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

Federal Office of Rural Health Policy
Community Based Division

Small Health Care Provider Quality Improvement Program

Announcement Type: New
Funding Opportunity Number: HRSA-16-019

Catalog of Federal Domestic Assistance (CFDA) No. 93.912

FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2016

Application Due Date: March 4, 2016

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: January 4, 2016

Issuance Date: January 4, 2016

Ann Ferrero, MPH
Public Health Analyst
Federal Office of Rural Health Policy
E-mail: aferrero@hrsa.gov
Telephone: (301) 443-3999
Fax: (301) 443-2803

Authority: Public Health Service Act, Title III, Section 330 A (g) (42 U.S.C. 254c (g)), as amended. ; P.L. 114-53.

EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA), Federal Office of Rural Health Policy is accepting applications for fiscal year (FY) 2016 Small Health Care Provider Quality Improvement Program. The purpose of this program is to provide support to rural primary care providers for planning and implementation of quality improvement activities.

Funding Opportunity Title:	Small Health Care Provider Quality Improvement Program
Funding Opportunity Number:	HRSA-16-019
Due Date for Applications:	March 4, 2016
Anticipated Total Annual Available Funding:	$4,150,000
Estimated Number and Type of Award(s):	Up to 21 grants
Estimated Award Amount:	Up to $200,000 per year
Cost Sharing/Match Required:	No
Project Period:	August 1, 2016 through July 31, 2019 (Three (3) years)
Eligible Applicants:	Eligible Applicants: - Must be a rural public or rural nonprofit private health care provider or provider of health care services, such as a critical access hospital or a rural health clinic; or another rural provider or network of small rural providers; and - Must not previously have received a grant under this subsection for the same or similar project. [See Section III-1 of this funding opportunity announcement (FOA) for complete eligibility information.]

Application Guide

All applicants are responsible for reading and complying with the instructions included in HRSA's *SF-424 Application Guide,* available online at http://www.hrsa.gov/grants/apply/applicationguide/sf424guide.pdf, except where instructed in this FOA to do otherwise. A short video for applicants explaining the *Application Guide* is available at http://www.hrsa.gov/grants/apply/applicationguide/.

Technical Assistance

The Federal Office of Rural Health Policy will hold a technical assistance webinar on Tuesday January 19, 2016 2:30-4:00 PM EST to assist applicants in preparing their applications. The technical assistance webinar is open to the general public. The purpose of the webinar is to

review the funding opportunity announcement (FOA), and to provide clarifying information that may be necessary. There will be a Q & A session at the end of the call to answer any questions. FORHP strongly recommends that potential applicants read this FOA prior to the webinar and have the FOA available during the webinar. While participation on the webinar is not required, it is highly recommended that anyone who is interested in applying for this program plan to attend the webinar. FORHP has found that it is most useful to the applicants when the funding opportunity announcement is easily accessible during the webinar and questions are written down ahead of time for easy reference.

Call-in number (for audio): 1-888-603-9222 (participants must call in to verbally ask questions)
URL (for web): https://hrsaseminar.adobeconnect.com/hrsa-16-019/

Prior to joining, please test your web connection:
https://hrsa.connectsolutions.com/common/help/en/support/meeting_test.htm.

Note: You must dial into the conference line to hear the audio portion of the webinar. No registration is required. To access the webinar recording, please visit
http://www.hrsa.gov/grants/index.html

Table of Contents

I. Program Funding Opportunity Description

1. Purpose

This announcement solicits applications for the Small Health Care Provider Quality Improvement Grant Program. The purpose of this program is to provide support to rural primary care providers for planning and implementation of quality improvement activities. Quality health care is the provision of appropriate services to individuals and populations that are consistent with current professional knowledge, in a technically competent manner, with good communication, shared decision-making and cultural sensitivity. The ultimate goal of the program is to promote the development of an evidence-based culture and delivery of coordinated care in the primary care setting. Additional objectives of the program include: improved health outcomes for patients; enhanced chronic disease management; and better engagement of patients and their caregivers.

Chronic diseases, such as diabetes and cardiovascular disease, are a leading cause of morbidity and mortality in the United States, as well as a significant contributor to health care costs and utilization.[1] Between 2006 and 2011, emergency department visits increased by 33% for diabetes and 25% for hypertension.[2] Among Medicaid patients, diabetes was the third leading cause for rehospitalization within 30 days following a hospital stay.[3] In rural areas, these issues are exacerbated by high rates of poverty, older populations, and less access to care. One study found that Medicare beneficiaries living in rural areas had higher rates of emergency department visits and lower rates of follow-up care compared to urban beneficiaries, increasing their risk for hospital readmission.[4]

The Affordable Care Act established the National Quality Strategy in 2011, with three broad aims: to improve the quality of health care; to improve population health; and to reduce the cost of health care. In January 2015, the Secretary of the Department of Health and Human Services (HHS) announced a plan for delivery system reform, which reinforces and expands the National Quality Strategy, by transforming the health care system to a value and quality driven system.[5,6] Delivery system reform includes three focus areas: incentives, care delivery, and information. The purpose of incentives is to encourage providers to deliver high quality care. Incentives include alternative payment models such as accountable care organizations (ACOs), patient centered medical home (PCMH), bundled payments, and other shared savings. Improving care

---

[1] Chronic Disease Overview. Centers for Disease Control and Prevention. Retrieved from http://www.cdc.gov/chronicdisease/overview/

[2] Skinner H, Blanchard J, Elixhauser A. Trends in Emergency Department Visits, 2006–2011. HCUP Statistical Brief #179. (2014). Agency for Healthcare Research and Quality, Rockville, MD http://www.hcup-us.ahrq.gov/reports/statbriefs/sb179-Emergency-Department-Trends.pdf

[3] Hines AL, Barrett ML, Jiang HJ, and Steiner CA. Conditions With the Largest Number of Adult Hospital Readmissions by Payer, 2011. HCUP Statistical Brief #172. (2014). Agency for Healthcare Research and Quality, Rockville, MD. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb172-Conditions-Readmissions-Payer.pdf.

[4] Toth M, Holmes M, Van Houtven C, Toles M, Weinberger M, and Silberman P. (2015). Rural Medicare Beneficiaries Have Fewer Follow-up Visits and Greater Emergency Department Use Post discharge. Medical Care, 53, 800-807.

[5] Burwell, S. (2015). Setting Value-Based Payment Goals - HHS Efforts to Improve US Health Care. New England Journal of Medicine, 372, 897-899.

[6] Better Care. Smarter Spending. Healthier People: Why It Matters. (2015). Retrieved from https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-2.html

delivery includes greater teamwork and integration, better coordination of providers across settings, promoting patient engagement, and more attention to population health. Improving distribution of information means creating transparency on cost and quality information and bringing electronic health information to the point of care for meaningful use.

The Small Health Care Provider Quality Improvement Program supports three years of funding with an overall outcome to demonstrate an improvement in health status and to show a reduction in emergency department visits due to chronic disease. This funding opportunity supports quality improvement programs that will focus on patients with the highest health care utilization due to chronic conditions, such as diabetes and cardiovascular disease. Organizations participating in the program will align their quality improvement programs with the goals of delivery system reform as previously described. Organizations will identify a patient population to track over the three-year project period, implement an evidence-based quality improvement model to provide a framework for improving care delivery, and use health information technology (HIT) to collect, report, and utilize information on cost and quality. HIT may include a patient registry or an electronic health record (EHR), and is a critical component for improving quality and patient outcomes. With HIT it is possible to generate and distribute timely and meaningful data, as well as other information to help providers and patients track and plan care. This program does not support funding for an EHR, but grantees may use funds to develop or purchase a module or interface or customize reports to support collection of data. If any applicant plans to use an EHR for this program, it is highly recommended that the product is certified by the Office of the National Coordinator for Health Information Technology (http://oncchpl.force.com/ehrcert). Organizations will also develop a sustainability plan to describe how their quality improvement programs will continue after federal funding has ended. To the extent possible, the sustainability plan should include incentives and participation in value-based payment systems.

Although it is not a requirement, the Federal Office of Rural Health Policy (FORHP) is strongly encouraging applicants to form a consortium or network for this program. The health care system is becoming increasingly collaborative, and organizations will need to form partnerships and leverage resources to participate in many incentive and payment programs. Through other grant programs, FORHP has found that consortia and networks can better meet community need, enhance each organization's role, and stabilize and expand needed services and rural delivery systems. In addition, organizations will report on 30-day hospital readmission rates and emergency department use if awarded, and it would be advantageous to work with other organizations to obtain this data.

Funding under this program may provide start-up funds which will allow recipients to develop necessary capacity and the ability to obtain funding from other sources. Recipients should maximize funding from other sources, using award funds for the difference between those amounts and their costs of operation. Therefore, applicants must describe whether other funding sources and/or services currently exist for the proposed population and, if so, how HRSA funds would be used.

Background

This program is authorized by the Public Health Service Act, Title III, Section 330A(g) (42 U.S.C. 254c(g)), as amended by Section 201, P.L. 107-251, and Section 4, P.L. 110-355. This authority directs FORHP to support grants for the planning and implementation of small health care provider quality improvement activities that expand access to, coordinate, contain the cost of, and improve the quality of essential health care services, including preventive and emergency services, through the development of health care networks in rural and frontier areas. Across these various programs, the authority allows HRSA to provide funds to rural and frontier communities to support the direct delivery of health care and related services, to expand existing services, or to enhance health service delivery through education, promotion, and prevention programs.

While many quality improvement initiatives focus on inpatient and hospital care, quality improvement is also needed in the primary care environment. Timely disease treatment and management in the outpatient setting can improve patient health and decrease costs by preventing emergency care and hospital admissions. The ultimate goal of quality improvement is to foster the development of an evidence-based culture and delivery of coordinated care among the entire medical team ranging from physicians to the front desk staff.

FORHP has administered the Small Health Care Provider Quality Improvement Program for 10 years, beginning as a two-year pilot program in 2006. The program increased to a three-year grant program in 2010 to allow more time for start-up activities. Beginning in 2013, organizations were encouraged to form a consortium and address sustainability of project activities beyond the grant period. In 2016, organizations participating in this program will be expected to align with the goals of delivery system reform, an HHS initiative to transform the health care system to one that provides better care at lower cost. FORHP has found that the most successful projects funded through the Small Health Care Provider Quality Improvement Program contain common elements, such as: coordination of care; provision of patient-centered care; use of multidisciplinary teams; collaboration and partnerships; the ability to collect, report and use data for quality improvement; participation in payment incentive programs; tracking utilization (e.g., hospital admissions, emergency department use); and integration of the social determinants of health.

To learn more about currently funded grant projects, please refer to the Small Health Care Provider Quality Improvement Grant Program Directory. This directory provides contact information and a brief overview of grantee's project for the 2013-2016 funding cycle and is available through the Rural Health Information Hub (RHIhub) formerly the Rural Assistance Center at https://www.ruralhealthinfo.org/pdf/2013-2016-small-provider-quality-improvement-grantee-directory.pdf.

II. Award Information

1. Type of Application and Award

Type(s) of applications sought: New.

Funding will be provided in the form of a grant.

2. Summary of Funding

This program will provide funding during federal fiscal years 2016 – 2019. Approximately $4,150,000 is expected to be available annually to fund up to 21 recipients. Applicants may apply for a ceiling amount of up to $200,000 per year. This program announcement is subject to the appropriation of funds, and is a contingency action taken to ensure that, should funds become available for this purpose, applications can be processed, and funds can be awarded in a timely manner. The project period is three (3) years. Funding beyond the first year is dependent on the availability of appropriated funds for the Small Health Care Provider Quality Improvement Program in subsequent fiscal years, satisfactory recipient 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 subject to the Uniform Guidance 2 CFR 200 as codified by HHS at 45 CFR 75, which supersede the previous administrative and audit requirements and cost principles that govern federal monies.

III. Eligibility Information

1. Eligible Applicants

Applicants for the Small Health Care Provider Quality Improvement Program must meet all of the eligibility requirements stated below.

A. Organization Requirements
   Eligible applicants must be a rural public or a rural nonprofit private health care provider or provider of health care services. For purposes of this program, "health care provider" may include, but is not limited to, entities such as black lung clinics, hospitals, public health agencies, home health providers, mental health centers and providers, 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 health centers/federally qualified health centers, Tribal health programs, churches and civic organizations that are providing health related services.

   i.   Please note that all Centers for Medicare and Medicaid Services (CMS)-certified critical access hospitals (CAH) and rural health clinics (RHC) are eligible to apply for this program, if they also meet the geographic eligibility requirement (described below). CAH can be found at this link: http://www.flexmonitoring.org/cahlistRA.cgi. RHC can be found at this link: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/rhclistbyprovidername.pdf.

   ii. If the applicant is a nonprofit entity, one of the following documents must be included in **Attachment 1** to document nonprofit status *(will **not** count toward the page limit)*.

- o A letter from the IRS stating the organization's tax-exempt status under Section 501(c)(3);
- o A copy of a currently valid IRS tax exemption certificate;
- o Statement from a state taxing body, state attorney general or other appropriate state official certifying that the applicant organization has a nonprofit tax status and that none of the next earnings accrue to any private shareholders or individuals;
- o A certified copy of the organization's certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization; or
- o 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 nonprofit affiliate.

iii. If the applicant is a public entity, proof of nonprofit status is not necessary. The applicant must submit an official signed letter on city, county, state or tribal government letterhead identifying them as a public entity in **Attachment 1**. 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: http://www.indianaffairs.gov/.

iv. The Rural Quality Program strongly encourages the establishment of a consortium to encourage creative and lasting relationships among service providers in rural areas. Examples of consortium member entities include hospitals, public health departments, FQHCs, RHCs, home health providers, primary care service providers, social service agencies, community and migrant health centers, and civic organizations. In addition, organizations will be required to report on 30-day readmissions and emergency department use if awarded, and it would be advantageous to work with a hospital to obtain this data.

vi. Organizations and/or consortia are not eligible if they have previously received a grant for the Small Health Care Provider Quality Improvement Program for the same or a similar project. **Current and former grantees** of any FORHP community-based grant programs are eligible to apply if the proposed project is a new proposal (entirely new project) or an expansion or enhancement of the previous grant project. The project should not supplant an existing program. The proposal should differ significantly from previous projects by expanding the service area of the project, serving a new population, providing a new service or expanding the scope of the previous grant activities. Please provide a one-page synopsis for any and all previously funded FORHP grant projects in **Attachment 12**.

vii. For organizations that are also funded by HRSA's Health Center Program (Section 330 of the Public Health Service Act (42 USCS § 254b)) and receiving support for the HRSA Patient-Centered Medical Home (PCMH) Recognition Initiative: please be advised that activities and personnel supported under this award for Small Health Care Provider Quality Improvement Program must not be duplicative of those funded by the Health Center Program. For more information on the PCMH

recognition initiative, please see:
http://bphc.hrsa.gov/qualityimprovement/clinicalquality/accreditation-pcmh/index.html.

Foreign entities are not eligible for HRSA awards, unless the authorizing legislation specifically authorizes awards to foreign entities or the award is for research. This exception does not extend to research training awards or construction of research facilities.

B. Geographic Eligibility Requirements

i. The applicant organization must be located in a non-metropolitan county or in a rural census tract of a metropolitan county and all services must be provided in a non-metropolitan county or rural census tract. To ascertain rural eligibility, please refer to http://datawarehouse.hrsa.gov/RuralAdvisor/RuralHealthAdvisor.aspx. This Web page allows potential applicants to search by county or street address and determine their eligibility.

ii. In addition to the 50 States, applicants can be 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.

iii. If the applicant is owned by or affiliated with an urban entity or health care system, the rural component may still apply as long as the rural entity has its own Employer Identification Number (EIN) and can directly receive and administer the grant funds in the rural area. The rural entity must be responsible for the planning, program management, financial management and decision making of the project. The urban parent may, through the request of the rural entity, assist with direct service delivery; provide expertise or health care personnel that would not otherwise be available. The urban parent organization must assure the FORHP in writing that, for the grant, they will exert no control over or demand collaboration with the rural entity. If applicable, submit a letter in **Attachment 2.**

iv. Organizations with headquarters located in a metropolitan county that serve non-metropolitan or metropolitan counties are not eligible solely because of the areas they serve. In addition, organizations located in a metropolitan county with branches in a non-metropolitan county are not eligible to apply if they are eligible only because of the areas or populations they serve.

v. In determining eligibility for this funding, FORHP realizes there are some Metropolitan Areas that would otherwise be considered non-Metropolitan if the core, urbanized area population count did not include federal and/or state prison populations. Consequently, FORHP has created an exceptions process whereby applicants from Metropolitan counties in which the combined population of the core urbanized area is more than 50,000 can request an exception by demonstrating that through the removal of federal and/or state prisoners from that count, they would have a population total of less than 50,000. Those applicants must present documented evidence of total population for the core urbanized area and demonstrate through data from the Census Bureau and State or Federal Bureaus of Prisons or Corrections Departments that show the total core urbanized area

population (which is not the county or town population), minus any the state and/or federal prisoners, results in a total population of less than 50,000. Any data submitted that does not take the total core urbanized area population into consideration will not be eligible. For further information, please visit: https://www.census.gov/geo/reference/ua/urban-rural-2010.html. Prisoners held in local jails cannot be removed from the core urbanized area population.

This exception is only for the purpose of eligibility for FORHP grant programs. To find out if you are eligible for a reclassification, please contact Steve Hirsch at 301-443-7322. If eligible, you will be required to request the exception and present the data in **Attachment 11** which will be verified by FORHP.

Please contact the FORHP with any questions or further clarification.

C. Management Requirements
If awarded, the applicant will be the grantee of record and must have financial management systems in place as well as the capability to manage the grant. The organization must:
- o Exercise administrative and programmatic direction over grant-funded activities;
- o Be responsible for hiring and managing grant-funded staff;
- o Demonstrate administrative and accounting capabilities to manage grant funds;
- o Have at least one permanent staff at the time a grant award is made;
- o Identify a Project Director who will have administrative and programmatic direction over grant-funded activities, and devote at least 0.25 FTE to the project;
- o Have an Employer Identification Number (EIN) form the Internal Revenue Service.

2. Cost Sharing/Matching

Cost sharing/matching is not required for this program.

3. 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.4* will be considered non-responsive and will not be considered for funding under this announcement.

NOTE: Multiple applications from an organization are not allowable.

If for any reason (including submitting to the wrong funding opportunity number or making corrections/updates), an application is submitted more than once prior to the application due date, HRSA will only accept the applicant's **last** validated electronic submission, under the correct funding opportunity number, prior to the Grants.gov application due date as the final and only acceptable application.

Notifying Your State Office of Rural Health (SORH)
Applicants are required to notify the SORH of their intent to apply to this program. A list of the SORHs can be accessed at http://nosorh.org/nosorh-members/nosorh-members-browse-by-state/. Applicants must include 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 in **Attachment 3.**

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 and technical assistance to applicants. Applicants should make every effort to seek consultation from the SORH at least three weeks in advance of the application due date and as feasible provide the SORH with 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 SORH. Therefore, applicants from these areas can request an email or letter confirming the contact from the National Organization of State Offices of Rural Health (NOSORH). The email address is: donnap@nosorh.org.

IV. Application and Submission Information

1. Address to Request Application Package

HRSA *requires* applicants for this FOA to apply electronically through Grants.gov. Applicants must download the SF-424 application package associated with this FOA 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 FOA 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 applicants to take appropriate measures to ensure the application 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*.

   Please place the following at the top of the abstract:
   - Project Title
   - Applicant Organization Name
   - Address
   - Type of entity (Rural Health Clinic, Critical Access Hospital, Tribal organization, Health Center (HRSA-funded), Public Health Department, etc.)
   - Project Director Name
   - Contact Phone Numbers (Voice, Fax)
   - E-Mail Address
   - Web Site Address, if applicable
   - If requesting a funding preference as outlined in Section V. 2. of this FOA, please indicate here. Please place request for funding preference at the bottom of the abstract. The applicant must explicitly request a qualifying funding preference and cite the qualification that is being met (see 42 U.S.C. 254c(h)(3)). FORHP highly recommends that the applicant include this language: "Applicant's organization name is requesting a funding preference based on qualification X. County Y is in a designated HPSA" at the bottom of the abstract if requesting funding preference so as to minimize confusion as to whether the applicant is certainly requesting funding preference. If applicable, the applicant needs to provide supporting documentation in **Attachment 10**. Please refer to Section V.2 for further information.

   The project abstract must be single-spaced and limited to one page in length.

   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. Applicants should summarize the project's goals and expected outcomes, and how they align with delivery system reform. Applicants should briefly describe the evidence-based quality improvement model they are proposing to use for this program, the HIT system to be used for data collection and reporting, and the approach to sustainability.

▪ *NEEDS ASSESSMENT -- Corresponds to Section V's Review Criterion #1 (NEED)*
This section outlines the needs of the community and/or organization. This section should help reviewers understand the community and/or organization that will be served by the proposed project.

A. Target Population
The target population and its unmet health needs must be identified, described, and documented in this section. Applicants must identify the target population that will achieve improved health status as a result of the activities of this project. The target population should include patients with the highest health care utilization due to chronic diseases. Applicants should demonstrate that they have used available hospital utilization data, such as emergency department (ED) visits and 30-day readmission data to determine the patient population they are proposing to target.

Applicants should also describe disparities based on race, ethnicity, gender identity, sexual orientation, geography, socioeconomic status, disability status, primary language, health literacy, and other relevant dimensions if applicable. Include socio-cultural determinants of health and health disparities impacting the population or communities served and unmet. Demographic data should be used and cited whenever possible to support the information provided. If awarded, grantees will track this patient population for the three-year project period.

B. Barriers/Challenges
Please describe any relevant barriers or challenges in the service area that the project hopes to overcome. Any geographic, socioeconomic, linguistic, cultural, ethnic or other barriers should be discussed. Some examples in rural communities include, but are not limited to, access to health care services and health care professional shortages. Applicants should include a plan to overcome barriers identified.

C. Geographic Details of Service Area
Applicants should describe the geographical features of the area to be served by the project. A map must be provided that clearly shows the entire service area, and includes relevant geographic barriers (e.g., mountainous terrain). Please be sure that any maps included are clear and will be easily reproducible in black and white, as this is what reviewers will see.

D. Health Care in Service Area
Applicants should identify and describe other health care services available in or near the target service area. Applicants should describe why the existing health care does not meet the need of the service area, and how the proposed project would not provide duplicative services. The applicant should also describe the potential impact of the project on other providers, programs and organizations.

E. Burden of Chronic Disease
Applicants should describe the burden of chronic diseases and conditions among the target population to be served. Chronic diseases may include, but are not limited to, diabetes, hypertension, cardiovascular disease, and mental health. The applicant should also address the impact of multiple chronic diseases, if this is a significant issue for the target population. In addition, the applicant should discuss the prevalence and impact

of risk factors such as obesity and tobacco use. The applicant should also describe the quality of life of those who are affected by these chronic diseases and conditions. Data should be used and cited whenever possible to support the information provided. Please note, that if awarded, organizations will be required to report on measures related to the chronic conditions identified above. See Methodology section and Appendix for more information.

The following resources may be helpful for developing the Needs Assessment section:

o Your local or state health department may be a valuable resource in acquiring data to respond to this section.
o Hospitals should consider including data and findings from recent community health needs assessments.The Rural Health Information Hub (RHIhub) helps rural communities and other rural stakeholders access available programs, funding and research that can enable them to provide quality health and human services to rural residents. RHIhub also provides free customized assistance to support gathering data, statistics, and general rural health information. https://www.ruralhealthinfo.org/
o Rural Health Research Gateway provides easy and timely access to all of the research and findings from FORHP-funded Rural Health Research Centers. http://www.ruralhealthresearch.org/

- *METHODOLOGY -- Corresponds to Section V's Review Criterion #2 (RESPONSE)* Propose methods that will be used to address the stated needs and meet each of the previously described program requirements and expectations in this FOA. Applicants must explain how their project aligns with delivery system reform, propose an evidence-based quality improvement model, use health information technology, and describe their approach to sustainability. As appropriate, include development of effective tools and strategies for ongoing staff training, outreach, collaborations, clear communication, and information sharing/dissemination with efforts to involve patients, families and communities of culturally, linguistically, socio-economically and geographically diverse backgrounds if applicable. If applicable, include a plan to disseminate reports, products, and/or project outputs so project information is provided to key target audiences.

A. Delivery System Reform
The applicant must explain how this proposal incorporates elements of delivery system reform, with a focus on transforming the delivery of health care into a patient and value-driven system. Delivery system reform has the following three focus areas, which should be addressed: care delivery, information, and incentives. More information on delivery system reform can be found at these links:
- http://www.nejm.org/doi/full/10.1056/NEJMp1500445
- https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-2.html

i. Care Delivery
Improving care delivery includes integration and coordination of care, provision of team-based care, promoting patient engagement and shared decision making, and improving population health.

The applicant must describe the evidence-based quality improvement model they plan to use for this program and how it will contribute to improvement of care delivery, as described above. An evidence-based quality improvement model provides a framework to improve patient care and processes. Quality improvement models can help an organization or team to focus on changes that have already proven to be effective, and they also provide guidance on different ways to approach change. Examples of evidence-based quality improvement models include, but are not limited to, the Care Model, the Lean Model, and the Model for Improvement or Six sigma).

Applicants should include a rationale for choosing this model and why this is the best model for the community/organization. Please describe how the model will be implemented, how staff will be trained, and the roles of the each staff member in implementation. Please describe the roles of consortium or network partners, if applicable. Please include references/citations.

Resources for quality improvement models, strategies and tools:
- HRSA Quality Toolkit: http://www.hrsa.gov/quality/toolbox/
- Agency for Healthcare Research and Quality: http://www.ahrq.gov/qual/qualix.htm
- Institute for Healthcare Improvement: http://www.ihi.org/Pages/default.aspx
- Office of the National Coordinator for Health Information Technology: http://www.healthit.gov/providers-professionals/implementation-resources/continuous-quality-improvement-cqi-strategies

ii. Information
Improving the way information is distributed includes creating transparency on cost and quality information and bringing electronic health information to the point of care for meaningful use. Data collection, reporting, and sharing are also an important component of using information for quality improvement.

Applicants must identify and describe the system that will be used for improving distribution of information, such as, a registry, electronic health record (EHR), or other health information technology (HIT). During the first year of the program, grantees should complete the following activities, if applicable: implementation of any additional HIT needed for data collection; training staff on data collection; and, begin collecting, testing and validating data.. If an applicant plans to use an EHR for this program, it is highly recommended that the product be certified by the Office of the National Coordinator for Health Information Technology (http://oncchpl.force.com/ehrcert). Additional information on HIT, including resources specifically for rural providers, can be found at this website: https://www.healthit.gov/providers-professionals/resource-center.

Applicants must provide a description of how data will be collected, validated for accuracy, analyzed and reported, and identify staff member(s) responsible for this task. Applicants should describe how information and data will be shared with providers for clinical decision making, with other staff within the organization, with consortium or community partners, and with patients. Explain how data will be used for quality improvement and population health.

FORHP has developed the Performance Improvement Measurement System (PIMS). The PIMS system includes information on patient demographics, workforce and staffing, sustainability, quality improvement, HIT, and clinical quality measures. If awarded, grantees will be required to report data in the PIMS annually.

Grantees will be required to report on the following National Quality Forum (NQF)-endorsed clinical quality measures:

- NQF 0059: Diabetes Care: Hemoglobin A1c Poor Control (>9.0%)
- NQF 0074: Chronic Stable Coronary Artery Disease: Lipid Control
- NQF 0018: Controlling High Blood Pressure
- NQF 0028: Tobacco Use: Screening & Cessation Intervention
- NQF 0421: Body Mass Index (BMI) Screening and Follow-Up
- NQF 0418: Screening for clinical depression
- NQF 0041: Influenza immunization

More details on NQF measures can be found at this website: http://www.qualityforum.org/Measuring_Performance/Measuring_Performance.aspx

In addition, grantees will be required to report on the following:

- Emergency department (ED) visit rate
- 30-day hospital readmission rate

See Appendix for Proposed PIMS Measures. Grantees will be required to report annually on all PIMS Measures. Please note that the measures are proposed, have not been finalized, and may be subject to change. The FORHP will provide more detail at the time of award.

iii. Incentives
The focus area entitled incentives refers to improving the way providers are paid and offering incentives for providing high quality health care. Promoting value-based payment systems includes participation in value-based payment systems, such as accountable care organizations (ACO), patient centered medical home (PCMH), bundled payments, and other shared savings models. Such incentives may also contribute toward creating sustainability. To the extent possible, FORHP strongly encourages grantees to incorporate incentives into the project and sustainability plan.

For organizations that are also funded by HRSA's Health Center Program (Section 330 of the Public Health Service Act (42 USCS § 254b)) and receiving support for the HRSA Patient-Centered Medical Home (PCMH) Recognition Initiative see section III.1.A.vii

B. Sustainability

Applicants must also propose a plan for project sustainability after the period of federal funding ends. Recipients are expected to sustain key elements of their projects, e.g., strategies or services and interventions, which have been effective in improving practices and those that have led to improved outcomes for the target population. This includes, but is not limited to: continuation of quality improvement strategies, including collection and use of data; addition of another disease, chronic condition, population, or prevention/wellness activity; and creating sustainable business models, as described under Incentives. In addition to the payment models described, organizations are also encouraged to incorporate and bill for chronic care management services to the extent possible: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf.

Applicants must describe their approach to sustainability. Please submit a sustainability strategy plan. After awards are made, grantees will be required to update their sustainability plans by the start of the third year of the project period. . Technical assistance will also be provided as grantees refine and revise their sustainability plans.

Resources for addressing sustainability:
- Institute for Healthcare Improvement: http://www.ihi.org/knowledge/Pages/Tools/HowtoGuideSustainabilitySpread.aspx
- Rural Health Information Hub (RHIhub) : https://www.ruralhealthinfo.org/sustainability
- Georgia Health Policy Center: http://ruralhealthlink.org/Resources/ResourceLibrary.aspx#

C. Dissemination Plan

Describe the plans and methods for dissemination of project results. Applicants must articulate a clear approach for widely disseminating information regarding results of their project. A dissemination plan must be outlined describing strategies and activities for informing respective target audiences, and stakeholders (i.e., policymakers, research community, etc.), including the general public.

- *WORK PLAN -- Corresponds to Section V's Review Criterion #2 (RESPONSE) and Review Criterion #4 (IMPACT)*
   A. Work Plan

Describe the activities or steps that will be used to achieve each of the activities proposed during the entire project period in the Methodology section. Use a time line that includes each activity and identifies responsible staff. As appropriate, identify meaningful support and collaboration with key stakeholders in planning, designing and implementing all activities, including development of the application and, further, the extent to which these contributors reflect the cultural, racial, linguistic and geographic diversity of the populations and communities served.

Applicants are strongly encouraged to present a matrix to illustrate the project goals, objectives, activities for each objective, anticipated outputs or outcomes, responsible entity or person, and timeframe. The work plan must include all three years of the

grant, but may be somewhat less detailed for the second and third years. Only charts may be generated in 10 inch fonts. Submit the work plan/matrix in **Attachment 4**.

The following resource may be helpful for developing work plans:
- Centers for Disease Control and Prevention, State-Based Oral Health Plans, Workplans: A Program Management Tool: http://www.cdc.gov/OralHealth/state_programs/pdf/workplans.pdf

B. Logic Model
Applicants must submit a logic model for designing and managing their project. A logic model is a one-page diagram that presents the conceptual framework for a proposed project and explains the links among program elements. While there are many versions of logic models, for the purposes of this announcement the logic model should summarize the connections between the:
- Goals of the project (e.g., objectives, reasons for proposing the intervention, if applicable);
- Assumptions (e.g., beliefs about how the program will work and is supporting resources. Assumptions should be based on research, best practices, and experience.);
- Inputs (e.g., organizational profile, collaborative partners, key staff, budget, other resources);
- Target population (e.g., the individuals to be served);
- Activities (e.g., approach, listing key intervention, if applicable);
- Outputs (i.e., the direct products or deliverables of program activities); and
- Outcomes (i.e., the results of a program, typically describing a change in people or systems).

An "outcomes approach" logic model attempts to logically connect program resources with desired results and is useful in designing effective evaluation results and strategies. Include the project's logic model and narrative description in **Attachment 5**.

Please refer to Section VIII. for more details.

- *RESOLUTION OF CHALLENGES -- Corresponds to Section V's Review Criterion #2 (RESPONSE)*
Discuss challenges that are likely to be encountered in designing and implementing the activities described in the Work Plan, and approaches that will be used to resolve such challenges. Some challenges to consider include, but are not limited to, the following: collaboration and coordination among staff members; sharing of data; buy-in from senior leadership, providers, and other staff; implementation of additional HIT to support data collection, if necessary; or staff turnover.

- *EVALUATION AND TECHNICAL SUPPORT CAPACITY -- Corresponds to Section V's Review Criterion #3 (EVALUATIVE MEASURES) and Review Criterion #5 (RESOURCES/CAPABILITIES)*
Applicants must describe the plan for the program performance evaluation that will contribute to continuous quality improvement. The program performance evaluation should monitor ongoing processes and the progress towards the goals and objectives of the project. Include descriptions of the inputs (e.g., organizational profile, collaborative

partners, key staff, budget, and other resources), key processes, and expected outcomes of the funded activities.

Applicants must describe the systems and processes that will support the organization's performance management requirements through effective tracking of performance outcomes, including a description of how the organization will collect and manage data (e.g., assigned skilled staff, data management software) in a way that allows for accurate and timely reporting of performance outcomes. Describe current experience, skills, and knowledge, including individuals on staff, materials published, and previous work of a similar nature. As appropriate, describe the data collection strategy to collect, analyze and track data to measure process and impact/outcomes, with different cultural groups (e.g., race, ethnicity, language) and explain how the data will be used to inform or improve program development and service delivery. Applicants must describe any potential obstacles for implementing the program performance evaluation and how those obstacles will be addressed.

A. Project Monitoring

Applicants must describe approaches to be implemented for assuring effective performance of the proposed grant-funded activities. In addition, the applicant must 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 strategies for reaching a goal is found to be ineffective, the applicant describes a plan or strategy in place to identify and address the situation.

B. Self-Assessment

In an effort to maximize allocation of grant funds towards project activities, the applicant is not required to conduct a formal evaluation but rather a self-assessment at the end of their project period. This self-assessment will provide information to help identify the project's strengths and areas for improvement. The self-assessment plan should be linked to the work plan, logic model, and identified goals, objectives and process and outcome measures. Specifically, this self-assessment should include, but not limited to, the following elements:

- **Outcomes focused**: Ensures that the goals and objectives of the project are assessed. Outcomes should demonstrate improved health outcomes and impact to the community. The applicant should explain how resources are leveraged and utilized to enhance the community's health care delivery system. Applicants should also identify quantifiable impact on business and clinical operations, as well as impact on patients.
- **Data collection**: Illustrates accuracy and consistency of data collected, producing results that are as objective as possible. Ensures that data collection methods are feasible for the project and data are collected in a timely manner. FORHP developed a set of standard measures, called Performance Improvement Measurement System (PIMS), to assess the overall impact that FORHP programs have on rural communities and to enhance ongoing quality improvement. Grantees are required to collect, report, and analyze data on PIMS through HRSA's Electronic Handbook (EHB) after each budget period. Data collected from PIMS will be aggregated by FORHP to demonstrate the overall impact of the program.

- **Sustainability**: Identify factors and strategies that will lead to viability and sustainability after federal funding ends. Utilize tools and resources to illustrate the economic impact of the project throughout its project period. Explains how it will use sustainability data to help inform quality improvement strategies and future efforts.

- **Other**: In addition to the elements described above, the self-assessment should also include process measures, patient experience of care, and impact on providers and staff.

Applicants are required to submit a self-assessment plan in their application under **Attachment 6**. The self-assessment plan should include measures and baseline data. Please note that if funded, grantees will be required to submit a final self-assessment report after the end of the project period.

- *ORGANIZATIONAL INFORMATION -- Corresponds to Section V's Review Criterion #5 (RESOURCES/CAPABILITIES)*
  Provide information on the applicant organization's current mission and structure, scope of current activities, and an organizational chart, and describe how these all contribute to the ability of the organization to conduct the program requirements and meet program needs and expectations. Provide information on the program's resources and capabilities to support provision of culturally and linguistically competent and health literate services. Describe how the unique needs of target populations of the communities served are routinely assessed and improved

A. Organizational Information
   Provide information on the applicant organization's current mission and structure, scope of current activities, and an organizational chart, and describe how these all contribute to the ability of the organization to conduct the program requirements and meet program expectations. This includes, but not limited to, financial and accounting management systems in place and capability to exercise administrative and programmatic direction over the grant project. Provide information on the program's resources and capabilities to support provision of culturally and linguistically competent and health literate services. Describe how the unique needs of target populations of the communities served are routinely assessed and improved. Provide an organizational chart of the applicant organization in **Attachment 7**.

B. Staffing Plan
   Applicants must provide a description of the plan for managing and staffing the project. FORHP strongly recommends a team of at least three staff, which includes a Project Director, a provider or clinician (e.g., physician, nurse, nurse practitioner, physician assistant, etc.), and a data/evaluation specialist. The Project Director has day-to-day responsibility for the project, including administrative and programmatic direction over grant-funded activities. The provider or clinician provides clinical technical expertise and works regularly with patients whose care is affected by quality improvement efforts. The data/evaluation specialist collects, analyzes and reports data including PIMS, and is responsible for program evaluation if conducted internally, or oversight of program evaluation if contracted to an external evaluator. Other team members to consider include information technology (IT) and operations staff. For

each staff member included, please describe qualifications, skills, experience and full-time equivalent (FTE) to be devoted to the project. **The Project Director must devote at least 0.25 FTE to the project.** Provide Staffing Plan and Position Descriptions in **Attachment 8**.

Role of Organizational Leadership
Senior leaders are not expected to be involved in the day-to-day operation of the program. However, leadership engagement plays an important role in development and sustainability of a quality improvement program. Senior leaders may contribute to the success of the program by setting priorities, providing support, acting on recommendations, and allocating resources. Applicants should describe the role leadership will play to support and oversee the project.

Resources on quality improvement teams:

HRSA Quality Toolkit:
http://www.hrsa.gov/quality/toolbox/methodology/improvementteams/part3.html
http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/part2.html

AHRQ: http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod14.html

IHI:http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementForming theTeam.aspx

C. Consortium/Network (OPTIONAL)
Although it is not a requirement, FORHP strongly encourages organizations to form consortia for this program. The purpose of the consortium or network is to encourage creative and lasting collaborative relationships among health and social service providers in rural areas. Working collaboratively with other organizations will be necessary for providing coordinated care and improving population health. In addition, recipients will be required to report on 30-day readmission rates and emergency department use if awarded, and it would be advantageous to work with a hospital to obtain this data. Other examples of possible consortium member entities include, but are not limited to, public health departments, Federally Qualified Health Centers, Rural Health Clinics, home health providers, primary care service providers, social service agencies, community and migrant health centers, and civic organizations.

If the applicant organization is forming a consortium, they should identify the consortium members and briefly describe their contributions to the project and history of working together, if any. The applicant should address how communication and coordination will occur between consortium members.

NARRATIVE GUIDANCE
In order to ensure that the Review Criteria are fully addressed, this table provides a crosswalk between the narrative language and where each section falls within the review criteria.

Narrative Section	**Review Criteria**
Introduction	(1) Need
Needs Assessment	(1) Need
Methodology	(2) Response
Work Plan	(2) Response and (4) Impact
Resolution of Challenges	(2) Response
Evaluation and Technical Support Capacity	(3) Evaluative Measures and (5) Resources/Capabilities
Organizational Information	(5) Resources/Capabilities
Budget and Budget Justification Narrative	(6) Support Requested – the budget section should include sufficient justification to allow reviewers to determine the reasonableness of the support requested.

iii.   Budget
See Section 4.1.iv of HRSA's *SF-424 Application Guide*. Please note: the directions offered in the SF-424 Application Guide differ from those offered by Grants.gov. Please follow the instructions included in the Application Guide and, *if applicable*, the additional budget instructions provided below.

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 HRSA-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, as applicable.

The Consolidated Appropriations Act, 2016, Division H, § 202, (P.L. 114-113) 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 may apply in FY 2016, as required by law.

Travel: Applicants should budget travel funds for a maximum of two (2) staff members to attend an annual grantee meeting in Washington, DC.

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: Proof of Nonprofit or Public Status (will **not** count toward the page limit)*

- If the applicant is a nonprofit entity, one of the following documents must be included in Attachment 1 to document nonprofit status.
  - o A letter from the IRS stating the organization's tax-exempt status under Section 501(c)(3);
  - o A copy of a currently valid IRS tax exemption certificate
  - o Statement from a state taxing body, state attorney general or other appropriate state official certifying that the applicant organization has a nonprofit tax status and that none of the next earnings accrue to any private shareholders or individuals;
  - o A certified copy of the organization's certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization; or
  - o 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 nonprofit affiliate.

- If the applicant is a public entity, proof of nonprofit status is not necessary. The applicant must submit an official signed letter on city, county, state or tribal government letterhead identifying them as a public entity in Attachment 1. 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: http://www.indianaffairs.gov/.

Attachment 2: Letter from Urban Parent Organization (if applicable)

If the applicant organization is owned by an urban parent, the urban parent must assure FORHP in writing that they will exert no control over the rural organization for this project. If applicable, a letter stating this should be submitted in Attachment 2.

Attachment 3: State Office of Rural Health (SORH) 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, 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 Attachment 3. If you do not receive a response from the SORH, submit a copy of your request for consultation to the SORH as Attachment 3.

Attachment 4: Work Plan

Applicants are required to submit the Work Plan for the project that includes all information detailed in Section IV. ii. Project Narrative as Attachment 4.

Attachment 5: Logic Model and Narrative Description
Applicants are required to submit a logic model and narrative that illustrates the inputs, activities, outputs, outcomes, and impact of the project.

Attachment 6: Self-Assessment Plan
Applicants are required to submit their self-assessment plan, which includes measures and baseline data, in Attachment 6.

Attachment 7: Organizational Chart
Applicants are required to submit an organizational chart in Attachment 7.

Attachment 8: Staffing Plan and Position Descriptions
Applicants are required to submit a staffing plan for the proposed project and the position descriptions for key personnel listed in the application. In the staffing plan, explain the staffing requirements necessary to complete the project, the qualification levels for the project staff, and rationale for the amount of time requested for each staff position. Provide the job descriptions for key personnel listed in the application that describes the specific roles, responsibilities, and qualifications for each proposed position. Keep each position description to one page, if possible. For the purposes of this grant application, key personnel is defined as persons funded by this grant or persons conducting activities central to this program. Provide a table of contents for this attachment.

Attachment 9: Biosketches of Key Personnel
Applicants must include biographical sketches for persons occupying key positions as Attachment 9, not to exceed two pages in length for each person. In the event that a biographical sketch is included for an identified individual who is not yet hired, please include a letter of commitment (attachments 13-15) from that person with the biographical sketch.

Attachment 10: Funding Preference
If requesting a funding preference, include proof of funding preference designation or eligibility in Attachment 10. Include a printout or screenshot that displays the HPSA and/or MUC/P designation and respective score: http://datawarehouse.hrsa.gov/GeoAdvisor/ShortageDesignationAdvisor.aspx. The printout or screenshot of HPSA designation can also be found at: http://hpsafind.hrsa.gov and the MUAS/P designation can also be found at http://muafind.hrsa.gov.

Attachment 11: Exception Request (if applicable)
Applicants from Metropolitan counties in which the combined population of the core urbanized area is more than 50,000 that request an exception by demonstrating that through the removal of federal and/or state prisoners from that count, they would have a population total of less than 50,000. Provide the required documentation for this attachment.

This exception is only for the purpose of eligibility for FORHP grant programs. To find out if you are eligible for a reclassification, please contact Steve Hirsch at 301-443-7322.

Attachment 12: Federal Office of Rural Health Policy Funding History Information

Current and former grantees of any FORHP community-based grant programs who apply must include: dates of any prior award(s) received; grant number assigned to the previous project(s); and a copy of the abstract or project summary that was submitted with the previously awarded grant application(s).

Attachments 13 – 15: Other Relevant Documents (Optional)
Include here any other documents that are relevant to the application, including letters of support and letters of commitment. Letters of support must be dated and specifically indicate support for the project/program.

3. Dun and Bradstreet Universal Numbering System Number and System for Award Management

Applicant organizations must obtain a valid DUNS number and provide that number in their application. Each 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/recipient organization has already completed Grants.gov registration for HRSA or another federal agency, confirm that the registration 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. Submission Dates and Times

Application Due Date
The due date for applications under this FOA is *March 4, 2016 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.

5. Intergovernmental Review

The Small Health Care Provider Quality Improvement 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.

6. 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:
(1) To build or acquire real property or for construction or major renovation or alteration of any space;

Minor renovations and alterations are allowable.

The General Provisions in Division H of the Consolidated Appropriations Act, 2016 (P.L. 114-113) 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 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 *Small Health Care Provider Quality Improvement Program* has six *(6)* review criteria:

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

a) The extent to which the applicant clearly describes the target population for this project, including:
- i. How the target population will be identified and tracked for the three-year project period.
- ii. Whether the population has patients with multiple chronic conditions, has the highest health care costs, or are the highest utilizers of care.
- iii. How the project will result in improved health status for the population.
- iv. The extent to which the applicant includes socio-cultural determinants of health and health disparities impacting the population or communities.
- v. The extent to which the applicant uses and cites demographic and utilization data whenever possible to support the information provided.

b) The extent to which the applicant describes relevant barriers or challenges to health care in the service area that the project hopes to overcome.

c) The extent to which the applicant describes the geographic details of the service area

d) The extent to which the applicant identifies and describes other health care services available in the target service area, including:
- i. the potential impact of the project on other providers.
- ii. why existing health care services do not meet the needs of the service area.
- iii. how the proposed project would not provide duplicative services.

e) The extent to which the applicant describes the burden of chronic diseases, multiple chronic diseases, and other population risk factors and:
- i. the impact on quality of life on the target population,
- ii. includes supporting data.

Criterion 2: RESPONSE (25 points) – Corresponds to Section IV's Methodology, Work Plan, and Resolution of Challenges

The extent to which the proposed project responds to the "Purpose" included in the program description and the strength of the proposed goals and objectives as they relate to the identified project.

a) The extent to which the applicant incorporates the elements of delivery system reform, including:
- i. The extent to which the applicant describes how delivery of health care will be improved as a result of the project.
  - o The selection of an evidence-based quality improvement model to improve health care delivery, including integration and coordination of care, provision of team-based care, promoting patient engagement, and improving population health.
  - o A description of how the model will be implemented.

o A description of how staff will be trained to use the model.

    ii.   The extent to which the applicant plans to use electronic health information
        o A description of staff responsible for data collection, reporting, and analysis.
        o A description of the system to be used for data collection, e.g., registry, EHR, or other HIT.
        o A description of how information and data will be shared with providers and staff, community partners and consortium members, and patients.
        o A description of how data will be used for quality improvement and population health.

    iii.   The extent to which the applicant plans to incorporate incentives for sustainability, such as participation in value based payment systems, including, but not limited to, ACO, PCMH, bundled payments, and other shared savings models.

b) The extent to which the applicant describes their sustainability strategy plan, including:
    i.   A description of quality improvement activities that would be sustained after the project period has ended.
    ii.   A description of how quality improvement strategies will be expanded to other chronic conditions, diseases, or prevention/wellness activities.
    iii.   A description of sustainable business models.

c) The extent to which the applicant discusses challenges that are likely to be encountered in implementation of the project, including approaches that will be used to resolve such challenges.

d) The feasibility and effectiveness of the proposed approach for widely disseminating information regarding results of the project.

Criterion 3: EVALUATIVE MEASURES (25 points) – Corresponds to Section IV's Evaluation and Technical Support Capacity

a) The strength and effectiveness of the method proposed to monitor the project. Evidence that the evaluative measures will be able to assess: 1) to what extent the program objectives have been met, and 2) to what extent these can be attributed to the project.

b) The extent to which the applicant describes project monitoring including ongoing quality assurance.

c) The extent to which the applicant describes project self-assessment, including:
    i.   Focus on outcomes.
    ii.   How data will be collected, analyzed and reported.
    iii.   How data will be used for quality improvement.
    iv.   Impact on clinic, operations, and patients.
    v.   Identification of factors that will lead to sustainability.

Criterion 4: IMPACT (20 points) – Corresponds to Section IV's Work Plan

a) The extent to which the applicant's work plan describes the project goals, objectives, activities, outputs, outcomes, and timeframe.

b) The extent to which the applicant provides an outcomes approach logic model to connect program resources with desired results.

Criterion 5: RESOURCES/CAPABILITIES (10 points) – Corresponds to Section IV's Evaluation and Technical Support Capacity and Organizational Information

a) The capabilities of the applicant organization and the quality and availability of facilities and personnel to fulfill the needs and requirements of the proposed project.

b) The extent to which project personnel are qualified by training and/or experience to implement and carry out the project.

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

a) The reasonableness of the proposed budget for each year of the project period in relation to the objectives, the complexity of the activities, and the anticipated results.
  i.   The extent to which costs, as outlined in the budget and required resources sections, are reasonable given the scope of work.
  ii. The extent to which key personnel have adequate time devoted to the project to achieve project objectives, including allocation of at least 0.25 FTE for the Project Director.

2. Review and Selection Process

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

HRSA will use other factors other than merit criteria in selecting applications for federal award. For this program, HRSA will use Funding Preferences.

Funding Preferences
This program provides a funding preference for some applicants as authorized by Section 330A (h)(3) of the Public Health Service (PHS) Act (42 U.S.C. 254c(e)). 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. Funding preference will be granted to any qualified applicant that specifically requests and demonstrates that they meet the criteria for preference(s) as follows:

> ***Qualification 1: Health Professional Shortage Area (HPSA)***
> An applicant can request this 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: http://datawarehouse.hrsa.gov/GeoAdvisor/ShortageDesignationAdvisor.aspx.

Qualification 2: Medically Underserved Community/Populations (MUC/MUPs)
An applicant can request this 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: http://datawarehouse.hrsa.gov/GeoAdvisor/ShortageDesignationAdvisor.aspx.

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.

If requesting a funding preference, please indicate which qualifier is being met in the **Project Abstract. F**ORHP highly recommends that the applicant include this language*: "Applicant's organization name is requesting a funding preference based on qualification X. County Y is in a designated HPSA."*

If a funding preference is requested, documentation of funding preference must be placed in **Attachment 10**. Please label documentation as "Proof of Funding Preference Designation/Eligibility." If the applicant does not provide appropriate documentation in **Attachment 10**, the applicant will not receive the funding preference.

Applicants only have to meet one of the three qualifiers stated above to receive the preference. Meeting more than one qualifier does not increase an applicant's competitive position.

3. Assessment of Risk

The Health Resources and Services Administration may elect not to fund applicants with management or financial instability that directly relates to the organization's ability to implement statutory, regulatory or other requirements (45 CFR § 75.205).

Effective January 1, 2016, HRSA is required to review and consider any information about the applicant that is in the Federal Awardee Performance and Integrity Information System (FAPIIS). An applicant may review and comment on any information about itself that a federal awarding agency previously entered. HRSA will consider any comments by the applicant, in addition to other information in FAPIIS in making a judgment about the applicant's integrity, business ethics, and record of performance under federal awards when completing the review of risk posed by applicants as described in 45 CFR § 75.205 Federal Awarding Agency Review of Risk Posed by Applicants.

A determination that an applicant is not qualified will be reported by HRSA to FAPIIS.

The decision not to make an award or to make an award at a particular funding level, is discretionary and is not subject to appeal to any HHS Operating Division or HHS official or board.

4. Anticipated Announcement and Award Dates

It is anticipated that awards will be announced prior to the start date of August 1, 2016.

VI. Award Administration Information

1. Award Notices

The Notice of Award will be sent prior to the start date of August 1, 2016. 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*.

Human Subjects Protection:
Federal regulations (45 CFR 46) require that applications and proposals involving human subjects must be evaluated with reference to the risks to the subjects, the adequacy of protection against these risks, the potential benefits of the research to the subjects and others, and the importance of the knowledge gained or to be gained. If research involving human subjects is anticipated, recipients must meet the requirements of the HHS regulations to protect human subjects from research risks as specified in the Code of Federal Regulations, Title 45 – Public Welfare, Part 46 – Protection of Human Subjects (45 CFR 46), available online at http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.html.

3. Reporting

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

1) **Progress Report**(s). The recipient must submit a progress report to HRSA on an **annual** basis. Further information will be provided in the Notice of Award (NoA).

2) **Performance Measures Reports**. Awardees must submit performance measures reports in PIMS. Awardees must report on clinical measures by six months after project start date and bi-annually thereafter. Awardees must report on the full set of measures annually (See Appendix). Further details will be provided in the NoA.

3) **Sustainability Plan**. Awardees are required to submit a final sustainability plan at the start of the third year of their project period. Further information will be provided in the NoA.

4) **Final Report**. A final report is due within 90 days after the project period ends. The final report collects 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 Handbooks system at https://grants.hrsa.gov/webexternal/home.asp.

5) **Final Self-Assessment Report**. The final self-assessment report is due within 90 days after the project period ends.

6) **Integrity and Performance Reporting.** The Notice of Award will contain a provision for integrity and performance reporting in FAPIIS, as required in 2 CFR 200 Appendix XII.

VII. Agency Contacts

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

LCDR Benoit M. Mirindi
Senior Public Health Analyst
Division of Grants Management Operations, OFAM
Health Resources and Services Administration
5600 Fishers Lane, Room 10N108F
Rockville, MD 20857
Telephone: (301) 443-6606
Fax: (301) 443-6343
E-mail: bmirindi@hrsa.gov

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

Ann Ferrero
Public Health Analyst
Federal Office of Rural Health Policy
Health Resources and Services Administration
5600 Fishers Lane, Room 17W21-B
Rockville, MD 20857
Telephone: (301) 443-3999
Fax: (301) 443-2803
E-mail: aferrero@hrsa.gov

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

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

Successful applicants/recipients 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 Contact 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

Logic Models:

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

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

Technical Assistance:

The Federal Office of Rural Health Policy will hold a technical assistance webinar on Tuesday January 19, 2016 2:30 - 4:00 PM EST to assist applicants in preparing their applications.   The technical assistance webinar is open to the general public. The purpose of the webinar is to review the funding opportunity announcement (FOA), and to provide clarifying information that may be necessary. There will be a Q & A session at the end of the call to answer any questions. FORHP strongly recommends that potential applicants read this FOA prior to the webinar and have the FOA available during the webinar. While participation on the webinar is not required, it is highly recommended that anyone who is interested in applying for this program plan to attend the webinar. It is most useful to the applicants when the funding opportunity announcement is easily accessible during the webinar and if questions are written down ahead of time for easy reference.

Call-in number (for audio) : 1-888-603-9222 (participants must call in to verbally ask questions)
Participant Passcode for call in number: 5381444
URL (for web): https://hrsaseminar.adobeconnect.com/hrsa-16-019/

Prior to joining, please test your web connection: https://hrsa.connectsolutions.com/common/help/en/support/meeting_test.htm.

Note: You must dial into the conference line to hear the audio portion of the webinar. No registration is required. To access the webinar recording, visit http://www.hrsa.gov/grants/index.html

IX. Tips for Writing a Strong Application

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

Appendix

Federal Office of Rural Health Policy
Community-Based Grant Programs

Performance Improvement and Measurement System (PIMS) Database –
PROPOSED MEASURES

Please Note: The following measures are proposed, have not been finalized, and are subject to change. They have been included to make applicants aware of the types of data reporting that will be required. The FORHP will provide additional information if awarded.

Small Health Care Provider Quality Improvement Grant Program

Table 1: ACCESS TO CARE

Information collected in this table provides an aggregate count of the number of people served through the program. Please refer to the detailed definitions and guidelines in answering the following measures. Please indicate a numerical figure.

Direct Services are defined as an interaction between a patient/client and a clinical or non-clinical health professional. Please include the number of patients served through this program, funded by Federal Office of Rural Health Policy (FORHP) grant dollars. Examples of direct services include (but are not limited to) patient visits, counseling, and education.

For the purposes of this data collection activity, indirect services will be limited to:
   1) billboards,
   2) flyers,
   3) health fairs and
   4) mailings/newsletters.
   5) Other mass media (e.g., radio, television, social media)

1	**Direct Services** Please provide the number of patients or clients your organization serves through *direct services* (e.g., patient visits, counseling, and education)	**Number**
2	**Indirect Services** Please provide the number of individuals your organization reaches through the following *indirect services:* billboards, flyers, health fairs, mailings/newsletters, other mass media	**Number**

Table 2: POPULATION DEMOGRAPHICS
Table Instructions:

Please provide the total number of people served by race, ethnicity, and age. The total for each of the following questions should equal to the total of the number of people served through Direct Services provided in the previous section. If the total number in any category is zero (0), please put zero in the appropriate section. Do not leave any sections blank. There should not be a N/A (not applicable) response since all measures are applicable.

Number of people served through program by ethnicity is defined as:
- Hispanic or Latino origin includes Mexican, Mexican American, Chicano, Puerto Rican, Cuban and other Hispanic, Latino or Spanish origin (i.e. Argentinean, Colombian, Dominican, Nicaraguan, Salvadoran, Spaniard etc.)

3	Number of people served by ethnicity:	Number
	Hispanic or Latino	
	Not Hispanic or Latino	
	Unknown	
4	Number of people served by race:	Number
	American Indian or Alaska Native	
	Asian	
	Black or African American	
	Native Hawaiian or Other Pacific Islander	
	White	
	More than one race	
	Unknown	
5	Number of people served, by age group:	Number
	Children (0-12)	
	Adolescents (13-17)	
	Adults (18-64)	
	Elderly (65 and over)	
	Unknown	

Table 3: INSURANCE STATUS/COVERAGE
Table Instructions:
Please respond to the following questions based on these guidelines:

- Uninsured is defined as those without health insurance.
- Medicare is defined as federal insurance for the aged, blind, and disabled (Title XVIII of the Social Security Act).
- Medicaid is defined as state-run programs operating under the guidelines of Titles XIX (and XXI as appropriate) of the Social Security Act.
- The Children's Health Insurance Program (CHIP) provides primary health care coverage for children.

- Other state-sponsored or public assistance program includes state and/or local government programs.
- Private insurance is health insurance provided by commercial and not for profit companies. Individuals may obtain insurance through employers or on their own.

Each patient should be counted once. The total for this table should equal to the total number of people served through Direct Services.

6	Number of uninsured people	Number
7	Number of people covered through Medicare	Number
8	Number of people covered through Medicaid	Number
9	Number of people covered through the Children's Health Insurance Program (CHIP)	Number
10	Number of people covered through other state-sponsored insurance or public assistance program	Number
11	Number of people covered by private insurance	Number
12	Unknown	Number

Table 4: STAFFING

Table Instructions:

Please provide the number of clinical and non-clinical positions funded by this grant. Please indicate a numerical figure. There should not be a N/A (not applicable) response since all questions are applicable.

Clinical staff includes, but is not limited to, physician (general or specialty), physician assistant, nurse, nurse practitioner, dentist, dental hygienist, psychiatrist, social worker, pharmacist, technician (medical, pharmacy, laboratory, etc.), therapist (behavioral, physical, occupational, speech, etc.), health educator, community health worker, promotora, case manager, interpreter/translator.

Non-clinical staff includes management (CEO, CFO, CIO, etc.), support staff, fiscal and billing staff, information technology (IT).

NOTE: Please report each staff person who is funded by this program only once. In the case of an individual whose time is split between clinical and non-clinical activities, please report them in the category that reflects the majority of their time.

13	Number of positions funded by grant dollars	Full-Time (1.0 FTE)	Part-Time (less than 1.0 FTE)
	Clinical		
	Non-Clinical		

14	How many staff received continuing education or training?	Number

Table 5: SUSTAINABILITY

Table Instructions:

- The definition of sustainability is "programs or services continue because they are valued and draw support and resources".
- Select your sources of sustainability and sustainability activities.
- Please indicate if any of your program's activities will sustain after the grant period.
- Use HRSA's Economic Impact Tool provide the ratio for Economic Impact vs. HRSA Program Funding.

15	**Annual program award** Please provide the annual program award based on box 12a of your Notice of Award (NOA).	**Dollar amount**
16	**Annual program revenue** Please provide the amount of annual program revenue made through the services offered through the program. Program revenue is defined as payments received for the services provided by the program that the grant supports. These services should be the same services outlined in your grant application work plan. Please do not include donations. If the total amount of annual revenue made is zero (0), please put zero in the appropriate section. Do not leave any sections blank.	**Dollar amount**
17	**Additional funding secured to assist in sustaining the project**	**Dollar amount**

18	**Sources of Sustainability** Select the type(s) of sources of funding for sustainability. Please check all that apply.	**Selection list**
	Network/Consortium revenue	
	In-kind Contributions (In-kind contributions are defined as donations of anything other than money, including goods or services/time.)	
	Membership fees/dues	
	Fundraising/Monetary donations	
	Contractual Services	
	Other grants	
	Fees charged to individuals for services	
	Reimbursement from third-party payers (e.g. private insurance, Medicare, Medicaid)	
	Product sales	
	Government (non-grant)	
	Other – specify type	
	None	

19	**Sustainability Activities:** Which of the following activities have you engaged in to enhance your sustainability? Please select all that apply.	**Selection list**
	Local, State and Federal Policy changes	

	Media Campaigns	
	Community Engagement Activities	
	Other – Specify activity	
20	**Have you developed any of the following:** Please select all that apply.	**(Y/N)**
	Sustainability Plan	
	Business Plan	
	Communications Plan	
	Fundraising Plan	

21	**What is your ratio for Economic Impact vs. HRSA Program Funding?** Use the the Economic Impact Analysis Tool developed for FORHP grantees (https://www.ruralhealthinfo.org/econtool) to identify your ratio.	**Ratio**
22	**Will the network/consortium sustain, if applicable?** If you are participating in this program as a network or consortium, please indicate if your current network/consortium will continue after the grant period is over	**(Y/N)**
23	**Will any of the program's activities be sustained after the grant period?**	**All/Some/None**

TABLE 6: CONSORTIUM/NETWORK (OPTIONAL)
Table Instructions:
If you are participating in this program as a network or consortium, please complete this section.

Please provide information about the consortium or network members, if applicable. A consortium or network is defined as collaboration between two or more separately owned organizations.

24	**Number of member organizations in the Consortium/Network**	**Number**
	Area Agency on Aging	
	Area Health Education Center (AHEC)	
	Business	
	Community Health Center/ Federally Qualified Health Center (FQHC)	
	Critical Access Hospital	
	Emergency Medical Service	
	Faith-Based Organization	
	Health Department	
	HIT Regional Extension Center	

	Hospice	
	Hospital, not Critical Access	
	Long Term Care Facility	
	Mental Health Center	
	Migrant Health Center	
	Pharmacy	
	Private Practice (Medical and/or Dental)	
	Professional Association	
	Public Health Department	
	Rural Health Clinic	
	School District	
	Social Services Organization	
	Tribal Entity	
	University/College/Community College/Technical College	
	Other – Specify Type:	

Table 7: HEALTH INFORMATION TECHNOLOGY

Table Instructions: Health Information Technology (HIT)
Please select all types of technology implemented, expanded or strengthened through this program.

25	**Type(s) of technology implemented, expanded or strengthened through this program:** (Please check all that apply)	**Selection list**
	Computerized provider order entry (CPOE)	
	Electronic entry of prescriptions/e-prescribing	
	Electronic medical records/electronic health records	
	Health information exchange (HIE)	
	Patient/disease registry	
	Telehealth/telemedicine	
	None	
	Other – please specify	
26	**Have your organization and/or any of your organization's providers attested to Meaningful Use?** If yes, please select all that apply.	**Y/N**
	Stage 1	
	Stage 2	
	Stage 3	
	If no, is your organization and/or providers planning to attest in the next 12 months?	
	If yes, have your organization and/or providers received incentive payments?	

Table 8: QUALITY IMPROVEMENT

Table Instructions:

Please report on quality improvement activities and initiatives implemented, expanded or strengthened through this program.

.

- An Accountable Care Organization (ACO) is a group of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to Medicare patients.
- A Medical Home is defined as comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes. To become a medical home an organization generally gains a level of certification from an accrediting body.
- Care coordination is defined as the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services.
- The Partnership for Patients is a public/private partnership focused on making hospital care safer, more reliable, and less costly through two goals: reducing preventable hospital-acquired conditions and improving care transitions. (http://partnershipforpatients.cms.gov/)
- Million Hearts is a national initiative to prevent 1 million heart attacks and strokes by 2017. (http://millionhearts.hhs.gov/index.html)
- The Medicare Beneficiary Quality Improvement Project (MBQIP) is a Flex Grant Program activity within the core area of quality improvement for Critical Access Hospitals (CAH). (https://www.ruralcenter.org/tasc/mbqip)

27	**Participation in Accountable Care Organization (ACO)** Is your organization participating in an ACO? (If yes, please check all that apply)	**Yes/No** **(Selection List)**
	Medicare Shared Savings Program	
	Advanced Payment ACO Model	
	Pioneer ACO Model	
	Other – specify	
28	**Participation in Medical Home** Is your organization participating in a Medical Home or Patient Centered Medical Home (PCMH) initiative?	**Yes/No**
	If yes, have you achieved or are you pursuing certification or recognition? (If yes, please check all that apply)	**Yes/No** **(Selection List)**
	National Committee for Quality Assurance (NCQA)	
	Accreditation Association for Ambulatory Health Care (AAAHC)	
	The Joint Commission	
	State/Medicaid Program	
	Other – specify	
29	**Care Coordination Activities**	**Yes/No** **(Selection List)**

	Referral tracking system	
	Patient support and engagement	
	Integrated care delivery system (agreements with specialists, hospitals, community organizations, etc. to coordinate care)	
	Case management	
	Care plans	
	Medication management	
	Other – specify	
30	**Participation in Partnership for Patients**	**Yes/No**
31	**Participation in Million Hearts**	**Yes/No**
32	**Critical Access Hospitals: Participation in Medicare Beneficiary Quality Improvement Project (MBQIP)**	**Yes/No**
33	**Other – please specify**	

Table 9: UTILIZATION

34	**Emergency department (ED) rate**	
35	**30-day hospital readmission rate**	

Table 10: CLINICAL MEASURES

Table Instructions:

Please use your health information technology system to extract the clinical data requested. Please refer to the specific definitions for each measure.

Measure 1: NQF 0059: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%): The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.

Numerator: Patients whose most recent HbA1c level is greater than 9.0% or is missing a result, or for whom an HbA1c test was not done during the measurement year. The outcome is an out of range result of an HbA1c test, indicating poor control of diabetes. Poor control puts the individual at risk for complications including renal failure, blindness, and neurologic damage. There is no need for risk adjustment for this intermediate outcome measure.

Denominator: Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.

Measure 2: NQF 0074: Chronic Stable Coronary Artery Disease: Lipid Control: Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who have a LDL-C result <100 mg/dL OR patients who have a LDL-C result >=100 mg/dL and have a documented plan of care to achieve LDL-C <100mg/dL, including at a minimum the prescription of a statin

Numerator: Patients who have a LDL-C result <100 mg/dL OR

Patients who have a LDL-C result >=100 mg/dL and have a documented plan of care1 to achieve LDL-C <100 mg/dL, including at a minimum the prescription of a statin within a 12 month period
Denominator: All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period

Measure 3: NQF 0421: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up: Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter. (Normal Parameters: Age 65 years and older BMI > or = 23 and < 30; Age 18 – 64 years BMI > or = 18.5 and < 25)
Numerator: Patients with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, follow-up is documented during the encounter or during the previous six months of the encounter with the BMI outside of normal parameters
Denominator: All patients aged 18 years and older

Measure 4: NQF 0018: Controlling High Blood Pressure: The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.
Numerator: The number of patients in the denominator whose most recent BP is adequately controlled during the measurement year. For a patient's BP to be controlled, both the systolic and diastolic BP must be <140/90 (adequate control). To determine if a patient's BP is adequately controlled, the representative BP must be identified.
Denominator: Patients 18 to 85 years of age by the end of the measurement year who had at least one outpatient encounter with a diagnosis of hypertension (HTN) during the first six months of the measurement year.

Measure 5: NQF 0028: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention: Percentage of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user
Numerator:
Patients who were screened for tobacco use* at least once during the two-year measurement period AND who received tobacco cessation counseling intervention** if identified as a tobacco user
*Includes use of any type of tobacco
** Cessation counseling intervention includes brief counseling (3 minutes or less), and/or pharmacotherapy
Denominator: All patients aged 18 years and older who were seen twice for any visits or who had at least one preventive care visit during the two year measurement period

Measure 6: NQF 0418: Screening for clinical depression: Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented
Numerator: Patient's screening for clinical depression using an age appropriate standardized tool AND follow-up plan is documented
Denominator: All patients aged 12 years and older

Measure 7: NQF 0041: Influenza immunization: Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization
Numerator: Patients who received an influenza immunization OR who reported previous receipt* of an influenza immunization
*Previous receipt can include: previous receipt of the current season's influenza immunization from another provider OR from same provider prior to the visit to which the measures is applied (typically, prior vaccination would include influenza vaccine given since August 1st).
Denominator: All patients aged 6 months and older seen for a visit between October 1 and March 31

		Numerator	Denominator	Percent
1	**NQF 0059: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)**			
2	**NQF 0074: Chronic Stable Coronary Artery Disease: Lipid Control**			
3	**NQF 0421: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up**			
4	**NQF 0018: Controlling High Blood Pressure**			
5	**NQF 0028: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention**			
6	**NQF 0418: Screening for clinical depression**			
7	**NQF 0041: Influenza immunization**			

OPTIONAL CLINICAL MEASURES
The following clinical measures are OPTIONAL.

Please use your health information technology system to extract the data requested. Please refer to the specific definitions for each measure.

Optional Measure 1: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Percentage of patients 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of the following during the measurement year:
- Body mass index (BMI) percentile documentation
- Counseling for nutrition
- Counseling for physical activity
Numerator: Body mass index (BMI) percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.

Denominator: Patients 3-17 years of age with at least one outpatient visit with a primary care physician (PCP) or OB-GYN.

Optional Measure 2: Eye Exam (retinal) performed: The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed: Comprehensive Diabetes Care: Eye Exam (retinal) performed
Numerator: Patients who received an eye screening for diabetic retinal disease. This includes people with diabetes who had the following: -a retinal or dilated eye exam by an eye care professional (optometrists or ophthalmologist) in the measurement year OR –a negative retinal exam or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year. For exams performed in the year prior to the measurement year, a result must be available.
Denominator: Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.

Optional Measure 3: Diabetes: Foot Exam: The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a foot exam (visual inspection and sensory exam with mono filament and a pulse exam) during the measurement year.
Numerator: Patients who received a foot exam (visual inspection and sensory exam with monofilament and pulse exam) during the measurement period.
Denominator: Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.

		Numerator	Denominator	Percent
1	**NQF 0024: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents**			
2	**NQF 0055: Comprehensive Diabetes Care: Eye Exam (retinal) performed**			
3	**NQF 0056: Diabetes: Foot Exam**			