver under the influence of drugs or alcohol, and benefits to increase seatbelt use.

5c. Providers should educate patients on the risk of worsening hypertension in pregnancy. If a diagnosis of hypertension is given, providers should ensure patients are aware of the full risks of the diagnosis and instruct patients to follow up.

6c. Providers should educate patients on the following: the need for continued treatment of substance use disorders during the peripartum period; risks of untreated illness and relapse; and benefits of naloxone to prevent death from overdose.

7c. Healthcare providers should educate staff on trauma informed care in marginalized populations with substance use disorders to decrease discrimination, stigma and racism within various potential points of care and engender a sense of trust from the patient.

Women and their Friends and Families:

1d. Family members, social workers, mental health providers and other trusted adults should assist women to develop skills that facilitate healthy relationships and disrupt pathways toward partner violence.

2d. Women should contact the cardiologist or maternal fetal medicine specialist with increased symptoms indicating a cardiac issue during and after pregnancy or anytime they feel something is not right.

3d. Women, their family members, and friends should do the following: Seek knowledge of domestic violence warning signs, and review any signs they are experiencing with their providers at the two week and six-week postpartum visits; Consider engaging a trusted family member, social worker or counselor to resolve domestic disputes related to child custody and; Seek education on lethality indicators.

4d. Women should seek out resources for smoking cessation in pregnancy. Family and friends should provide support to these women to assist them to quit smoking.

Sample project concepts that may be considered for funding*:

- Development and distribution of materials on the importance of seatbelt use among pregnant and postpartum women;
- Implicit bias and diversity training for providers in health systems;
- Provider education on pre-eclampsia, hemorrhage, and cardiovascular disease amongst all providers (i.e. labor and delivery, emergency department and intensive care unit);
- Social media or other advertising campaign to increase public awareness of support services and resources available to individuals experiencing intimate partner violence;
- Promotion of appointment adherence amongst high-risk populations;
- Training on depression screening; or
- Domestic violence screening implementation throughout hospital system.

*Please note this list of project concepts is not exhaustive, and should only serve as a sampling of the types of proposals that may be considered for funding. We value creativity and encourage you to submit a proposal addressing any of the recommendations on pages 3-4 of this document.

Non-Allowable Costs Include:

- Construction, alteration, maintenance of buildings or building space;
- Dues for organizational membership in professional societies;
- Food and drinks;
- Research projects;
- Lobbying;
- Gift or gas cards;
- Child care services;
- Billable services provided by physicians or other providers conducting medical treatment services;
- Permanent equipment (e.g. computers, video monitors, software printers, furniture) unless essential to project implementation and not available from other sources;
- Anything considered medication;
- Advertising materials and purchase of media time/space that has not been pre-approved by the Tennessee Department of Health;
- Clothing; and
- Incentives.

The State is seeking applications to provide the services outlined in this Request for Application (RFA). Applicants may apply for a grant of up to nine months with funds not to exceed Twenty Thousand dollars ($20,000.00). No match is required. The anticipated start date for grants is January 1, 2022. In addition to activities conducted under their proposed projects, successful applicants will also be required to perform the following deliverables (Please see the sample contract Section A. Scope of Service and Deliverables for the complete list.):

1. Participate in the maternal mortality task force meetings held in Virtually.

2. Submit quarterly reports in a format provided by the State which detail progress made in meeting project goals and activities.

3. Submit to the State an evaluation of the completed project utilizing performance indicators approved by the State.

II. APPLICATIONS:

To respond to this RFA, please complete the **Application** (**Attachment 1**)**.** See also IRS Form W9 and State of Tennessee, Department of Finance and Administration ACH (Automated Clearing House) Credits and Instructions for completion. The **Application** contains detailed questions about the organization's contact information and the specifics of the proposed project. Please provide a project narrative, goals and objectives, and a timetable

Attachment 3 is the Grant Budget. This section shall contain all information relating to cost, based on a line-item budget. Complete the Grant Budget form and the attached

Line-Item Details form. A description of how dollars will be used must be provided for each line item completed, as applicable for the Budget form.

Note: Please use the Department of Finance and Administration – Policy 03 Schedule A, (please refer to pages 11-16 of that policy) in determining which expense category an item should be listed in your grant budget. This policy can be found on the internet at the address listed below:

https://www.tn.gov/content/dam/tn/finance/documents/fa_policies/policy3.pdf

III. Schedule of Events

The following is the anticipated timeline for awarding grants for Maternal Mortality Action Projects. The State reserves the right to adjust the schedule as it deems necessary.

EVENT	TIME (Central Time)	DATE (all dates are state business days)
1. RFA issued		October 29, 2021
2. Pre-response teleconference	10:00 a.m.	November 2, 2021
3. Written "Questions & Comments" deadline	2:00 p.m.	November 5, 2021
4. State response to written "Questions & Comments"		November 10, 2021
5. Deadline for Applications	2:00 p.m.	November 19, 2021
6. Evaluation Notice released		December 3, 2021
7. Effective start date of Contract		January 1, 2022

Pre-response Teleconference:

A Pre-response Teleconference will be held at the time and date detailed in the RFA Schedule of Events to answer questions concerning the funding opportunity. The information for the Pre-response Teleconference is as follows:

Meeting Name: 34347-74322 Teleconference
Meeting Number (access code): 2311 658 6514
Meeting Password: tJQ26Qw5SaC

Meeting Link:
https://tn.webex.com/tn/j.php?MTID=mf535efa418956d7e89fa305c68f1a651
Join by phone: #1-415-655-0003 US TOLL

Any applicant desiring to submit an application in response to this RFA is encouraged to have at least one (1) representative on the teleconference; however, attendance is not mandatory. If you cannot participate, please direct your questions by the scheduled deadline as indicated above, to Melissa Painter, Competitive Procurement Coordinator, listed below in Section IV.

Questions and Answers:

All questions concerning this RFA must be presented to the Competitive Procurement Coordinator shown in Section IV., in writing, on or before the Deadline for Written Questions and Comments as detailed above in the Schedule of Events. Questions may be faxed, emailed, mailed, or hand-carried to the Competitive Procurement Coordinator. The State's responses will be emailed and posted as an Amendment to the following website:

https://www.tn.gov/health/funding-opportunities.html

Deadlines stated above are critical. If documents are submitted late, they will be deemed to be late and cannot be accepted. The clock-in time will be determined by the time of the online submission. No other clock or watch will have any bearing on the time of application receipt.

Each applicant shall assume the risk of the method of dispatching any communication or application to the State. The State assumes no responsibility for delays or delivery failures resulting from the method of dispatch.

IV. Submission of APPLICATIONS:

Please submit the completed application with all attachments by online submission via the following link no later than the deadline specified in Section III, Schedule of Events in the form and detail specified in this RFA.

Web Link: https://www.tn.gov/health/funding-opportunities.html

Please contact the Competitive Procurement Coordinator at the address shown below with all questions concerning this competitive process. **The APPLICATION and all attachments must use 12-point font.**

Melissa Painter
Competitive Procurement Coordinator
Service Procurement Program
Division of Administrative Services
Andrew Johnson Tower, 5th Floor
710 James Robertson Parkway
Nashville, TN 37243

Phone: (615) 741-0285
Fax: (615) 741-3840
Email: Competitive.Health@tn.gov

Checklist for Submission of Applications:

- ☐ Application Form (Attachment 1)
- ☐ Project Narrative (Exhibit 1)
- ☐ Goals and activities template (Exhibit 2)
- ☐ Performance indicator checklist (Exhibit 3)
- ☐ 2-page Budget Form (Attachment 3)
- ☐ State of Tennessee, Department of Finance and Administration ACH (Automated Clearing House) Credits and Instructions (**Please see form for mailing instructions.**)
- ☐ Form W-9, Request for Taxpayer Identification Number (TIN) and Certification (**Please mail with ACH form.**)

V. Application Evaluation:

An evaluation committee made up of at least three (3) representatives of the Department of Health will be established to judge the merit of eligible applications.

A. The committee shall review applications on the basis of the information requested in the RFA. Applications will be evaluated based on the following criteria:

- Alignment with the maternal mortality recommendations
- Detailed goals and activities
- Proposed expenses and cost effectiveness
- Expertise of staff involved
- Level of projected impact
- Targeted approaches to address health disparities (disproportionately affected populations and disproportionately affected geographic areas);

B. Any application that is incomplete or contains significant inconsistencies or inaccuracies shall be rejected. The State reserves the right to waive minor variances or reject any or all applications. The State reserves the right to request clarifications from all applicants.

VI. Sample Grant Contract:

Following the State's evaluation, grant contracts will be prepared as shown in the **Sample Grant Contract**.

It is imperative that each applicant review the entire Sample Contract with legal counsel prior to submitting an application for a Maternal Mortality Action Project grant award and notify the State *in advance* if it cannot accept any terms or conditions. The Application for a Maternal Mortality Action Project grant award asks the applicant to list any terms or conditions that its organization cannot accept. **Taking any exceptions to State contract**

language may result in the Application being deemed non-responsive and rejected. Any later requests for contract changes will not be considered.