FUNDING OPPORTUNITY ANNOUNCEMENT
Fiscal Year 2015

Application Due Date: April 6, 2015

Ensure 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: February 5, 2015
Issuance Date: February 5, 2015

Sara Afayee
Public Health Analyst, Federal Office of Rural Health Policy
Email: SAfayee@hrsa.gov
Telephone: (301) 945-4169
Fax: (301) 443-2803

Authority: Public Health Service Act, Section 330A(f) (42 U.S.C. 254(c)(f)), as amended.
EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA), Federal Office of Rural Health Policy (FORHP) is accepting applications for fiscal year (FY) 2015 Rural Health Care Coordination Network Partnership Program. The purpose of this grant program is to support the development of formal, mature rural health networks that focus on care coordination activities for the following chronic conditions: diabetes, congestive heart failure and chronic obstructive pulmonary disease.

<table>
<thead>
<tr>
<th>Funding Opportunity Title:</th>
<th>Rural Health Care Coordination Network Partnership Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding Opportunity Number:</td>
<td>HRSA-15-123</td>
</tr>
<tr>
<td>Due Date for Applications:</td>
<td>April 6, 2015</td>
</tr>
<tr>
<td>Anticipated Total Annual Available Funding:</td>
<td>$1,600,000</td>
</tr>
<tr>
<td>Estimated Number and Type of Award(s):</td>
<td>Up to 8 grants</td>
</tr>
<tr>
<td>Estimated Award Amount:</td>
<td>Up to $200,000 per year</td>
</tr>
<tr>
<td>Cost Sharing/Match Required:</td>
<td>No</td>
</tr>
<tr>
<td>Project Period:</td>
<td>September 1, 2015 through August 31, 2018 (3 years)</td>
</tr>
</tbody>
</table>

Eligible Applicants:

The lead applicant organization (A) shall be a rural public or rural nonprofit private entity; and

The network (B) shall represent a mature network composed of participants that include 3 or more separate, existing health care providers that may be nonprofit or for-profit entities.

[See Section III-1 of this funding opportunity announcement (FOA) for complete eligibility information.]


The Office of Rural Health Policy will hold a technical assistance webinar on Thursday, February 12, 2015 at 2:00 PM Eastern Standard Time to assist applicants in preparing their applications. The Adobe Connect webinar and call-in information are as follows:
Meeting Name:  Rural Health Care Coordination Network Partnership Program
To join the meeting as a guest:  https://hrsa.connectsolutions.com/rhccnpp/
Toll-free call in number:  1-888-946-7496  (participants must call in to verbally ask questions)
Participant Passcode for call in number:  Care Coordination
# Table of Contents

I. FUNDING OPPORTUNITY DESCRIPTION ................................................................. 1
   1. PURPOSE .................................................................................................................. 1
   2. BACKGROUND ......................................................................................................... 3

II. AWARD INFORMATION ......................................................................................... 3
   1. TYPE OF AWARD ..................................................................................................... 3
   2. SUMMARY OF FUNDING ......................................................................................... 3

III. ELIGIBILITY INFORMATION ............................................................................... 4
   1. ELIGIBLE APPLICANTS .......................................................................................... 4
   2. COST SHARING/MATCHING .................................................................................. 6
   3. DUN AND BRADSTREET UNIVERSAL NUMBERING SYSTEM NUMBER AND SYSTEM FOR AWARD MANAGEMENT (FORMERLY, CENTRAL CONTRACTOR REGISTRATION) .......................................................... 6
   4. OTHER .................................................................................................................... 7

IV. APPLICATION AND SUBMISSION INFORMATION .......................................... 7
   1. ADDRESS TO REQUEST APPLICATION PACKAGE ........................................... 7
   2. CONTENT AND FORM OF APPLICATION SUBMISSION ................................... 8
      i. Project Abstract ..................................................................................................... 8
      ii. Project Narrative .................................................................................................. 8
      iii. Budget .................................................................................................................. 16
      iv. Budget Justification Narrative .......................................................................... 16
      v. Attachments ......................................................................................................... 16
   3. SUBMISSION DATES AND TIMES ...................................................................... 18
   4. INTERGOVERNMENTAL REVIEW ....................................................................... 19
   5. FUNDING RESTRICTIONS .................................................................................... 19

V. APPLICATION REVIEW INFORMATION ............................................................ 19
   1. REVIEW CRITERIA ................................................................................................ 19
   2. REVIEW AND SELECTION PROCESS .............................................................. 26
   3. ANTICIPATED ANNOUNCEMENT AND AWARD DATES ................................. 27

VI. AWARD ADMINISTRATION INFORMATION ................................................... 28
   1. AWARD NOTICES ................................................................................................ 28
   2. ADMINISTRATIVE AND NATIONAL POLICY REQUIREMENTS ....................... 28
   3. REPORTING ........................................................................................................... 28

VII. AGENCY CONTACTS ........................................................................................ 29

VIII. OTHER INFORMATION .................................................................................... 30

IX. TIPS FOR WRITING A STRONG APPLICATION ............................................. 35
I. Funding Opportunity Description

1. Purpose

This announcement solicits applications for the Rural Health Care Coordination Network Partnership Program (Care Coordination Program).

The purpose of the Rural Health Care Coordination Network Partnership Program is to support the development of formal, mature rural health networks that focus on care coordination activities for the following chronic conditions: diabetes, congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). Care coordination in the primary care practice involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient’s care to achieve safer and more effective care. Rural Americans are unhealthier, with higher rates of chronic illnesses, such as diabetes, CHF, and COPD and have higher rates of high-risk behaviors such as smoking, physical inactivity, and poor nutrition.1,2,3,4 These high-risk behaviors cause many of the illnesses, suffering and deaths due to chronic diseases and conditions. The increasing prevalence of chronic diseases and the high cost of health care in the U.S. bring treatment of the “whole” person to the forefront, especially as there are often psychosocial (psychological and social) issues related to chronic diseases; for example, there is a link between diabetes and depression. In addition, more mental health problems are seen in the primary care setting than other health care settings; thus, integrating behavioral health care into primary care helps address both the physical and psychosocial aspects of health and wellness. Reviews and reports from the Agency for Healthcare Quality and Research (AHRQ) have shown a positive impact from integrating a team approach to care for a variety of disease conditions.6 Health care coordination for people living with chronic conditions is vital to providing high quality care, especially in rural areas where access to health care is an issue.

The main goal of care coordination is to meet patients’ needs and preferences in the delivery of high-quality, high-value health care. This means that the patient’s needs and preferences are known ahead of time and communicated at the right time to the right people; this information is used to provide safe, appropriate, and effective care to the patient. Care coordination is identified by the Institute of Medicine as a key strategy that has the potential to improve the effectiveness, safety, and efficiency of the American health care system. Well-designed, targeted care coordination that is delivered to the right people can improve outcomes for everyone: patients,

providers, and payers. Care coordination is especially important in the changing health care landscape where payments increasingly focus on value. The ultimate goal of the program is to promote the delivery of coordinated care in the primary care setting.

There are numerous developments in state health policy that support the adoption of care coordination models, including patient centered medical homes (PCMH), accountable care organizations (ACO), and enhanced health information technology (HIT) such as electronic health records (EHR) and telehealth capabilities. Care coordination strategies can be tailored for a rural community’s resources and challenges. Strategies may include a special emphasis on: recruiting or training personnel to assume care coordination responsibilities or supporting other staff, such as, community health workers, in taking on this role; developing new or making creative use of existing resources, such as co-locating available behavioral and primary health care services; and addressing quality improvement through innovations like telehealth or system redesign using models such as, Six Sigma or the Lean Model, for example.

Applicants shall develop creative and innovative approaches to address outcomes in one or more of the three pre-specified disease states, diabetes, CHF, and/or COPD, through application of care coordination strategies. Applicants shall disseminate the information regionally or nationally, including efforts by grassroots, faith-based or community-based organizations. The proposed projects should demonstrate improved outcomes. Applicants may address the prevalence and management of diabetes, CHF, and COPD conditions using innovative or evidence-based care coordination strategies, relevant to their community needs. At a minimum, networks will be asked to report on four outcome measures for each chronic condition (Type 2 Diabetes, CHF and COPD). In addition to reporting on these outcome measures, networks will be also asked to report at least three care coordination measures. Performance on those measures will be aggregated across the funded sites to measure program impact. To review the outcome measures for each chronic condition, please refer to Section IV: Application and Submission Information.

To the extent possible, grantees are encouraged to bill for third party reimbursement for covered services and participate in pay-for-performance and other incentive programs in order to aid in the sustainability of the project. By thinking beyond the day-to-day activities and services and planning for sustainability early in the grant cycle, organizations can better position their programs for long-term sustainability and leverage the investment of federal grant dollars to maintain successful programs that improve the health of rural Americans.

---


9 Pay-for-performance programs can either be from the private-sector such as, the California Pay for Performance Program or from the public-sector such as, the Medicare Hospital Value-Based Purchasing Program. An example of an incentive program is the Medicare and Medicaid EHR Incentive Programs, which provides financial incentives for the meaningful use of certified EHR technology to improve patient care.

2. Background

This program is authorized under Section 330A(f) of the Public Health Service (PHS) Act (42 U.S.C. 254(c)(f)), as amended. This authority permits the Federal Office of Rural Health Policy to support grants for eligible entities to promote, through planning and implementation, the development of integrated health care networks that have combined the functions of the entities participating in the networks in order to: (i) achieve efficiencies; (ii) expand access to, coordinate, and improve the quality of essential health care services; and (iii) strengthen the rural health care system as a whole.

On July 9, 2011, the President signed Executive Order 13575 creating the White House Rural Council, the first body of its kind to engage Cabinet-level agencies in addressing the challenges facing rural America. With an emphasis on collaboration at the Federal level, the Council makes recommendations for streamlining and improving the effectiveness of economic investments in rural areas and coordinates engagement and partnerships with a variety of rural stakeholders. The Federal Office of Rural Health Policy provides staff representation to the Council on behalf of the Secretary, Department of Health and Human Services. Under the auspices of the Council, in 2012, the Federal Office of Rural Health Policy partnered with Grantmakers in Health (GIH) and the National Rural Health Association (NRHA) to encourage new public-private partnership in rural health. Private and federal stakeholders have met to discuss their common interest in improving health outcomes in rural communities.

Notifying Foundations in the Rural Health Public-Private Partnership

ORHP provides the staff representation to the White House Rural Council on behalf of the Secretary, Department of Health and Human Services. Under the auspices of the Council, in 2012, the ORHP partnered with Grantmakers in Health (GIH) and the National Rural Health Association (NRHA) to encourage new public-private partnership in rural health. Many of the foundations participating in this partnership have expressed interest in using care coordination networks as a strategy toward improving health outcomes in rural communities. This interest resulted in continuing partnership meetings that have led to the development of this funding opportunity as well as continued engagement on the part of the foundations. To find out further information on this collaboration, please visit:


II. Award Information

1. Type of 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 – 2017. Approximately $1,600,000 is expected to be available annually to fund up to 8 awardees. Applicants may apply for a ceiling amount of up to $200,000 per year. The project period is three (3) years. Funding beyond the first year is dependent on the availability of appropriated funds for the Rural
Health Care Coordination Network Partnership 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.

III. Eligibility Information

1. Eligible Applicants

a) Ownership and Geographic Requirements:

Applicants for the Rural Health Care Coordination Network Partnership Program must meet the ownership and geographic requirements stated below. (Note: If an incorporated network does not apply on behalf of its members, the award will be made to only one member of the network that will be the grantee of record and only that organization needs to meet the eligibility criteria:

1) The lead applicant organization must be a public or private non-profit entity located in a rural area or in a rural census tract of an urban county, and all services provided by a HRSA grant awarded under this FOA must be provided in a rural county or census tract. The applicant’s Employer Identification Number (EIN) provided by the Internal Revenue Service will verify it is a rural entity. To ascertain rural eligibility, please refer to: http://datawarehouse.hrsa.gov/RuralAdvisor/ and enter the applicant organization’s state and county. An application that proposes a network serving rural communities where the applicant organization is not in a designated rural area will not be considered for funding under this announcement. Rural faith-based and community-based organizations, Tribes, and tribal organizations are eligible to apply.

2) In addition to the States listed on the Rural Advisor (link above) only Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, American Samoa, the U.S. Virgin Islands, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau may apply. Applications submitted from organizations located outside the 50 states, must meet the rural eligibility requirements.

One of the following documents must be included in Attachment 3 to prove non-profit status (not applicable to State, local, and Tribal government entities; Tribal organizations, however, must provide one of the following):

- A letter from the IRS stating the organization’s tax-exempt status under Section 501(c)(3);
- A copy of a currently valid IRS Tax exemption certificate;
- Statement from a State taxing body, State attorney general or other appropriate State official certifying that the applicant organization has a non-profit tax status
and that none of the net earnings accrue to any private shareholders or individuals;

- A certified copy of the organization’s certificate of incorporation or similar document if it clearly establishes the non-profit status of the organization; or

- If the applicant is an affiliate of a parent organization, a copy of the parent organization’s IRS 501(c) (3) Group Exemption letter; and if owned by an urban parent, a statement signed by the parent organization that the applicant organization is a local non-profit affiliate.

- If the applicant organization is a public entity, the proof of non-profit status is not necessary. The applicant organization must, however, identify themselves as a public entity and submit an official signed letter on city, county, State, or Tribal government letterhead in Attachment 3. (Applicants may include supplemental information such as documentation of the law that created the organization or documentation showing that the State or a political subdivision of the State controls the organization.) Tribal government entities should verify their Federally-recognized status via the Bureau of Indian Affairs website: http://www.bia.gov.

b) **Network Requirements:**

Applicants must meet the following requirements.

1) The network is composed of at least three health care providers that are separate, existing organizations which require them to have their own EIN number. The members may be for-profit or non-profit and may be in a rural or urban area. Multiple health care providers owned by the same overarching entity or health system are not considered a separate entity. A formally established and incorporated 501(c)(3) network may apply on behalf of all network members.

2) The network organizational relationship is formal. Each member of the network must sign a Memorandum of Agreement or a Memorandum of Understanding submitted in Attachment 6. The purpose of this document is to signify the formal commitment of network members. It must describe the network’s purpose and the member’s responsibilities in terms of financial contribution, participation and membership benefits.

3) The network has a governing body that includes representation from all network member organizations and ensures that the governing body, rather than an individual network member, will make financial and programmatic decisions. An advisory board which merely provides advice is not considered a governing body. An already-existing non-profit board of individuals convened for providing oversight to a single organization is not an appropriate board structure. The applicant will be required to depict the governing body’s relationship to the network within Attachment 4.
4) The network has a permanent network director (i.e. network executive director) or has established an interim network director capable of overseeing the network’s administrative, fiscal, and business operations at the time of the application. Applicants should note that the network director role is different from the project director role. During the grant period, the project director should be at least a half time employee (0.5 FTE) of the applicant organization.

For the purposes of this grant, a rural health network consists of at least three health care providers that are separately owned entities involved in a formal organizational arrangement and have collaborated on projects previously. A network in this context is not a large health system whereby multiple health care providers or organizations are owned and/or created by the same overarching entity to collaborate and achieve a particular goal. For previously established networks, new members may be added to accomplish the goals of this grant program. Network partners can include, but are not limited to, hospitals, health care clinics, educational institutions, faith-based organizations, Federally-recognized tribal governments, local government agencies, social service organizations, etc. The applicant organization applying on behalf of the network must meet the eligibility requirements stated in Section III.1.

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.

NOTE: Multiple applications from an organization are not allowable. An applicant may not be involved as a formal network member in different networks applying to this funding opportunity.

Notifying your State Office of Rural Health

Applicants are required to notify the State Office of Rural Health (SORH) of their intent to apply to this program. A list of the SORHs can be accessed at http://www.hrsa.gov/ruralhealth/about/directory/index.html. Applicants must include in Attachment 7 a copy of the letter or email sent to the SORH, and any response received to the letter that was submitted to the SORH describing their project.

Each State has a SORH, and the FORHP recommends contacting the SORH entity early in the application process to advise them of your intent to apply. The SORH may be able to provide some consultation to applicants including information on model programs, data resources, technical assistance for consortiums, evaluation, introductions to partner organizations, or support of information dissemination activities. Another list of the SORH is available online at http://www.nosorh.org/regions/directory.php. Applicants should make every effort to seek consultation from the State Office of Rural Health at least three weeks in advance of the due date and as feasible provide the State Office of Rural Health a simple summary of the proposed project. If no response is received, please include the original letter of intent requesting the support.

Applicants located in Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, American Samoa, the U.S. Virgin Islands, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau do not have a designated State Office of Rural Health. Therefore, applicants from these areas can request an email or letter confirming the contact from NOSORH. The email address is: donnap@nosorh.org.

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 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 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 Application Guide except where instructed in the funding opportunity announcement to do otherwise.

See Section 8.5 of the 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 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 Application Guide.

   If requesting a funding preference, please indicate which qualification is being met in the Project Abstract. (See page 36 of the HRSA SF-424 Application Guide.) ORHP highly recommends that the applicant include this language: “Applicant’s organization name is requesting a funding preference based on qualification X” Please provide a brief description of how the applicant meets the requirement (one to two sentences).

   If a funding preference is requested, documentation of funding preference must be placed in Attachment 12. (Please label documentation as “Proof of Funding Preference Designation/Eligibility”.) If the applicant does not provide appropriate documentation in Attachment 12, the applicant will not receive the funding preference.

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. It should be succinct, self-explanatory and well organized so that reviewers can understand the proposed project.

- **NEEDS ASSESSMENT** -- Corresponds to Section V’s Review Criterion #1 (Need) and #4 (Impact)
  This section outlines the needs of the community and/or network. This section should help reviewers understand the community and/or entities that will be served by the proposed project. The following items must be addressed within the needs assessment:

  1. **Target Population**
     - The target population and its unmet health needs must be described including the estimated size of the target population and the number of counties being addressed by the network project, and appropriate demographic data should be used and cited wherever possible to support the information provided. If the focus is specifically on the needs of the network members (such as enhancing HIT and obtaining PCMH recognition), describe how addressing the network member needs will directly correlate to the unmet health needs of the community. Compare local data to State and Federal data where possible to highlight the local community’s/region’s unique need.

  2. **Chronic Disease Burden**
     - Describe the burden of chronic diseases and conditions among the target population to be served, specifically diabetes, CHF and COPD. The applicant should describe the quality of life for those affected by these chronic diseases and conditions. Data should be used and cited wherever possible to support the information provided.

  3. **Geographic Details of Service Area**
     - Include a map that shows the location of network members, the geographic area that will be served by the network and any other information that will help reviewers visualize and understand the scope of the proposed activities. Please be sure that any maps included will photo copy clearly in black and white, as this is what reviewers will see. Color maps will not be helpful for the reviewers.

  4. **Barriers/Challenges**
     - Identify key challenges and barriers related to network functions as a whole and those related to the service area, such as geographic, socioeconomic, linguistic, cultural, ethnic or other barriers, and discuss how the network plans to overcome identified barriers.

  5. **Health Care in Service Area**
     - a. Describe relevant services currently available in or near the service area of the network. The applicant should describe the potential impact of the network’s activities on providers, programs, organizations and other network entities in the community. The applicant should identify gaps in existing service and activities that the program and network can perform to fill that gap.
b. Describe how the local community or region to be served will benefit from the network as a result of the care coordination program.

c. Demonstrate the need for federal funding to support network care coordination activities by describing the environment in which the network has developed and why federal funds are appropriate at this point in time.

**METHODOLOGY -- Corresponds to Section V’s Review Criterion #2 (Response) and #4 (Impact)**

Propose methods that will be used to meet each of the previously-described program requirements and expectations.

(1) Define the specific goals and objectives of the network’s proposed grant-funded activities. The goals and objectives should directly relate to the information presented in the Needs Assessment section.

(2) Explain the network’s strategy for accomplishing the stated goals and objectives. The narrative should include a description of how the proposed grant-funded activities will further the network’s strategic plan and/or business plan.

(3) Describe the communication plan that will be used within the network and how network activities will be integrated into the individual network members’ organizational activities to the extent this is appropriate. In addition, the applicant should describe the approach and frequency of network meetings. Please describe the medium used for network meetings and why the particular medium was chosen (i.e. if network meetings are virtual or face-to-face).

(4) Outlines the specifics of the care coordination model and activities and address the following questions:

   a. Briefly illustrate the level of collaboration of network members in the network.

   b. Describe the care coordination model and types of activities that will be funded through the Rural Health Care Coordination Network Partnership Program.

   c. Describe any anticipated challenges to the care coordination activities described previously. Suggest solutions to the challenges described above.

   d. Explain elements of health care redesign, with a focus on transforming health care delivery into a patient and value-driven system. This includes, but is not limited to the implementation of the Affordable Care Act to improve outcomes, reduce costs, ensure access and efficient transitions of care, and promote innovative approaches.

(5) Demonstrate a cohesive sustainability plan which positions the network to continue the care coordination activities. The plan should identify:

   a. A mechanism for assessing continued need for the programs and services provided to the network and to the community.
b. How the network plans to disseminate information about the care coordination activities and results to network members and their communities, including the general public.

c. The anticipated plan to sustain the network and maintain activities and services and impact created as a result of the Care Coordination Program.

d. How the network will document and disseminate the value of its programs and services. The applicant shall describe how they will disseminate information gained regionally or nationally, including efforts by grassroots, faith-based or community-based organizations.

e. How the network plans to acquire sustained financial commitment from its network members to support network activities

f. Plans to bill for third party reimbursement for covered services and participate in pay-for-performance and other incentive programs.

(6) Promising Practices/ Evidence-Based Practices/ Evidence Informed Practices (if applicable): If the application proposal is based upon a program that worked in another community, please describe that program and include an abstract in Attachment 13. If applicable, describe why that approach will succeed in your community and what elements will be different in your community (how will it be tailored?).

- WORK PLAN -- Corresponds to Section V’s Review Criterion(a) #2 (Response)
Describe the activities or steps that will be used to achieve each of the activities proposed in the methodology section. Use a time line that includes each activity and identifies responsible staff. The following should be addressed in this section:

(1) Describes a clear and coherent work plan that is aligned with the network’s goals and objectives. Applicants are strongly encouraged to present a matrix that illustrates the network’s goals, objectives, strategies, activities, and measurable process and outcome measures in Attachment 8. The work plan must outline the individual or organization responsible for carrying out each activity and include a timeline for all three years of the grant. It is expected that certain activities will be accomplished by the end of each grant year as a condition of the award. The accomplishment of these activities (grantee satisfactory progress as stated) will factor into the decision to fund subsequent fiscal years. The deliverables to be provided each year of the grant by awarded grantees are as follows:
YEAR 1
• MONTH 6: By the Start of Month 6, a final assessment plan\textsuperscript{11} is finalized
• MONTH 12: By the End of Month 12, a network strategic plan is finalized.

YEAR 2
• MONTH 1: By the End of Month 12, a sustainability formative\textsuperscript{12} assessment is completed.

YEAR 3
• MONTH 9: By the End of Month 9, a sustainability plan is finalized.
• MONTH 15: By the End of Month 15, a final assessment report\textsuperscript{13} is completed.

(2) Project Monitoring: Describe measures to be implemented for assuring effective performance of the proposed grant-funded activities. Provide clear benchmarks of success for each year, to include process, outcome, patient and provider satisfaction measures. Describe on-going quality assurance/quality improvement strategies that will assist in the early identification and modification of ineffective efforts. For example, if one of the network’s key strategies for reaching a network goal turns out to be ineffective, the applicant includes a description of the measures in place to identify and address the situation.

- RESOLUTION OF CHALLENGES -- Corresponds to Section V’s Review Criterion #2 (Response)

(1) 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 Criterion #3 (Evaluative Measures)

(1) Provide an “outcomes approach” logic model that clearly illustrates the inputs, activities, outputs, short-term and long-term outcomes, and the impact of the proposed

\textsuperscript{11} The assessment plan should detail the strategy for assessing performance measures (implementation and operations) to determine program effectiveness so that adjustments, as needed, can be made. The assessment plan should outline indicators such as reduction in hospital readmissions or the decrease in clinical outcome measures such as HgA1c.

\textsuperscript{12} The Sustainability Formative Assessment is self-assessment tool to assist networks and their local partners in preparing in the early stages of the grant process for the long-term viability and success of local health initiatives. For more information, visit: http://www.ruralhealthlink.org/Portals/0/Resources/Sustainability%20Formative%20Self-Assessment%20Tool%20C2%20A9.pdf.

\textsuperscript{13} The assessment report is the key product of the assessment process, which is derived from the assessment plan. Its purpose is to provide a transparent basis for accountability for results, for decision-making on policies and programs, for learning, for drawing lessons and for improvement: http://www.undp.org/eo/documents/erc/Evaluation_Report.doc.
care coordination activities and clearly provides a basis for the work plan. Illustrate a logical flow and how it relates to customers (people served), network members, and the community at all social-ecological levels (intrapersonal/individual, interpersonal, organizational/institutional, community, and public policy). Include the following information:

a. Inputs and resources utilized to implement care coordination activities.

b. Outputs, outcomes, and impacts as related to care coordination in rural communities.

c. A narrative explaining the logic model (i.e. presumed effects of the care coordination model).

Include the project’s Logic Model and Narrative in Attachment 9. Additional information on developing logic models can be found in Section VIII of this FOA.

(2) Describes how progress toward meeting grant-funded goals will be tracked, measured, and assessed. Explains any assumptions made in developing the project matrix/work plan and discuss the anticipated outputs and outcomes of grant-funded activities. Both outcome, process, patient and provider satisfaction measures, benchmarks and established baseline data must be used to assess the progress of efforts. An assessment plan including these measures, benchmarks and baseline data should be included in Attachment 10. Additional resources that will aid in the development of an assessment plan can be found in Section VIII of this FOA.

(3) Describes the process by which data/information for these measures will be collected and analyzed. Describe the process that will be used to create a final assessment plan. Provide details about the person conducting the assessment and their proposed approach for conducting the program assessment. As a condition of the award, grantees will be required to report on process, outcome, patient and provider satisfaction performance measures related to the care coordination activities, clinical operations and the network. Applicants can find information on the core measures and optional measures below.

Core Measures for Type 2 Diabetes, CHF and COPD:
At a minimum, applicants are required to report on four outcome measures for each chronic condition (Type 2 Diabetes, CHF and COPD) outlined below, for a total of 12 measures. These required measures will be considered core measures.

Optional Measures for Type 2 Diabetes, CHF and COPD:
Applicants may identify outcome and process measures related to Type 2 Diabetes, CHF and COPD measures in addition to the required outcomes listed below. These additional measures are not required and will be considered optional measures.
Clinical outcome measures:

1. For Chronic Heart Failure (CHF)
   a. PQRS #5: ACE Inhibitor/ARB Therapy LVSD,
   b. PQRS #8: Beta-Blocker Therapy for LVSD,
   c. PQRS #198: LVEF Assessment,
   d. PQRS#226: Tobacco Use: Screening and Cessation Intervention.

2. For Type 2 Diabetes
   a. PQRS #1: Hemoglobin A1c Control in Diabetes Mellitus,
   b. PQRS #2: LDL-C Control in Diabetes Mellitus,
   c. PQRS#117: Dilated Eye-Exam in Diabetic Patient,
   d. PQRS #119: Urine Screening for Microalbumin,
   e. PQRS#163: Foot exam for diabetic patient.

3. For Chronic Obstructive Pulmonary Disease (COPD)
   a. PQRS#1: Spirometry Exam,
   b. PQRS #52: COPD Brochodilator Therapy,
   c. PQRS #110: Influenza Immunization,
   d. PQRS #111: Pneumonia Vaccination for Patients 65 and older,
   e. PQRS #226: Tobacco use: screening and cessation intervention.

Core Measures for Care Coordination:
In addition to reporting on the core measures for Type 2 diabetes, CHF and COPD, networks are required to report at least three care coordination measures (listed below). Performance on those measures will be aggregated across the funded sites to measure program impact.

Core care coordination process measures (all three are required to be measured):

1. CMS 4: Chronic Care ACSC Composite
2. NQF 0646: Reconciled Medication list Received by Discharged, and
3. NQF 0326: Advance Care Plan.

- ORGANIZATIONAL INFORMATION -- Corresponds to Section V’s Review Criterion #5 (Resources/Capabilities)

(1) Provide a brief overview of the network that includes information such as their mission (which should be provided in Attachment 5), structure (which should be provided in Attachment 4), and current primary activities.

(2) Identify and describe each of the network members and include each partner’s organization name, address, primary contact person, and current role in the community/region. A table may be used to present this information, if helpful, and included with Attachment 4. If the applicant organization is an existing network, the applicant makes clear that the network is comprised of at least three separate organizations; OR if there is no separate network entity, that the applicant is applying on
behalf of at least three separate organizations. Please provide an EIN number for each organization.

a. Describe the governance structure for the network that demonstrates there is effective, independent network-driven leadership in place. Applicants must demonstrate that the governing body, rather than an individual network member, will make financial and programmatic decisions. Providers of care should be represented on the governing body. (Note: An already-existing non-profit board of individuals convened for providing oversight to a single organization is not an appropriate board structure. The network’s board must be primarily made up of representatives of the organizations participating in the network to ensure they control decisions regarding network activities and budget.)

b. Provide a one page organizational chart of the network that depicts the relationship between the network members and the network governing board. Additionally, specify and depict the network director’s name and relationship to the network. If a network member is serving as the lead applicant on behalf of the network, they must also include a one page organizational chart of the lead applicant organization. The organizational chart(s) should be uploaded as Attachment 4.

c. Supply letters of support from entities such as local clinics and providers, regional health systems, and areas businesses. Each of these organizations can prove effective partners. Letters of support should be uploaded in Attachment 11.

(3) Outline the roles and responsibilities, within the network, of each network member while addressing capacity to carry out program goals and how the members all contribute to the ability of the organization to conduct the program requirements and meet program expectations. Describe the relationship between the applicant and the other network members. Explain why each of the network members are appropriate collaborators, what expertise they bring to the network, and why other key groups were not included.

(4) Describe the relationship of the network with the community/region it serves. Describe the extent to which the network engages the community in its planning and functioning and demonstrates the role of lay consumers of care in its planning and functioning.

(5) Describe the extent of prior collaboration among network members that demonstrates an ability to accomplish set goals. Describe challenges that the network members overcame to accomplish previous objectives.

(6) Describes a clear coherent plan for staffing detailing requirements necessary to run the network and to implement the identified care coordination activities. A staffing plan is required in Attachment 1. Specifically, the following should be addressed:

   a. State whether the applicant has a project director in place. If the network has does not have a project director, discuss the process and timeline for hiring a
full-time director (i.e. the number of known candidates, the projected starting date for the position of the full-time director, etc.).

b. The number and types of staff, qualification levels, and FTE equivalents.

c. Illustrate both the capabilities (current experience, skills, knowledge, experience with previous work of a similar nature, and materials published) of key staff already identified and the requirements that the applicant has established to fill other key positions if the grant is received.

d. Staffing needs should have a direct link to the activities proposed in the project narrative and budget portion of the application.

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 Application Guide.

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 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 Application Guide.

v. 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: Staffing Plan and Job Descriptions for Key Personnel

Provide a staffing plan that discusses the staffing requirements necessary to run the network. Staffing needs should be explained, and should have a direct link to activities proposed in the project narrative and budget portion of your application. Provide the job descriptions for key personnel listed in the application. Keep each description to one page if possible. For the purposes of this grant application, Key Personnel is defined as Individuals who contribute to the execution of the project in a substantive, measurable way, whether or not they receive salaries or compensation under the grant. The Project Director is classified as key personnel.
Attachment 2: Résumés/ Biographical Sketches of Key Personnel
 Provide résumés or biographical sketches for persons identified as key personnel described in the application. Résumés and biographical sketches should be brief, one or two pages are preferred. 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. If the Project Director (PD) serves as a PD for other federal grants, please list the federal grants as well as the percent FTE for each respective federal grant.

Attachment 3: Proof of Non-profit Status
 Include a letter from the IRS or eligible State entity that provides documentation of non-profit status. In place of the letter documenting non-profit status, public entities must, however, submit an official signed letter on city, county, State, or Tribal government letterhead identifying them as a public entity. Tribal government entities should verify their Federally-recognized status via the Bureau of Indian Affairs website: http://www.bia.gov.

Attachment 4: Organizational Chart
 Provide a one page organizational chart of the network that depicts the relationship between the network members and includes the network governing board. The organizational chart of the network should contain the network director’s name and EIN number of each organization depicted in chart. If a network member is serving as the lead applicant on behalf of the network, they must also include a one page organizational chart of the lead applicant organization.

Attachment 5: Network Vision and Mission/Purpose
 Include a statement of the Network’s Vision and a statement of the Network’s Mission/Purpose.

Attachment 6: Network Memorandum of Agreement/Understanding
 Include a Memorandum of Agreement or Memorandum of Understanding (MOA/MOU) signed and dated by all network members, that reflects the mutual commitment of the members. Note: A signed, copy of the MOA/MOUs should be included with the application. The original signed and dated MOA/MOU should be kept by the applicant organization.

Attachment 7: State Office of Rural Health Letter
 All applicants are required to notify their State Office of Rural Health (SORH) early in the application process to advise them of their intent to apply. The SORH can often provide technical assistance to applicants. Applicants should request an email or letter confirming the contact. State Offices of Rural Health also may or may not, at their own discretion, offer to write a letter of support for the project. Please include a copy of the letter or confirmation of contact. In the case that you do not receive a response from the SORH, submit a copy of your request for consultation to the SORH as Attachment 7.

Attachment 8: Work Plan
 Attach the work plan for the project that includes all information detailed in Section IV. i. Project Narrative. The work plan should be presented in a matrix that illustrates the network’s goals, strategies, activities, and measurable process and outcome
measures. The work plan must outline the individual or organization responsible for carrying out each activity and include a timeline for all three years of the grant.

**Attachment 9: Logic Model and Narrative**
Submit a logic model and narrative that illustrates the inputs, activities, outputs and outcomes and impact of the project. Refer to Section IV. i. Project Narrative for more information.

**Attachment 10: Assessment Plan**
The assessment plan should address process, outcome, patient and provider measures. It should include: assessment questions; indicators; benchmarks; baseline data; data sources; assessment methods (e.g. review of documents, interviews with project staff and providers, patient surveys, etc.); and how the assessment findings will be shared throughout the project.

**Attachment 11: Letters of Support**
Supply letters of support from informal network partner organizations that are not official members of the network but may play a role in the implementation of the proposed grant project.

**Attachment 12: Proof of Funding Preference Designation/Eligibility, if applicable**
If requesting a Funding Preference, include proof of qualification in this section. Include a printout or screenshot that displays the HPSA and/or MUC/P designation and respective score: [http://datawarehouse.hrsa.gov/geoadvisor/ShortageDesignationAdvisor.aspx](http://datawarehouse.hrsa.gov/geoadvisor/ShortageDesignationAdvisor.aspx). The printout or screenshot of the HPSA designation can also be found at [http://hpsafind.hrsa.gov/](http://hpsafind.hrsa.gov/) and the MUC/P designation can also be found at [http://muafind.hrsa.gov/](http://muafind.hrsa.gov/).

**Attachment 13: Evidence-Based Practices/ Promising Practices Abstract, if applicable**
If the proposed methodology to address care coordination is based upon a project or program that has worked in another community or network, include an abstract of that practice.

**Attachment 14: Other documents, as necessary**
Please include any other documents (not provided for elsewhere in this Table of Contents) that you chose to submit, as necessary. Be sure the attachment is clearly labeled.

3. **Submission Dates and Times**

**Application Due Date**
The due date for applications under this funding opportunity announcement is **APRIL 6, 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 Application Guide** for additional information.
4. Intergovernmental Review

The Rural Health Care Coordination Network Partnership Program is a program subject to the provisions of Executive Order 12372, as implemented by 45 CFR 100. See Executive Order 12372 in the HHS Grants Policy Statement.

See Section 4.1 ii of HRSA’s SF-424 Application Guide for additional information.

5. Funding Restrictions

Applicants responding to this announcement may request funding for a project period of up to three (3) years, at no more than $200,000 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.

Funds under this announcement may not be used for the following purposes:

Prior written approval is required to purchase equipment and requests to use grant funds to purchase equipment will only be approved in cases where the cost of the equipment is reasonable and the equipment is directly related to the purpose, goals and activities of the Rural Health Care Coordination Network Partnership Program. Given the nature and goals of the program, requests to use more than 20% of the grant funds on equipment will ordinarily be deemed unreasonable.

Grant funds may not be spent, either directly or through contract, to provide inpatient care.

Grant funds may not be spent, either directly or through contract, to pay for the purchase, construction, major renovation or improvement of facilities or real property.

Grant funds may not be used to purchase vehicles.

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 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 Rural Health Care Coordination Network Partnership Program has six (6) review criteria:

**Criterion 1: NEED (15 points) – Corresponds to Section IV’s Introduction and Needs Assessment**

The extent to which the application demonstrates the problem and associated contributing factors to the problem.

*Sub-criterion One:* 8 points

Analysis of the Community Data and Existing Services and Programs

(1) The extent to which the relationship is clear and logical between the challenges impacting the network’s rural community(ies) and the need for the Care Coordination Program.

(2) The demographic, chronic care burden, quality of life, and network environmental data submitted by the applicant indicates the need for the identified care coordination activities.

(3) The applicant uses appropriate data sources (e.g., local, State, Federal) in their analysis of the health care and network needs and the environment in which the network is functioning and the degree to which this evidence substantiates the need for the network and proposed care coordination activities.

(4) The applicant provides quantifiable information on the lack of existing services/programs available in the applicant’s community/region. Extent to which the applicant clearly demonstrates the nature of geographical services area, including network membership. Manner in which applicant will meaningfully contribute to fill gaps in existing services.

(5) The extent to which the key challenges and barriers to network functions and implementation of the care coordination activities/services in the service area are identified and the extent to which plans to overcome the identified challenges and barriers are discussed.

*Sub-criterion Two:* 7 points

Addressing Community Needs and Demonstrating Need for Grant Funds

(6) The extent to which relevant services currently available in or near the network service area are discussed as well as the potential impact of the network’s activities on providers, programs, organizations, and other network entities in the community.

(7) The extent to which the applicant describes how the local community or region to be served will benefit from the network as a result of the care coordination program.
The extent to which the applicant demonstrates the need for federal funding to support network care coordination activities by describing the environment in which the network has developed and why federal funds are appropriate at this point in time.

A clear explanation of how this effort does not duplicate any other Federal investments members of the network may be getting (i.e., if a network member is a community health center and taking part in funded patient centered medical home models or if the network includes a CAH or small rural hospital that is taking part in ongoing projects related to the HHS Partnership for Patients or Medicare Quality Improvement Organization activities or have been or are currently funded for similar activities such as the through a Rural Health Outreach, Network Development or Small Health Care Provider Quality Improvement grant programs).

Criterion 2: RESPONSE (30 points) – Corresponds to Section IV’s Methodology, Work Plan and Resolution of Challenges
The extent to which the application responds to the “Needs Assessment” section and devises a Work Plan to address the network and its health care coordination goals and objectives and solutions to potential challenges.

Sub-criterion One: 8 points
Developing Strategies to Accomplish Goal

(1) Extent to which applicant’s goals and objectives are clear, concise and appropriate for the network’s proposed grant-funded activities. Degree to which these goals and objectives directly relate to the information presented in the Needs Assessment section. Appropriateness of these activities and extent to which they flow logically from the goals and objectives. Extent to which the applicant’s approach and strategy is innovative and clearly relates to the process and outcome measures chosen by the applicant.

(2) Appropriateness of the network’s strategy for accomplishing the stated goals and objectives and the extent to which it will specifically address the network’s strategic and business priorities.

(3) Adequacy of the applicant’s strategy to address the potential challenges in providing coordinated quality health care.

(4) Extent to which the application present a clear and cohesive plan for communicating network activities and, to the extent that it is appropriate, the extent to which the plan is integrated into the individual network members’ organizational activities. Appropriateness of the approach, frequency, and medium used for network meetings.

Sub-criterion Two: 7 points
Addressing Care Coordination Model and Activities

(5) Degree to which the applicant outlines the specifics of the care coordination model and activities in the following areas:
a. The extent to which the applicant describes the network level of collaboration and whether the collaboration level is appropriate to achieve the stated activities.

b. Detail and appropriateness of the care coordination model and activities.

c. Extent to which the application demonstrates a comprehensive understanding of potential challenges likely to be encountered in designing and implementing the activities described in the Work Plan. Appropriateness of proposed approaches to resolve the identified potential challenges.

d. The extent to which the applicant describes their approach to health care redesign and transforming health care delivery into a patient and value-driven system, including a description of how the specified approach will have the potential to improve outcomes and reduce avoidable costs.

**Sub-criterion Three:** 8 points

**Demonstrating an Appropriate Work Plan and Sustainability Plan**

(6) Degree to which the applicant demonstrates a cohesive sustainability plan, which positions the network to sustain the care coordination activities and impact. The extent to which the applicant presents:

a. A feasible mechanism for assessing continued need for programs and services provided to the network and community.

b. A thorough and comprehensive plan to document the value of the network and care coordination services, acquire sustained financial commitment from network members to support ongoing activities, and bill for third party reimbursement for covered services and participate in pay-for-performance and other incentive programs.

(7) Degree to which the application includes a clear and coherent work plan aligned with the network’s annual goals, objectives, and strategies. Appropriateness of the work plan in identifying responsible individual(s) and organization(s) and a timeline for each activity for all three years. Appropriateness of associated process, outcome, and patient and provider satisfaction measures and their benchmarks for each activity and respective goal.

(8) Degree to which the applicant’s Work Plan aligns with the implementation timeline and deliverables.

**Sub-criterion Four:** 7 points

**Monitoring Grant Activities through Measures and Demonstrating Success**

(9) Extent to which the applicant demonstrates how the network will monitor the project. Presence and appropriateness of specific measures to use for assuring effective performance of the proposed grant-funded activities and on-going quality assurance/quality improvement strategies that will assist in the early identification and modification of ineffective efforts.
(10) Extent to which the application presents clear benchmarks of success for each year. Extent to which the benchmarks to be applied to the project are industry standard from recognized sources, such as NQF, NCQA, CMS; or, the extent to which the applicant proposes appropriate benchmarks if industry standards are not available.

Criterion 3: EVALUATIVE MEASURES (10 points) – Corresponds to Section IV’s Evaluation and Technical Support Capacity
The extent to which the proposed assessment plan is thorough and linked to the Work Plan, logic model, and identified goals, objectives and process and outcome measures.

(1) Degree to which the logic model strengthens the work plan as evidenced by the inputs, activities, outputs, short-term and long-term outcomes, and the impact of the project in Attachment 9. Logic model presents a rational flow that emphasizes a correlation between program components for patients, providers, network members, and the community at all social-ecological levels (intrapersonal/individual, interpersonal, organizational/institutional, community, and public policy).

(2) Strength of evidence that progress towards meeting goals will be tracked, measured, and assessed. Feasibility and effectiveness of the identified outcome, process, and patient and provider satisfaction measures for assessing the progress of efforts.

(3) Effectiveness of the process for collecting and analyzing data/information for program assessment measures and the approach for assessing the network’s progress in relation to proposed outputs and outcomes.

(4) Effectiveness of the proposed method to create a strong program assessment. The strength of the assessment plan included in Attachment 10 in regards to the needs assessment, program goals, work plan, and sustainability.

Criterion 4: IMPACT (10 points) – Corresponds to Section IV’s Needs Assessment and Methodology
The extent to which the the network and its proposed care coordination activities (discussed in the applicant’s Work Plan and logic model) are feasible and effective, and will affect the patients, providers, network members, and community. The extent to which the applicant will disseminate the information regionally or nationally, including efforts by grassroots, faith-based or community-based organizations. Degree to which project activities are sustainable. The extent to which the applicant clearly articulates process and outcome measures related to their activities (i.e. NQF, PQRS, and CMS measures).

(1) Clarity with which the application identifies how the local community or region to be served will benefit from the network as a result of its integration and coordination of activities (e.g., will strengthen the viability of key providers, will obtain PCMH recognition, etc.).

(2) Extent to which and level of clarity as to how the network will strengthen its relationship with the community/region it serves. Degree to which, where appropriate, applicant
clearly demonstrates the role of lay consumers of care in the network and care coordination planning and functioning.

(3) Extent to which the applicant’s program will impact a large rural service area and many rural health care providers.

(4) Promising Practices/ Evidence-Based Practices/ Evidence Informed Practices: Where applicable, the extent to which the applicants demonstrate the strength of the approach and its success in the target community.

(5) Appropriateness and diversity of the applicant-specified groups to share information regarding the network’s care coordination activities.

(6) Appropriateness of approach to disseminate the program results widely and to the community and general public.

Criterion 5: RESOURCES/CAPABILITIES (25 points) – Corresponds to Section IV’s Organizational Information

The extent to which the applicant describes current experience, skills, and knowledge of the network and staff. The extent to which the current experience, skills, and knowledge of the network and staff enable the applicant to fulfill the Rural Health Care Coordination Network Partnership Program requirements and meet expectations.

Sub-criterion One: 10 points
Network Member Roles and Commitment to Network Goals

(1) Degree of collective strength of the network as evidenced by the extent to which each network member is identified and respective current roles are described. The clarity with which the applicant identifies and describes each of the network members and includes each partner’s organization name, EIN, address, primary contact person, and current role in the community/region. The clarity with which the applicant describes the network as comprised of at least three separate organizations, OR if there is no separate network entity, does the extent to which the applicant clearly demonstrates it is applying on behalf of at least three separate organizations.

(2) Demonstrate the administrative and accounting capabilities to manage the grant funds;

(3) Extent of prior collaborative history among network members commensurate with the proposed care coordination activities. Degree to which network members overcame challenges to accomplish previous objectives. Evidence that the network is highly functioning in its prior collaboration. Extent of the network’s ability to immediately begin implementation of the project.

(4) Strength of evidence as to why each of the network members are appropriate collaborators and thorough indication of the expertise each member brings to the network. Appropriate rationale for excluding other key groups from the network and, if so, a reasonable justification.
The extent to which the network members demonstrate the strength of their mutual commitment and a Memorandum of Agreement or Memorandum of Understanding (MOA/MOU) that is signed and dated by all network members.

Extent to which the application provides evidence that all organizations will contribute to the ability of the network to conduct the program requirements and meet program expectations.

**Sub-criterion Two:** 5 points

Network Relationship to the Community

Strength of the relationship between the network and the community/region it serves. Degree to which the network is capable of partnering with appropriate organizations in the community to fulfill the goals of the network and the care coordination program.

a. Extent to which the applicant demonstrates community support for and committed involvement in care coordination activities via letters from entities such as, but not limited to, local clinics and providers, regional health systems, and areas businesses.

**Sub-criterion Three:** 10 points

Network Staffing Plan and History of Collaboration

Extent to which the application demonstrates a strong and feasible staffing plan that incorporates requirements necessary to run the network and care coordination activities. The extent to which and quality with which the staffing plan and résumés establish and appropriately specify:

a. The number and types of staff, qualification levels, and FTE equivalents.

b. The capabilities (current experience, skills, knowledge, experience with previous work of a similar nature, and materials published) of key staff already identified and the requirements that the applicant has established to fill other key positions if the grant is received.

c. Staffing needs in relation to the activities proposed in the project narrative and budget portion of the application.

d. The process and timeline for hiring a full-time project director, if the network doesn’t already have a project director. Extent to which the application clearly demonstrates how the project director’s role contributes to the success of care coordination.

Strength of the applicant organization’s and network’s mission, structure, and current primary activities.

Clarity of the roles and responsibilities, within the network, of each network member and evidence for a strong relationship between the applicant and the other network members.
(11) Effectiveness of the governance structure for the network and the presence of an independent network-driven leadership in place. Clear demonstration that the governing body, rather than an individual network member, will make financial and programmatic decisions. Strength of the evidence that providers of care are or will be represented on the governing body. (Note: An already-existing non-profit board of individuals convened for providing oversight to a single organization is not an appropriate board structure. The network’s board must be primarily made up of representatives of the organizations participating in the network to ensure they control decisions regarding network activities and budget.)

(12) Extent to which the organizational chart(s) demonstrates a clear and distinct relationship between the network member organizations and provides evidence of a network governing board.

Criterion 6: SUPPORT REQUESTED (10 points) – Corresponds to Section IV’s Budget
The extent to which the proposed budget in relation to the objectives, the complexity of the activities, and the anticipated results are reasonable for each year.

(1) Clarity, and appropriateness of an itemized budget table or spreadsheet for each year of requested funding.

(2) Extent to which the budget narrative provides a detailed justification for each item presented in the budget tables.

(3) Extent to which the budget narrative abides by the funding restrictions described in Section IV.5.

(4) Degree to which the budget justification logically documents how and why each line item request (such as personnel, travel, equipment, supplies, information technology, and contractual services) supports the goals and activities of the proposed grant-funded activities.

(5) Inclusion and appropriateness of the costs for proposed grant-funded activities.

(6) Inclusion of a project director that should be at least a half time employee (0.5 FTE) of the network organization and on the grant program.

2. Review and Selection Process

Please see Section 5.3 of HRSA’s SF-424 Application Guide. Applicants have the option of providing specific salary rates or amounts for individuals specified in the application budget or the aggregate amount requested for salaries.

Funding Preferences
The authorizing legislation Section 330A(f) of the Public Health Service (PHS) Act, as amended (42 U.S.C. 254(c)(f)) provides a funding preference for some applicants. Applicants receiving the preference will be placed in a more competitive position among applications that can be
funded. Applications that do not receive a funding preference will be given full and equitable consideration during the review process. The funding factor will be determined by the Objective Review Committee. The law provides that a funding preference be granted to any qualified applicant that specifically requests the preference and meets the criteria for the preference as follows:

Qualification 1: Health Professional Shortage Area (HPSA)
An applicant can request funding preference if the service area of the applicant is located in an officially designated health professional shortage area (HPSA). Applicants should include a screenshot or printout from the HRSA Shortage Designation website which indicates if a particular address is located in a HPSA:

Qualification 2: Medically Underserved Community/Populations (MUC/MUPs)
An applicant can request funding preference if the applicant is located in a medically underserved community (MUC) or serves medically underserved populations (MUPs). Applicants should include a screenshot or printout from the HRSA Shortage Designation website which indicates if a particular address is located in a MUC or serves an MUP:

Qualification 3: Focus on primary care and wellness and prevention strategies.
An applicant can request this funding preference if their project focuses on primary care and wellness and prevention strategies. This focus must be evident throughout the project narrative.

Applicants only have to meet one of the qualifications stated above to receive the preference. Meeting more than one qualification does not affect the applicant’s funding preference.

If requesting a funding preference, please indicate which qualification is being met in the Project Abstract. (See page 36 of the HRSA SF-424 Application Guide.) ORHP highly recommends that the applicant include this language: “Applicant’s organization name is requesting a funding preference based on qualification X” Please provide a brief description of how the applicant meets the requirement (one to two sentences).

If a funding preference is requested, documentation of funding preference must be placed in Attachment 12. (Please label documentation as “Proof of Funding Preference Designation/Eligibility”.) If the applicant does not provide appropriate documentation in Attachment 12, the applicant will not receive the funding preference.

3. Anticipated Announcement and Award Dates

It is anticipated that awards will be announced prior to the start date of September 1, 2015.
VI. Award Administration Information

1. Award Notices

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

2. Administrative and National Policy Requirements

See Section 2 of HRSA’s SF-424 Application Guide.

3. Reporting

The successful applicant under this funding opportunity announcement must comply with Section 6 of HRSA’s SF-424 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) **Other required reports and/or products.**

   a. **Performance Measures Report.** A performance measures report is required after the end of each project period in the Performance Improvement Measurement System (PIMS). Upon award, grantees will be notified of specific performance measures required for reporting.

   The measures selected for this grant program widely accepted measures recognized by the National Quality Forum (NQF), Physician Quality Reporting System (PQRS), National Committee for Quality Assurance (NCQA) and Centers for Medicare and Medicaid Services (CMS).

   **NOTE:** ORHP will create specific performance measures that grantees will be required to report within the Performance Improvement System (PIMS) located in HRSA’s Electronic Handbook (EHB). This data helps HRSA to determine the larger impact of its Rural Health Programs and in particular, will help determine the impact of the new Rural Health Care Coordination Network Partnership Program. Performance measures can be process or outcome measures that allow grantees to track their progress toward meeting stated objectives. Grantees will be expected to track their performance over the life of their grant. Once these measures are finalized by ORHP, all Care Coordination Program grantees will be required to use the approved measures and to provide data on these measures annually for continued funding.

   b. **Final Report.** A final report is due within 90 days after the project period ends. The final report will collect information such as program-specific goals and progress on strategies; core performance measurement data; impact of the overall project; the degree to which the grantee achieved the mission, goal and strategies outlined in the program; grantee objectives and accomplishments; barriers encountered; and responses to summary questions regarding the grantee’s overall experiences over the entire project period. The final report must be submitted on-
line by awardees in the Electronic Handbook system at
https://grants.hrsa.gov/webexternal/home.asp. Further information will be
provided upon receipt of reward.

c. **Strategic Plan.** Awardees will be required to submit a Five-Year Strategic Plan
during the first year of their grant period. This strategic plan will provide
guidance for program development throughout the grant period and beyond.
Further information will be provided upon receipt of the award.

d. **Final Assessment Plan.** Awardees are required to submit a final assessment plan
detailing the strategy for assessing performance measures (implementation and
operations) to determine program effectiveness so that adjustments, as needed,
can be made. Further information will be provided upon receipt of the award.

e. **Sustainability Formative Assessment.** As part of receiving the grant, awardees
are required to submit a Sustainability Formative Assessment during the second
year of their grant period. Further information will be provided upon receipt of
the award.

f. **Final Sustainability Plan.** As part of receiving the grant, awardees are required
to submit a final Sustainability Plan during the third year of their grant period.
Further information will be provided upon receipt of the award.

g. **Final Assessment Report.** Awardees are required to submit a final Program
Assessment Report at the end of their grant period that would show, explain and
discuss their results and outcomes. Further information will be provided in the
award notice.

**VII. Agency Contacts**

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

Ms. Ann Maples
Grants Management Specialist
HRSA Division of Grants Management Operations, OFAM
Parklawn Building, Room 18-75
5600 Fishers Lane
Rockville, MD  20857
Telephone: (301) 443-2963
Fax: (301) 443-9810
E-mail: Amaples@hrsa.gov

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

Sara Afayee
Public Health Analyst
Attn: Rural Health Care Coordination Network Partnership Program
Federal Office of Rural Health Policy, HRSA
Parklawn Building, Room 17W45-C
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 945-4169
Fax: (301) 443-2803
E-mail: safayee@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

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

Technical Assistance Webinar:

The Office of Rural Health Policy will hold a technical assistance webinar on Thursday, February 12, 2015 at 2:00 PM Eastern Standard Time to assist applicants in preparing their applications. The Adobe Connect webinar and call-in information are as follows:

Meeting Name: Rural Health Care Coordination Network Partnership Program
To join the meeting as a guest: https://hrsa.connectsolutions.com/rhccnpp/
Toll-free call in number: 1-888-946-7496 (participants must call in to verbally ask questions)
Participant Passcode for call in number: Care Coordination

Prior to joining, please test your web connection:

Note: You must dial into the conference line to hear the audio portion of the webinar.
For your reference, the Technical Assistance webinar will be recorded and available to access via http://www.hrsa.gov/grants/index.html. The audio portion of the Technical Assistance webinar will also be recorded and available for playback within one hour of the end of the webinar and will be available until March 29, 2015. The phone number to hear the recorded call is 800-283-9442.

The Technical Assistance webinar is open to the general public. The purpose of the webinar is to go over the grant funding opportunity announcement, and to provide any additional or clarifying information that may be necessary regarding the application process. There will be a Q&A session at the end of the webinar to answer any questions. While the webinar is not required, it is highly recommended that anyone who is interested in applying for the Rural Health Care Coordination Network Partnership Program plan to join the webinar. It is most useful to the applicants when the grant funding opportunity is easily accessible during the webinar and if questions are written down ahead of time for easy reference.

Logic Models:

Additional information on developing logic models can be found at the following website: http://www.wkkf.org/knowledge-center/resources/2006/02/WK-Kellogg-Foundation-Logic-Model-Development-Guide.aspx.

(Note: Although there are similarities, a logic model is not a work plan. A logic model is overarching and provides a visual depiction of the program’s presumed effects. An “outcomes approach” logic model attempts to logically connect program resources with desired results and is useful in designing effective program assessment and reporting strategies. 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.)

Additional information on the social-ecological model framework can be found at the following websites:
http://www.cdc.gov/cancer/crccp/sem.htm;
http://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html;
http://heb.sagepub.com/content/15/4/351.full.pdf+html

Helpful Websites:

Agency for Healthcare Research and Quality: http://www.ahrq.gov

Centers for Medicare & Medicaid Services: http://www.cms.gov


Federal Office of Rural Health Policy: http://ruralhealth.hrsa.gov


National Quality Forum: http://www.qualityforum.org
National Committee for Quality Assurance:  http://www.ncqa.org

Program Assessment:
http://www.cdc.gov/healthyyouth/evaluation/resources.htm#4:

Rural Assistance Center (RAC): http://www.raonline.org

Rural Care Coordination Toolkit: http://www.raonline.org/communityhealth/care-coordination

Rural Community Health Gateway: http://www.raonline.org/communityhealth
Rural Eligibility List:

Rural Health Research Gateway: http://www.ruralhealthresearch.org

Rural Health Philanthropy Information:

Social-Ecological Model Framework:
http://www.cdc.gov/cancer/crcp/sem.htm;
http://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html;
http://heb.sagepub.com/content/15/4/351.full.pdf+html

State Office of Rural Health (SORH) List: http://ruralhealth.hrsa.gov/funding/50sorh.htm

Common Definitions:

For the purpose of this guidance, the following terms are defined:

**Budget Period** – An interval of time (typically twelve months) into which the project period is divided for budgetary and reporting purposes.

**Care Coordination** – Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care.

**Equipment** – Durable items that cost over $5,000 per unit and have a life expectancy of at least 1 year.

**Evidence-Based Practice** – Evidence-based practices are approaches to prevention or treatment that are validated by some form of documented scientific evidence. Scientific evidence includes findings established through controlled clinical studies, research and other methods of establishing evidence.
Evidence-Informed Practice – Evidence-informed practice is the best available research and practice knowledge to guide program design and implementation. This informed practice allows for innovation while incorporating the lessons learned from the existing research literature.

Evolving – An evolving network typically has worked together for at least two or three years, may have begun to develop shared services, or developed joint community-based initiatives, and may have begun to integrate functions such as joint purchasing, information systems and shared staffing.

Formative – A formative network is in the start-up phase of becoming organized and typically has been in operation for less than two years. Usually the impetus for organizations to form a network is to address a particular problem faced within a community. A formative network typically focuses on systems analysis, understanding the needs of potential network partners, program and strategic planning, formalizing relationships among the network participants, and developing a strategic plan including performance measures and financial sustainability strategies.

Grantee – A non-profit or public entity to which a grant is awarded and which is responsible and accountable for the use of the funds provided for the project.

Health Care Provider – Health care providers are defined as: hospitals, public health agencies, home health providers, mental health centers, substance abuse service providers, rural health clinics, primary care providers, oral health providers, social service agencies, health profession schools, local school districts, emergency services providers, community and migrant health centers, federally qualified health centers, Tribal health programs, churches and civic organizations that are/will be providing health care services.

Health Professional Shortage Area (HPSA) – HPSAs are defined as: (1) An urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services); (2) a population group; or (3) a public or non-profit private medical facility that has a shortage of primary medical care, dental or mental health professionals.

Horizontal Network – A network composed of the same type of health care providers, e.g., all hospitals or all community health centers as one network.

Integrated Rural Health Network – A formal organizational arrangement among at least three separately owned health care providers or other entities that provide or support the delivery of health care services. The purpose of an Integrated Rural Health Network is to foster collaboration and integration of functions among network entities to strengthen the rural health care system.

Mature – A network typically has been in existence for more than five years, has skilled and experienced staff as well as a highly functioning network board, and offers integrated products and services. It may engage in common resource planning and bring in revenue from diverse sources, thereby enabling it to build capital reserves and be financially self-sufficient.
Medically Underserved Area (MUA) – Refers to an area in which residents have a shortage of personal health services. A MUA may be a whole county, a group of contiguous counties, a group of county or civil divisions, or a group of urban census tracts.

Medically Underserved Populations (MUP) – Refers to a group of persons who face economic, cultural or linguistic barriers to health care.

Memorandum of Agreement – The Memorandum of Agreement is a written document that must be signed by all network member CEOs or Board Chairs to signify their formal commitment as network members. An acceptable MOA must describe the network purpose and activities in general; member responsibilities in terms of financial contribution, participation, and voting; and membership benefits.

Network Director – An individual designated to direct the network and is capable of overseeing the network’s administrative, fiscal, and business operations. The network director reports to the network governing body.

Non-profit – Any entity that is a corporation or association of which no part of the net earnings may benefit private shareholders or individuals and is identified as non-profit by the IRS.

Notice of Award – The legally binding document that serves as a notification to the recipient and others that a grant has been made, contains or references all terms of the award and documents the obligation of Federal funds in the Health and Human Services accounting system.

Project – All proposed activities specified in a grant application as approved for funding.

Project Director – The individual responsible for managing a grant project at the strategic level. The project director is typically the grant project's point person, managing resources and overseeing finances to ensure that the project progresses on time and on budget. The director reviews regular progress reports and makes staffing, financial, or other adjustments to align the developing project with the broader outcome goals.

Project Period – The total time for which support of a discretionary project has been approved. A project period may consist of one or more budget periods. The total project period comprises the original project period and any extension periods.

Promising Practice – A promising practice has strong quantitative and qualitative data showing positive outcomes, but does not yet have enough research or replication to support generalizable positive public health outcomes.

Tribal Government – Includes all Federally recognized tribes and state recognized tribes.

Tribal Organization – Includes an entity authorized by a Tribal government or consortia of Tribal governments.

Vertical Network – A network composed of a variety of health care provider types, e.g., a hospital, rural health clinic and public health department.
IX. Tips for Writing a Strong Application

See Section 4.7 of HRSA’s *SF-424 Application Guide*. 