

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

Bureau of Health Workforce
Division of Medicine and Dentistry

Primary Care Training and Enhancement Program

Announcement Type: Initial: New
Funding Opportunity Number: HRSA-16-042

Catalog of Federal Domestic Assistance (CFDA) No. 93.884

FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2016

Application Due Date: December 16, 2015

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

Release Date: October 14, 2015

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Anthony Anyanwu
Project Officer, Division of Medicine and Dentistry
Email: aanyanwu@hrsa.gov
Telephone: (301) 443-8437
Fax: (301) 443-1945

Authority: Section 747(a) of the Public Health Service (PHS) Act (42.U.S.C. 293k(a)), as amended by section 5301 of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148)

EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA), Bureau of Health Workforce is accepting applications for the fiscal year (FY) 2016 Primary Care Training and Enhancement (PCTE) program. The purpose of this program is to strengthen the primary care workforce by supporting enhanced training for future primary care clinicians, teachers and researchers and promoting primary care practice, particularly in rural and underserved areas. The focus of this grant program is to produce primary care providers who will be well prepared to practice in and lead transforming healthcare systems aimed at improving access, quality of care, and cost effectiveness.

Funding Opportunity Title:	Primary Care Training and Enhancement Program
Funding Opportunity Number:	HRSA-16-042
Due Date for Applications:	December 16, 2015
Anticipated Total Annual Available Funding:	\$14,937,979
Estimated Number and Type of Award(s):	Up to 37 grants
Estimated Award Amount:	Up to \$250,000 per year – single project Up to \$500,000 per year – collaborative project
Cost Sharing/Match Required:	No
Project Period:	July 1, 2016 through June 30, 2021 (5 years)
Eligible Applicants:	Eligible entities include an accredited public or nonprofit private hospital, school of medicine or osteopathic medicine, academically affiliated physician assistant training program, or a public or private nonprofit entity which the Secretary has determined is capable of carrying out the grant activities. [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 R&R Application Guide*, available online at <http://www.hrsa.gov/grants/apply/applicationguide/sf424rrguide.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

A technical assistance call has been scheduled for applicants as follows:

Date: Nov. 5, 2015

Time: 3-4:30 p.m. (ET)

Call-In Number: 1-800-369-1882

Participant Code: 1847935

Web link: https://hrsa.connectsolutions.com/pcte_foa/

A recorded replay of the webinar will be available after the call, through the closing date of the funding opportunity. The information for the webinar recording will be placed on our website: <http://bhw.hrsa.gov/grants/medicine/pcte.html>.

Additional contact information for technical assistance is available in *Section VIII*.

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I. Program Funding Opportunity Description

1. Purpose

This announcement solicits applications for the Fiscal Year (FY) 2016 Primary Care Training and Enhancement (PCTE) program.

Program Purpose

The overarching purpose of the PCTE program is to strengthen the primary care workforce by supporting enhanced training for future primary care clinicians, teachers, and researchers.

Program Requirements

In FY 2016, applicants for the PCTE program must focus on training for transforming healthcare systems, particularly enhancing the clinical training experience of trainees. Some of the characteristics identified by the Centers for Medicare and Medicaid Services (CMS) that are closely associated with transformed healthcare delivery systems include:

- Providers across the care continuum participate in integrated or virtually integrated delivery models,
- Care is coordinated across all providers and settings,
- There is a high level of patient engagement and quantifiable results on patient experience,
- Providers leverage the use of health information technology to improve quality,
- Providers perform at the top of their license and board certification,
- Population health measures are integrated into the delivery system, and
- Data is used to drive health system processes.¹

In addition, projects that address the social determinants of health while addressing health care delivery transformation are encouraged.

Also consistent with the White House initiative to facilitate career paths for veterans who want to become physician assistants, physician assistant training programs that demonstrate activities that improve recruitment, retention, and education of veteran applicants and students will be encouraged.

This FOA further encourages interprofessional education and provides an option to apply for either a single or a collaborative project that incorporates training for interprofessional teams. Collaborative projects qualify for a higher funding ceiling in recognition of the additional costs associated with providing interprofessional training and experiences for primary care trainees. While the lead applicant training program for this FOA must be from one of the following professions/disciplines: family medicine, general internal medicine, general pediatrics, medical students, physician assistant students, or faculty in any of these areas, collaborative projects must propose training across the training continuum (e.g., student, resident, faculty development, and practicing primary care physician or physician assistants) and across primary care professions

¹ CMS State Innovation Models Cooperative Agreement Announcement (May 2014). Available at: <http://innovation.cms.gov/Files/x/StateInnovationRdTwoFOA.pdf>

(e.g., physicians, physician assistants, and other primary care professions). See [Section IV's Methodology](#) for more information on qualifying for a collaborative project.

Applicants must also propose an evaluation plan focused on assessment of outcomes related to graduate career choices and patient access, quality of care, and cost effectiveness in the clinical training environment. Evaluation plans may include integration of evaluation activities with existing institution efforts, such as quality improvement initiatives. Examples of outcomes are changes in:

- Rate of graduates/program completers practicing in primary care, at least 1 year after program completion
- Rate of graduates/program completers practicing in underserved areas, at least 1 year after program completion
- Patient service provided by graduates/program completers
- Quality of care provided by graduates/program completers
- Patient service provided by trainees and faculty at participating PCTE clinical training sites
- Quality of care provided by trainees and faculty at participating PCTE clinical training sites
- Cost of care provided by trainees and faculty at participating PCTE clinical training sites

During the funded grant period, award recipients will be required to work with an evaluation technical assistance contractor identified by HRSA to support program evaluation. The evaluation technical assistance contractor will review evaluation plans and provide feedback to award recipients. Award recipients will be required to address any evaluation concerns identified by the contractor with the Project Officer and will need to submit a revised evaluation plan to HRSA before the end of the first budget period.

Applicants may use funds to plan, develop, and operate programs that:

1. *Provide training experiences in new competencies as recommended by the Advisory Committee on Training in Primary Care Medicine and Dentistry—including training in integrated care with other health professionals, in interprofessional teams that include diverse professions outside of medicine and dentistry, in team-based practice models such as the Patient-Centered Medical Home, and in leading practice transformation.*²
2. *Provide training in the field of family medicine, general internal medicine, or general pediatrics for medical students, interns, residents, or practicing physicians.*
3. *Provide training to physician assistant students.*
4. *Train physicians who plan to teach in family medicine, general internal medicine, or general pediatrics.*
5. *Train physicians or physician assistants teaching in community-based settings.*
6. *Operate joint interdisciplinary and interprofessional graduate degree programs in public health and other professions to provide training in environmental health, infectious disease, disease prevention and health promotion, epidemiological studies and injury control.*

² Advisory Committee on Training in Primary Care Medicine and Dentistry. Eleventh Annual Report to the Secretary of DHHS and to Congress. July 2014. Available at: <http://www.hrsa.gov/advisorycommittees/bhpradvisory/actpcmd/>

7. *Provide need-based financial assistance in the form of traineeships and fellowships to students, residents, practicing physicians or other medical personnel, who are participants in any such program and who plan to work, teach, or conduct research in family medicine, general internal medicine, or general pediatrics. Activities to support trainees must be consistent with the FY 2016 focus of the PCTE program to train primary care providers for transforming healthcare systems. **Stipends are not allowed for medical residents or medical students.***

Preferences

Section 791(a)(1) of the PHS Act provides for funding preferences for the PCTE program. Applicants receiving a funding preference will be placed in a more competitive position among applications that can be funded. A funding preference is available for applicants that:

- a) demonstrate a high rate for placing graduates/program completers in Medically Underserved Communities or demonstrate a significant increase in the rate of placing graduates/program completers in MUC settings over the preceding 2 years; or
- b) are new programs as defined in this funding opportunity announcement (FOA).

In order to receive the funding preference you must clearly indicate the funding preference you are applying for in the abstract, provide all required information and meet the designated targets. Refer to [Section V](#) of this FOA for detailed information on qualifying for a funding preference.

2. Background

This program is authorized by Title VII, Section 747(a) of the Public Health Service Act, as amended by section 5301 of the Affordable Care Act (P.L. 111-148). The focus of these authorities is on improving the Nation's access to well-trained primary care physicians and physician assistants by supporting primary care community-based residency training, pre-doctoral training, interdisciplinary and interprofessional training, joint-degree training, curriculum development, and by preparing faculty to teach in primary care fields.

Research shows that a strong primary care foundation is critical for health care system performance and improved health.^{3,4} Recent evidence also suggests that primary care workforce is associated with higher quality care at lower spending.⁵ Despite this evidence, the U.S. primary care system remains challenged and health disparities remain persistent. Demand for primary care services is projected to grow more rapidly than supply, and lack of providers leads to inadequate access to primary care services for some communities.⁶

³ Starfield B, Shi I, Macinko J. Contributions of primary care to health systems and health. *Millbank Quarterly* 2005;83:457-502.

⁴ Chang C, Stukel TA, Flood AB, Goodman DC. Primary care physician workforce and Medicare beneficiaries' health outcomes. *JAMA*. 2011;305(20):2096-2104.

⁵ Baicker K, Chandra A. Medicare spending, the physician workforce, and beneficiaries' quality of care. *Health Affairs*. 2004. Available at: <http://content.healthaffairs.org/content/early/2004/04/07/hlthaff.w4.184.full.pdf+html>.

⁶ HRSA. Projecting the supply and demand for primary care practitioners through 2020. HRSA. 2013. Available at: <http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/primarycare/projectingprimarycare.pdf>.

HRSA has long recognized the importance of training primary care physicians and physician assistants to become effective clinicians, teachers, researchers and leaders. These programs help produce high quality, diverse primary care clinicians who will be able to address the Nation's health care needs. Addressing the need for primary care providers is particularly critical for rural and underserved areas. More than 10 percent of the U.S. population lives in a federally designated Health Professional Shortage Area where they have limited or nonexistent health care services.⁷ Rural communities have great difficulty recruiting and sustaining an adequate health care workforce.⁸ Yet, there is evidence that physicians who receive training in rural and underserved areas are more likely to practice in similar settings.^{9,10} This FOA will support efforts to enhance the primary care workforce, including supporting training for rural and underserved communities.

The mission of HRSA's Bureau of Health Workforce (BHW) is to improve the health of the underserved and vulnerable populations by strengthening the health workforce and connecting skilled professionals to communities in need. BHW is committed to ensuring that the U.S. has the right clinicians, with the right skills, working where they are needed most.

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 – 2020. Approximately \$14,900,000 is expected to be available annually to fund up to 37 grants. Applicants may apply for a ceiling amount of up to \$250,000 per year for single training level and profession projects or up to \$500,000 per year for collaborative projects. **These ceilings include both direct and indirect costs.** Collaborative projects must include activities targeted at more than one training level (student, resident, faculty development, and practicing primary care physician or physician assistants) and more than one primary care profession (physician, physician assistants, and other primary care professions); see [Section IV, Project Narrative](#) for more information.

Of the total funds available, HRSA plans that at least \$1,800,000 will be awarded to programs that provide training to physician assistant students, faculty, or practicing physician assistants. The actual amount available will not be determined until enactment of the final FY

⁷ Rhyne, R., Sanders, M., Skipper, B., VanLeit, B., Daniels, Z. "Factors in Recruiting and Retaining Health Professionals for Rural Practice." [Journal of Rural Health](#). 2007: 23(1) 62-71.

⁸ Lucado, J., Schur, C., (PAEA), Social and Scientific Systems, Inc., "National Survey of Physician Assistants and Preceptor Experiences: Survey Findings." 2011.

⁹ Center for Policy Studies, AAFP: The effect of accredited rural training tracks on physician placement. *Am Fam Phys* 2000;62(1):22.

¹⁰ Health Resources Services Administration: US Medical School Rural Track Policy Brief. 2013

2016 federal budget. 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 five (5) years. Funding beyond the first year is dependent on the availability of appropriated funds for 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.

Indirect costs under training awards to organizations other than state, local or Indian tribal governments will be budgeted and reimbursed at 8 percent of modified total direct costs rather than on the basis of a negotiated rate agreement, and are not subject to upward or downward adjustment. Direct cost amounts for equipment and capital expenditures, tuition and fees, and sub-grants and subcontracts in excess of \$25,000 are excluded from the direct cost base for purposes of this calculation.

III. Eligibility Information

1. Eligible Applicants

Lead applicant eligible entities include accredited public or nonprofit private hospitals, schools of allopathic or osteopathic medicine, academically affiliated PA training programs, or a public or nonprofit private entity that the Secretary has determined is capable of carrying out such grants. Faith-based and community-based organizations, Tribes and tribal organizations may apply for these funds, if otherwise eligible.

Organizations that competed for the FY 2015 Primary Care Training and Enhancement program funding opportunity and successfully received an award are not eligible for this competition because of concerns around duplication of programs and organizational capacity, as well as the Department's commitment to ensuring a broad geographical distribution of PCTE award recipients. However, organizations that received a new PCTE award in FY 2015 can come in as a collaborator with another organization.

All training activities must be conducted by an accredited entity. Provisional accreditation is acceptable for new programs. The applicant must submit accreditation documentation for the lead applicant training program in Attachment 7.

Required Eligibility Documentation

The applicant organization must provide: (1) a statement that they hold continuing accreditation from the relevant accrediting body and are not on probation, and (2) the dates of initial accreditation and next expected accrediting body review. The full letter of accreditation is not required. Documentation of accreditation must be provided for all training programs included in the collaborative project proposals. Award recipients must immediately inform the HRSA

project officer of any change in accreditation status. If a partner organization holds the accreditation for a training program, a letter of agreement must be provided in Attachment 6.

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.

2. Cost Sharing/Matching

Cost sharing/matching is not required for this program.

3. Other

Ceiling Amount

Applications that exceed the ceiling amount of \$250,000 for single projects or \$500,000 for collaborative projects will be considered non-responsive and will not be considered for funding under this announcement.

Deadline

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

Maintenance of Effort (MoE)

The recipient must agree to maintain non-federal funding for award activities at a level which is not less than expenditures for such activities during the fiscal year prior to receiving the award as required by Section 797(b) of the Public Health Service Act. Complete the Maintenance of Effort document and submit as Attachment 5.

NOTE: Multiple applications from an organization as the lead applicant are not allowable. An “organization” for this FOA is defined as an institution with a single Employer Identification Number (EIN).

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.

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

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 R&R application package associated with this FOA following the directions provided at [Grants.gov](https://www.grants.gov).

Applicants should always supply an email address to grants.gov when downloading an FOA or application package. As noted on the Grants.gov APPLICATION PACKAGE download page, as well as in the Grants.gov User Guide on pages 57-58, this allows us to email you in the event the FOA is changed and/or republished on Grants.gov before its closing date. Responding to an earlier version of a modified announcement may result in a less competitive or ineligible application.

2. Content and Form of Application Submission

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

See Section 8.5 of the [SF-424 R&R Application Guide](#) for the Application Completeness Checklist.

Application Page Limit

The total size of all uploaded files may not exceed the equivalent of **70 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. **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 R&R Application Guide](#) (including the budget, budget justification, staffing plan and personnel requirements, assurances, certifications, and abstract), please include the following:

i. Project Abstract

See Section 4.1.ix of HRSA's [SF-424 R&R Application Guide](#).

The Abstract must include:

1. A brief overview of the project as a whole.
2. Specific, measurable objectives that the project will accomplish.
3. How the proposed project for which funding is requested will be accomplished, i.e., the "who, what, when, where, why and how" of a project.

4. Whether the application is for a single or collaborative project. If applying for a collaborative project, identify and label the lead applicant training program and the partnering collaborative training programs. Requirements for a collaborative project are described in *Section IV Project Narrative*.
5. If applicable, state the funding preference for which you are applying, as outlined in *Section V. 2*.

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.

- *PURPOSE AND NEED -- Corresponds to Section V's Review Criterion #1*

Provide a brief statement of the purpose of the proposed project. Describe how the proposed program is relevant at the national, state, or local level. Describe gaps in the current primary care workforce, particularly for your program's targeted professions, including their training needs. Explain how developing the proposed training will address the health workforce gaps you have identified.

Describe the specific community/communities in which the proposed training will take place, including diversity, social determinants of health, health disparities, and any unmet needs, and identify those that will be addressed through your proposed training program.

Describe the current state of the health care delivery system that will serve as a training site for your program. Identify specific gaps in your current training sites that will be addressed through the proposed program. Describe the diversity of the current primary care workforce serving your population.

Data must be used and cited whenever possible to support the information provided.

- *RESPONSE TO PROGRAM PURPOSE -- This section includes 3 sub-sections—(a) Methodology/Approach; (b) Work Plan; and (c) Resolution of Challenges—all of which correspond to Section V's Review Criteria #2 (a), (b), and (c).*
- *(a) METHODOLOGY/APPROACH -- Corresponds to Section V's Review Criterion #2 (a).*

Describe in detail your proposed project goals, objectives, and intended outcomes. Objectives should be specific, measurable, realistic, and achievable within the project period. Clearly relate the project goals and objectives to the overall purpose of your proposed project. Describe the key activities proposed for accomplishing project goals and objectives including, but not limited to, any proposed changes to the clinical learning environment and any proposed didactic or clinical curricula to be developed or enhanced.

Clearly describe how your proposed project enhances training to produce primary care providers who are well prepared to practice in and lead transforming health care delivery

systems. Describe how your project addresses the CMS characteristics of a transformed health care system:

- Providers across the care continuum participate in integrated or virtually integrated delivery models,
- Care is coordinated across all providers and settings,
- There is a high level of patient engagement and quantifiable results on patient experience,
- Providers leverage the use of health information technology to improve quality,
- Providers perform at the top of their license and board certification,
- Population health measures are integrated into the delivery system, and
- Data is used to drive health system processes.

Clearly describe activities to enhance your program's clinical training environment to align with the transforming health care system and any didactic or clinical curricula focused on the characteristics described above.

Describe the trainees that will benefit from the project, how trainee experiences will be enhanced, and how the proposed activities are expected to improve access, quality, and cost of care for patients in the clinical training environment. Projects that propose training across the training continuum (i.e., student, resident, faculty, and practicing primary care physician or physician assistants) and interprofessional education in team-based care models are encouraged.

The lead applicant training program for either single or collaborative projects must be from one of the following professions/disciplines: family medicine, general internal medicine, general pediatrics, medical students, physician assistant students, or faculty in any of these areas.

In this section, you must clearly indicate if you are applying for a collaborative project, identify your lead and collaborating training programs, describe your interprofessional education team-based care model and the role of each profession, and describe how the different training levels and professions will equitably benefit from the project. To qualify for the collaborative project funding ceiling, your proposal must focus on more than one level in the training continuum (as listed above) AND more than one health professional training program. Qualifying health professional training programs are from those professions engaged in primary care team-based care models. The lead applicant training program must be from one of the following professions/disciplines: family medicine, general internal medicine, general pediatrics, medical students, physician assistant students, or faculty in any of these areas. Collaborative projects must include at least two of the following professions: primary care physicians, physician assistants, nurse practitioners, dentists, mental health providers, pharmacists, and other allied health professionals

Applicants must describe how your proposed activities will increase diversity in the health workforce to meet the needs of the community/communities described in the *Purpose and Need* section. Applicants must include examples of their commitment to increasing diversity in health professions training programs and the health workforce and, to the extent possible, that the workforce reflects the diversity of the nation. Applicants must describe how their

training programs will develop the competencies and skills needed for intercultural understanding and expand cultural fluency, bring people of diverse backgrounds and experiences together, and facilitate innovative and strategic practices that enhance the health of all people.

If applicable, provide a brief narrative entitled “Helping Veterans Become Physician Assistants Activities” that provides a statement of veteran related activities. Include existing or proposed activities in the grant application with a special focus on activities that improve recruitment, retention, and education of veterans. States the impact of these activities on increasing the number of veteran trainees and veteran graduates, the quality of the curriculum, curriculum fit for veterans, or other appropriate process and endpoint outcomes. Provide data to support the statement of impact..

- (b) *WORKPLAN -- Corresponds to Section V’s Review Criterion #2 (b).*
Describe, in detail, the activities or steps, and the staff responsible for achieving each of the activities proposed during the entire project period. Identify key partner programs, departments, and organizations, particularly community-based organizations, involved in the project and describe how you will function and coordinate carrying out the grant activities.

Use a timeline that includes each activity and identifies responsible staff and amount of time estimated to carry out each step. As appropriate, identify meaningful support and collaboration with key stakeholders in planning, designing and implementing all activities. The Work Plan must also provide a timeline for the awardee’s evaluation plan. Attach the Work Plan in a chart format as Attachment 1. A sample work plan can be found at <http://bhw.hrsa.gov/grants/technicalassistance/workplantemplate.docx>.

You must also provide a logic model in Attachment 9. Your logic model provides a framework for your project and connects your program activities with the short and long term outcomes and goals of your project. More information on logic models is provided in *Section VIII*.

You must also include an annual training chart that indicates the number of trainees you plan to train through the proposed activities. The chart must include information on the following:

- Information on the individuals that will be trained through the grant. For each category of trainee: medical student, resident, physician, physician assistant student, or physician assistant; and specialty (when appropriate): Family Medicine, General Internal Medicine, General Pediatrics; include the following:
 - the number of trainees you propose to train each year,
 - the number trainees you project to complete the program each year,
 - the number of underrepresented minorities you project to train each year,
 - the number from a rural or disadvantaged background that you project to train each year, and
 - the number of veterans that you project to train each year, if applicable.
- Other Health Care Trainees:

- the expected number of other health professions trainees (not listed above), by profession, level of training, and specialty when appropriate, that you propose to train alongside the above trainees during each year of the project period.
- *(c) RESOLUTION OF CHALLENGES -- Corresponds to Section V's Review Criterion #2 (c)*

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

- *IMPACT -- This section includes 2 sub-sections— (a) Evaluation and Technical Support Capacity; and (b) Project Sustainability—both of which correspond to Section V's Review Criteria #3 (a) and (b).*
- *(a) EVALUATION AND TECHNICAL SUPPORT CAPACITY -- Corresponds to Section V's Review Criterion #3 (a)*

A comprehensive evaluation will yield outcome data that both the award recipient and HRSA can use throughout the project to ensure the success of the project. Meaningful and accurate endpoint data will demonstrate the success of the funding opportunity, inform quality improvement activities, and demonstrate accountability to stakeholders.

The evaluation plan must describe how program performance and outcomes will be evaluated against goals, objectives, sub-objectives, activities and timelines of the project. The evaluation plan should include descriptions of the inputs (e.g., key evaluation staff and organizational support, collaborative partners, budget, and other resources); key processes; variables to be measured; expected outcomes of the funded activities; and a description of how all key evaluative measures will be reported. The evaluation plan must demonstrate evidence that the evaluative measures selected will be able to assess: 1) the extent to which the program objectives have been met, and 2) the extent to which these can be attributed to the project. Programs will be expected to report on their findings in their annual Progress Report.

The evaluation plan must contain the following components:

Program Impact

Applicants must also propose an evaluation plan focused on proposed assessment of outcomes related to graduate outcomes and patient access, quality of care, and cost effectiveness in the clinical training environment. Evaluation plans must include integration of evaluation activities with existing institution efforts, such as quality improvement initiatives, when appropriate. Evaluation methods, including instruments and tools to be used and primary and secondary data sources, must be described.

Examples of relevant outcomes are changes in:

- Rate of graduates practicing in primary care or in underserved areas, at least 1 year after program completion;
- Patient services provided by graduates;
- Quality of care provided by graduates;

- Patient services provided by trainees and faculty at participating PCTE clinical training sites;
- Quality of care provided by trainees and faculty at participating PCTE clinical training sites; and
- Cost of care provided by trainees and faculty at participating PCTE clinical training sites.

Patient service, quality of care and cost of care outcomes must be matched to the proposed activities of applicant. For reference, examples of clinical quality measures used by the HRSA-funded Community Health Center program are available at: <http://bphc.hrsa.gov/qualityimprovement/performanceasures/index.html>. Clinical quality measures used by CMS can be found here: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/Eligible-Providers-2014-Proposed-EHR-Incentive-Program-CQM.pdf>.

Program Assessment and Improvement:

You must describe a continuous quality improvement plan to measure and assess your program's performance. Your plan must provide meaningful and frequent monitoring of ongoing processes, outcomes of implemented activities and curriculum, and progress toward meeting grant goals and objectives. Your plan must also discuss how the results of these activities will inform improvements in the project over the 5-year project period. This must include rapid-cycle improvement strategies that will provide feedback to the applicant and HRSA about early results of the implementation and potential modifications to better meet the goals of the program.

HRSA Required Performance and Progress Reporting

Applicants must describe the systems and processes that will support the organization's collection of HRSA's performance measurement requirements for this program. At the following link, you will find the required data forms for this program: <http://bhw.hrsa.gov/grants/reporting/index.html>. This includes a description of how the organization will effectively track performance outcomes, including 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 to HRSA. Applicants must describe any potential obstacles for implementing the program performance evaluation and meeting HRSA's performance measurement requirements, and how those obstacles will be addressed. The evaluation and reporting plan also should indicate the feasibility and effectiveness of plans for dissemination of project results, the extent to which project results may be national in scope, and the degree to which the project activities are replicable.

Technical Capacity

The applicant must demonstrate that it has the capacity to achieve the proposed evaluation plan. In demonstrating technical capacity for developing and implementing the proposed evaluation plan, the applicant must address the following elements:

- 1) Technical Capacity – experience in program evaluation and knowledge of individual(s) responsible for conducting the evaluation and reporting findings. The proposed lead evaluator’s curriculum vitae must be included.
- 2) Obstacles – identify any potential obstacles for the evaluation plan and potential ways to address those obstacles.
- 3) Dissemination Plan – describe a plan for dissemination of evaluation findings.

In addition, award recipients will be required to work with an evaluation technical assistance contractor identified by HRSA and their Project Officer in regard to their evaluation plan. The contractor will review evaluation plans and provide feedback to award recipients. Award recipients will be required to address any evaluation concerns identified by the contractor and submit a revised evaluation plan to HRSA before the end of the first budget period.

- *(b) PROJECT SUSTAINABILITY -- Corresponds to Section V’s Review Criterion #3 (b)*

Applicants must provide a clear plan for project sustainability after the period of federal funding ends, including a description of specific actions the applicant will take to highlight key elements of their grant projects, e.g., training methods or strategies, which have been effective in improving practices; and obtain future sources of potential funding, as well as a timetable for becoming self-sufficient. The applicant must discuss challenges that are likely to be encountered in sustaining the program and approaches that will be used to resolve such challenges.

- *ORGANIZATIONAL INFORMATION, RESOURCES AND CAPABILITIES -- Corresponds to Section V’s Review Criterion #4*

Applicants must describe their capacity to effectively manage the programmatic, fiscal, and administrative aspects of the proposed project. Provide information on the applicant organization’s current mission and structure, organizational chart, relevant experience, and scope of current activities. (A project organizational chart is requested in Section IV.2.v, Attachment 3.) The applicant must describe how the organization has the ability to implement the proposed project and meet the program requirements 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.

In addition to the above, collaborative projects must include a project organizational chart demonstrating how each entity works together. Describe how all of these contribute to the ability of the organization to conduct the program requirements and meet program expectations.

Provide evidence, where appropriate, of success in the past by your program or organization in addressing diversity in the health workforce.

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.	
<u>Narrative Section</u>	<u>Review Criteria</u>
Purpose and Need	(1) Purpose and Need
Response to Program Purpose: (a) Methodology/Approach (b) Work Plan (c) Resolution of Challenges	(2) Response to Program Purpose (a) Methodology/Approach (b) Work Plan (c) Resolution of Challenges
Impact: (a) Evaluation and Technical Support Capacity (b) Project Sustainability	(3) Impact: (a) Evaluation and Technical Support Capacity (b) Project Sustainability
Organizational Information, Resources and Capabilities	(4) Organizational Information, Resources and Capabilities
Budget and Budget Narrative	(5) 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 R&R Application Guide](#). Please note: the directions offered in the SF-424 R&R Application Guide differ from those offered by Grants.gov. Please follow the instructions included 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 General Provisions in Division G, § 203, of the Consolidated and Further Continuing Appropriations Act, 2015 (P.L. 113-235) states, “None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II.” Please see Section 4.1.iv Budget –

Salary Limitation of HRSA's [SF-424 R&R Application Guide](#) for additional information. Note that these or other salary limitations will apply in FY 2016, as required by law.

iv. Budget Justification Narrative

See Section 4.1.v. of HRSA's [SF-424 R&R Application Guide](#). In addition, the Primary Care Training and Enhancement program requires the following:

Collaborative Projects: Applicants that propose a collaborative project as described in *Section IV Project Narrative* must include a budget table within the budget justification that provides a specific line item budget breakdown for each of the proposed disciplines/professions and training levels involved.

Travel Costs: List travel costs according to local and long distance travel. Travel costs for consultants should be listed under consultant costs. For local travel, the mileage rate, number of miles, reason for travel and staff member/consumers completing the travel should be outlined. Include travel support for the project director to attend up to four award recipient meetings (approximately one per year in project period years two through five) each held over 3 days in the Washington D.C. area.

Consultant Services: For applicants that are using consultant services, list the total costs for all consultant services. In the budget justification, identify each consultant, the services he/she will perform, the total number of days, travel costs, and the total estimated costs.

Subawards/Consortium/Contractual Costs: For applicants that have subawards/contracts, provide a clear explanation as to the purpose of each subaward/contract, how the costs were estimated, and the specific contract deliverables. Applicants are responsible for ensuring that their organization or institution has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring all contracts. Applicants must provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. Reminder: recipients must notify potential subrecipients that entities receiving subawards must be registered in SAM and provide the recipient with their DUNS number.

Evaluation Costs: Applicants may request funding to support annual reporting requirements (i.e., software, personnel time, etc.), and to conduct the required program evaluation as described in this funding opportunity announcement. Applicants must ensure adequate resources are requested to conduct an evaluation that meets the requirements as outlined in *Section IV*.

Participant/Trainee Support Costs: For applicants with participant/trainee support costs, list tuition/fees/health insurance, stipends, travel, subsistence, other, and the number of participants/trainees. Ensure that your budget breakdown separates these trainee costs, and includes a separate sub-total entitled "total Participant/Trainee Support Costs" which includes the summation of all trainee costs. Trainee costs must be delineated by profession/discipline trained to be complete.

Stipends may only be used for cost of living expenses during the period of training. Other educational expenses (such as tuition, travel, and conference fees) should be itemized and justified apart from any planned stipend allotment. **Trainee stipends are not allowable for medical residents or medical students.** The maximum stipend rate for predoctoral students is \$22,920 per year.¹¹

Maximum stipend levels for postdoctoral trainees and faculty are:

Postdoctoral Years of Experience	Stipend for FY 2015
0	\$42,840
1	\$44,556
2	\$46,344
3	\$48,192
4	\$50,112
5	\$52,116
6	\$54,216
7 or more	\$56,376

Enter the number and total stipend amount for each trainee or faculty category as appropriate. The payment of stipend must also be consistent with institutional policy. **Grant funds may not be used to pay fringe benefits for trainees receiving stipend support.** Stipends must be paid in accordance with the award recipient’s usual payment schedule and procedures. Any trainee who receives 100% of their salary from non-grant sources is not eligible for grant supported stipends.

Requests for stipend support must fully document that 1) trainees or faculty are in need of the support, 2) alternative sources of financial support for such stipends are not available, and 3) grant funds will not be used to supplant other available funds. Each individual receiving stipend support from grant funds must be a citizen of the United States, a non-citizen national, or a foreign national having in his/her possession a visa permitting permanent residence in the United States.

Applicants must indicate the percentage of support (if any) covered by other sources, including state grants, institutional support, and/or other sources including federal education awards (fellowships, traineeships, etc.) except for educational assistance under the Veterans Readjustment Benefits Act (“GI Bill”).

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.** Missing attachments or incomplete applications could negatively affect your application during a review. **Each attachment must be clearly labeled.**

¹¹ National Institutes of Health 2015 stipend guidelines. Available at: <http://grants.nih.gov/grants/guide/notice-files/NOT-OD-15-048.html>

Attachment 1: Work Plan Chart

Attach the Work Plan for the project using a table or chart that accounts for all of the information you provided in *Section IV, ii. Project Narrative*.

Attachment 2: Staffing Plan and Job Descriptions for Key Personnel See *Section 4.I.vi.* of HRSA’s [SF-424 R&R Application Guide](#) for required information. Keep each job description to one page in length as much as is possible. Include the role, responsibilities, and qualifications of proposed project staff. Refer to Attachment 8 regarding inclusion of Biographical Sketches.

Attachment 3: Project Organizational Chart

Provide a one-page figure that depicts the organizational structure of the project (not the applicant organization).

Attachment 4: Funding Preference, if applicable

To receive a funding preference, include a statement that the applicant is eligible and identify the preference. Include documentation of this qualification and clearly indicate which preference you are applying for. Refer to *Section V* of this funding opportunity announcement (FOA) for detailed information on funding preferences.

Attachment 5: Maintenance of Effort Documentation

Applicants must provide a baseline aggregate expenditure for the prior fiscal year and an estimate for the next fiscal year using a chart similar to the one below.

NON-FEDERAL EXPENDITURES	
<p>FY 15 (Actual) Actual FY 15 non-federal funds, including in-kind, expended for activities proposed in this application.</p> <p>Amount: \$ _____</p>	<p>FY 16 (Estimated) Estimated FY 16 non-federal funds, including in-kind, designated for activities proposed in this application.</p> <p>Amount: \$ _____</p>

Attachment 6: Letters of Agreement and/or Support

Include any relevant letters of agreement and/or support. If you are applying as a part of a collaborative you must include letters of agreement from your collaborating partners. Letters must be from someone who holds the authority to speak for the organization or department (CEO, Chair, etc.), must be dated, and must specifically indicate understanding of the project and a commitment to the project, including any resource commitments (in-kind services, dollars, staff, space, equipment, etc.).

Attachment 7: Accreditation Documents

The applicant organization must provide: (1) a statement that they hold continuing accreditation from the relevant accrediting body and are not on probation, and (2) the dates of initial accreditation and the next accrediting body review. The full letter of accreditation is not required. If a partner organization holds the accreditation for a training program, a letter of agreement must be provided as well.

Attachment 8: Biographical Sketches of Key Personnel

Include biographical sketches for persons occupying the key positions described in Attachment 2, not to exceed two pages in length. In the event that a biographical sketch is included for an identified individual who is not yet hired, please include a letter of commitment from that person with the biographical sketch.

Attachment 9: Logic Model

Attach the Logic Model for the project. More information on logic models is provided in *Section VIII*.

Attachment 10: Other Relevant Documents

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 R&R 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 *December 16, 2015 at 11:59 P.M. Eastern Time.*

See Section 8.2.5 – Summary of emails from Grants.gov of HRSA’s [SF-424 R&R Application Guide](#) for additional information.

5. Intergovernmental Review

Primary Care Training and Enhancement program is not a program subject to the provisions of Executive Order 12372, as implemented by 45 CFR 100.

See Section 4.1 ii of HRSA’s [SF-424 R&R Application Guide](#) for additional information.

6. Funding Restrictions

Applicants responding to this announcement may request funding for a project period of up to 5 years, at no more than \$250,000 per year for single projects or \$500,000 per year for collaborative projects, in total costs (direct and indirect). 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 purposes specified in HRSA’s [SF-424 R&R Application Guide](#). In addition, funds may not be used for the following purposes:

Stipends are not allowable for medical residents or medical students.

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

All program income generated as a result of awarded 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 the objective review.

Review Criteria are used to review and rank applications. The *Primary Care Training and Enhancement* program has *FIVE (5)* review criteria:

Criterion 1: PURPOSE AND NEED (10 points) – Corresponds to Section IV’s Purpose and Need

The extent to which the application demonstrates the problem and associated contributing factors to the problem, including the quality of and extent to which the applicant:

- Demonstrates the national, regional, and/or local health need for the project;
- Demonstrates the national, regional, and/or local health workforce need for the project;
- Identifies the need for aligning training with the changing practice environment;
- Describes the gaps in their current delivery system and proposes to address the gaps;
- Describes the community/communities served, including diversity, social determinants of health, health disparities, and unmet needs; and
- Describes the diversity of the population served and the diversity of the workforce involved in the delivery of services and training.

Criterion 2: RESPONSE TO PROGRAM PURPOSE (35 points) – Corresponds to Section IV’s Response to Program Purpose Sub-section (a) Methodology/Approach, Sub-section (b) Work Plan and Sub-section (c) Resolution of Challenges

Criterion 2 (a): METHODOLOGY/APPROACH (20 points) – Corresponds to Section IV’s Response to Program Purpose Sub-section (a) Methodology/Approach

The application will be evaluated on the extent to which the applicant demonstrates an understanding of the program requirements and expectations, and the extent to which the proposed goals, objectives, and activities will address the needs highlighted in the Purpose and Needs section. The methodology will specifically be reviewed on the extent to which the project does the following:

- Addresses the PCTE program’s focus to enhance education and training to better prepare primary care providers to practice in and lead transforming health care delivery systems while addressing social determinants of health, and health disparities;

- Addresses the characteristics of a transformed delivery system as described by CMS and is likely to improve access, quality, and cost of care in the clinical training environment;
- Proposes interprofessional and/or community-based partnerships that demonstrate a high level of collaboration and involvement by the contributing partners;
- Proposes a feasible plan to increase diversity in the health workforce to meet the needs of the community/communities described in the *Purpose and Need* section; and
- **For applicants proposing a collaborative project**, the extent to which the project equitably benefits trainees in at least two of the designated training levels (student, resident, faculty, and practicing primary care physician or physician assistants) and in at least two of the following primary care professions: primary care physicians, physician assistants, nurse practitioners, dentists, mental health providers, pharmacists, and other allied health professionals; and the extent to which the trainees are engaged in interprofessional education in team-based care models, as defined in *Section I Program Definitions*; and
- Demonstrates clear benefits to trainees from the project and explains how trainee experiences will be enhanced;
- Proposes methods, tools, and strategies that are clearly described, will adequately address the stated goals, program requirements, and expectations of the FOA, and provides evidence to support the proposed methodologies, including published literature, prior experience, and historical data, for the appropriateness of the proposed methodology; and
- Proposes innovative strategies to address PCTE program focus.
- **For applicants proposing “Helping Veterans Become Physician Assistants Activities,”** the likely impact of the activities to improve the quality of PA education for veterans including but not limited to veteran specific recruitment and retention strategies, accepting transfer of military college credit hours, and alternate curricula for veterans with medical training and/or experience and the quality of the proposed needs assessment and outcome data supporting these activities.

Criterion 2 (b): WORKPLAN (10 points) – Corresponds to Section IV’s Response to Program Purpose Sub-section (b) Workplan

- The extent to which the applicant provides a clear, comprehensive, and specific set of goals and objectives and the concrete steps that will be used to achieve those goals and objectives. The description should include timeline, stakeholders, and a description of the cultural, racial, linguistic and geographic diversity of the populations and communities served;
- The feasibility of the proposed activities and timelines;
- The extent to which the applicant provides a logic model that clearly connects the activities, short and long term outcomes, and goals of the program;
- The extent to which the applicant clearly describes and justifies the number of cohorts of graduates/program completers planned during the 5-year project period; and
- The adequacy of the staffing plan to implement the proposed work plan. Reviewers will consider level of staffing, skill sets proposed, and qualifications of key personnel.

Criterion 2 (c): RESOLUTION OF CHALLENGES (5 points) – Corresponds to Section IV’s Response to Program Purpose Sub-section (c) Resolution of Challenges

The extent to which the applicant demonstrates an understanding of potential obstacles and challenges during the design and implementation of the project, as well as a plan for dealing with identified contingencies that may arise.

Criterion 3: IMPACT(30 points) – Corresponds to Section IV’s Impact Sub-section (a) Evaluation and Technical Support Capacity, and Sub-section (b) Project Sustainability

Criterion 3(a): EVALUATION AND TECHNICAL SUPPORT CAPACITY (25 points) – Corresponds to Section IV’s Impact Sub-section (a) Evaluation and Technical Support Capacity
The extent to which the applicant is able to effectively report on the measurable outcomes being requested. This includes both their internal program performance evaluation plan and HRSA’s required performance measures, as outlined in the corresponding Project Narrative Section IV’s Impact Sub-section (a). Specific criteria include:

Program Impact (10 points):

- The extent to which the proposed project evaluation plan addresses outcomes related to patient access, quality of care, and/or cost effectiveness;
- The extent to which each activity’s outcome measures reflect back to the needs statement from which its objectives were derived;
- The extent to which the proposed evaluation methods are feasible within the project timeframe, evidence-based and clearly described;
- The extent that the applicants’ proposed evaluation methods are appropriate for the proposed project, including instruments/tools to be used, data sources, timelines, and measureable outputs and outcomes; and
- The extent to which project results may be national in scope, the degree to which the project activities are replicable, and the sustainability of the program beyond the federal funding.

HRSA Required Performance and Progress Reporting, and Program Assessment and Improvement (5 points):

- Strength and effectiveness of the plan to incorporate continuous quality improvement of grant activities including how and when feedback from evaluation findings will be incorporated into the project’s continuous quality improvement plans.
- Strength of applicant’s ability to report on HRSA’s program progress and performance measures, including systems, processes, and adequate staff to collect, manage, analyze, and report data.

Technical Capacity (10 points):

- The strength and effectiveness of the method proposed to monitor and evaluate the project results;
- 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;
- The extent to which the evaluation plan includes necessary components (descriptions of the inputs, key processes, variables to be measured, expected outcomes of the funded

activities, and how key measures will be reported), as well as a description of how the organization will collect and manage data in such a way that allows for accurate and timely reporting of performance outcomes;

- The extent to which the proposed evaluation plan to collect, monitor and evaluate the project outputs and outcomes is supported by appropriate program staffing and the applicant organization's infrastructure;
- The extent to which the applicant anticipates obstacles to the evaluation and proposes how to address those obstacles; and
- The extent to which the applicant describes the feasibility and effectiveness of plans for dissemination of project results.

Criterion 3(b): PROJECT SUSTAINIBILITY (5 points) – Corresponds to Section IV's Impact Sub-section (b) Project Sustainability

The extent to which the applicant describes a solid plan for project sustainability after the period of federal funding ends. The extent to which the applicant clearly articulates likely challenges to be encountered in sustaining the program, and describes logical approaches to resolving such challenges.

Criterion 4: ORGANIZATIONAL INFORMATION, RESOURCES AND CAPABILITIES (10 points) – Corresponds to Section IV's Organizational Information, Resources and Capabilities

- The extent to which project personnel are qualified by training and/or experience to implement and conduct the project. This will be evaluated through both the project narrative and the attachments;
- The capability and commitment of the applicant organization and partner organization(s), and quality and availability of personnel to carry out the proposed project;
- The extent to which the accreditation is appropriate for the lead applicant training program level and discipline/profession to be trained.
- The capability and commitment of the institution to providing culturally and linguistically competent and health-literate services;
- The extent to which the current community-based training settings and patient population will be appropriately assessed and improved during the proposed project;
- The extent to which current and existing resources will be made available to support the proposed project; and
- The extent to which the program and organization demonstrate evidence of success in the past in addressing diversity in the health workforce.

Criterion 5: SUPPORT REQUESTED (15 points) – Corresponds to Section IV's Budget Justification Narrative and SF-424 R&R budget forms

- The reasonableness of the proposed budget for each year of the project period, in relation to the objectives, the complexity of the research activities, and the anticipated results;
- The extent to which costs, as outlined in the budget and required resources sections, are reasonable given the scope of work;

- The extent to which key personnel have adequate time devoted to the project to achieve project objectives;
- The extent to which trainee stipends, fellowships, or traineeships are reasonable, supportive of the project objectives, and allowable; and
- **For applicants proposing a collaborative project**, the extent to which the budget reflects an equitable distribution to at least two of the designated training levels (student, resident, faculty, and practicing primary care physician or physician assistants) and in at least two of the primary care professions. Equitable does not require equal distribution of resources. Reviewers will take into account the different levels of resources required at the different levels of training or between the different disciplines/professions. Budgets must clearly detail the support for each of the training levels and professions/disciplines in order for reviewers to award points.

2. Review and Selection Process

Please see Section 5.3 of HRSA's [SF-424 R&R Application Guide](#).

Funding Preferences

HRSA will use other factors other than merit criteria in selecting applications for federal award. For this program, HRSA will use funding preference and special consideration.

This program provides a funding preference for some applicants as authorized by Section 791(a)(1) of the PHS Act. Applicants receiving the preference will be placed in a more competitive position among other eligible applications that can be funded. An applicant can only receive a maximum of one funding preference. Applications that do not receive a funding preference will be given full and equitable consideration during the review process. Whether or not an applicant receives a funding preference will be determined by the Objective Review Committee and then confirmed by HRSA Staff.

In order to qualify for a funding preference, the applicant must provide the required data for the identified lead applicant training program. The lead applicant training program must be from one of the following areas: family medicine, general internal medicine, general pediatrics, medical students, physician assistant students, or a faculty in these areas. **The requested data must be provided for the lead applicant institution and training program, i.e. the medical school, physician assistant school, residency program, or fellowship program.**

“Tracks,” such as primary care or rural tracks within existing institutions DO NOT qualify under either the Medical Underserved Community or the New Program funding preference qualification. Programs that have been significantly changed or improved with a new focus also do not qualify for the New Program funding preference qualification.

A funding preference will be granted to any qualified applicant that demonstrates that they meet the criteria for the preference(s) as follows:

Qualification 1: Medically Underserved Community (MUC) Funding Preference

This preference focuses on the number of completers from your program that were placed in Medically Underserved Communities (MUC). To apply you must provide and clearly label in Attachment 4 that you are requesting consideration for the **High Rate** calculation. You must provide all of the requested data shown below and you must include a description of how you determined graduate practice in a MUC, including which federal designations or definitions you used to identify practice in a MUC. A definition of MUC is provided in *Section VIII*. Failure to provide all required information will result in not meeting the funding preference. There are two ways to qualify, as outlined below.

A) High Rate

To qualify under **High Rate** you must demonstrate that the percentage of graduates/program completers placed in practice settings serving a MUC for the two academic years (AY) indicated below is greater than or equal to 30 percent for student trainees (i.e. medical and physician assistant students) or greater than or equal to 80 percent for resident or fellow trainees.

To calculate the MUC Preference by demonstrating High Rate with **medical school graduates**, the numerator will be the number of graduates from AY 2010-2011 who are currently practicing in a MUC added to the number of graduates in AY 2011-2012 who are currently practicing in a MUC. Medical school graduates who are currently in residency or fellowship training are not considered in practice and should not be included in the numerator. The denominator will be the total number of medical school graduates in AY 2010-2011 added to the total number of medical school graduates in AY 2011-2012. The applicant should report all graduates, regardless of their training's source of funding.

N₂₀₁₀₋₂₀₁₁– Numerator (2010-2011) = the number of AY 2010 -2011 medical school graduates currently in practice in an MUC

N₂₀₁₁₋₂₀₁₂– Numerator (2011-2012) = the number of AY 2011-2012 medical school graduates currently in practice in a MUC

D₂₀₁₀₋₂₀₁₁– Denominator (2010-2011) = the TOTAL number of medical school graduates in AY 2010-2011.

D₂₀₁₁₋₂₀₁₂– Denominator (2011-2012) = the TOTAL number of medical school graduates in AY 2011-2012.

$$\text{High Rate} = \frac{\text{N}_{2010-2011} + \text{N}_{2011-2012}}{\text{D}_{2010-2011} + \text{D}_{2011-2012}} \times 100$$

To calculate the MUC Preference by demonstrating High Rate for **all other graduates and program completers** (i.e. physician assistant graduates or residency program completers), the numerator will be the number of graduates/program completers from AY 2013-2014 who are currently in practice in a MUC added to the number of graduates/program completers from AY 2014-2015 who are currently in practice in a MUC. Any graduates that are currently in further training programs, such as residency programs, further traineeships or fellowships, are not considered in practice and should not be included in the numerator. The denominator will be the total number of graduates/program completers for AY2013-2014 added to the total number of

graduates/program completers in AY 2014-2015. The applicant should report all graduates/program completers, regardless of their training's source of funding.

$N_{2013-2014}$ – Numerator (2013-2014) = the number of AY 2013-2014 program completers in practice in a MUC

$N_{2014-2015}$ – Numerator (2014-2015) = the number of AY 2014-2015 program completers in practice in a MUC.

$D_{2013-2014}$ – Denominator (2013-2014) = the TOTAL number of program completers in AY 2013-2014.

$D_{2014-2015}$ – Denominator (2014-2015) = the TOTAL number of program completers in AY 2014-2015.

To calculate the rate of placement in practice settings, follow the formula below:

$$\text{High Rate} = \frac{N_{2013-2014} + N_{2014-2015}}{D_{2013-2014} + D_{2014-2015}} \times 100$$

B) Significant Increase

To qualify under **Significant Increase** you must demonstrate a **Percentage Point Increase** of 25% in the rate of placing program completers in practice in a MUC for the academic years indicated below.

To calculate the MUC Preference by demonstrating a Significant Increase with **medical school graduates**, calculate the difference between the percent of graduates between AY 2010-2011 and AY 2008-2009 who are currently practicing in a MUC. Medical school graduates in residency or fellowship training are not considered in practice and should not be included in the numerators.

$N_{2008-2009}$ – Numerator (2008-2009) = the number of AY 2008-2009 medical school graduates who are currently in practice in a MUC

$D_{2008-2009}$ – Denominator (2008-2009) = the TOTAL number of medical school graduates in AY 2008-2009

$N_{2010-2011}$ – Numerator (2010-2011) = the number of AY 2010-2011 medical school graduates who are currently in practice in a MUC

$D_{2010-2011}$ – Denominator (2010-2011) = the TOTAL number of medical school graduates in AY 2010-2011

To calculate the difference in percentages, please use the formula below:

$$\text{Percentage Point Increase} = ((N_{2010-2011}/D_{2010-2011}) - (N_{2008-2009}/D_{2008-2009})) \times 100$$

To calculate the MUC Preference by demonstrating significant increase **for all other graduates and program completers** (i.e. physician assistant graduates or residency program completers), calculate the difference between the percent of graduates/program completers in AY 2014-2015 and AY 2012-2013 who are currently practicing in a MUC. Any graduates that are currently in further training programs, such as residency programs or fellowships are not considered in practice and should not be included in the numerators.

$N_{2014-2015}$ – Numerator (2014-2015) = the number of AY 2014-2015 program completers who are currently in practice in a MUC

$D_{2014-2015}$ – Denominator (2014-2015) = the TOTAL number of program completers in AY 2014-2015.

$N_{2012-2013}$ – Numerator (2012-2013) = the number of AY 2012-2013 program completers who are currently placed in practice in a MUC

$D_{2012-2013}$ – Denominator (2012-2013) = the TOTAL number of program completers in AY 2012-2013.

To calculate the difference in percentages, please use the formula below:

$$\text{Percentage Point Increase} = ((N_{2014-2015}/D_{2014-2015}) - (N_{2012-2013}/D_{2012-2013})) \times 100$$

Note: New programs or programs that had no program completers in the indicated base years are not eligible to apply for the Medically Underserved Community (MUC) funding preference due to the absence of baseline data.

Qualification 2: New Program Funding Preference

New programs for the purpose of this FOA have completed training of less than three consecutive classes. As a result they lack the required data to apply for the MUC preference through the above qualification.

New programs can qualify for the New Program funding preference if they meet **at least four** of the following criteria as determined by the independent review panel, and have completed training for less than three consecutive classes as mentioned above:

- The training institution’s mission statement includes preparing health professionals to serve underserved populations.
- The curriculum of the program includes content which will help to prepare practitioners to serve underserved populations.
- Substantial clinical training in MUCs is required.
- A minimum of 20 percent of the clinical faculty of the program spend at least 50 percent of their time providing or supervising care in MUCs.
- The entire program or a substantial portion of the program is physically located in a MUC.

- Employment assistance is available for graduates entering positions in MUCs.
- The program provides a placement mechanism for helping graduates find positions in MUCs.

Although New Programs generally lack the required data to apply for the MUC preference, if the training program was closed for at least 3 years, during which time there were no students, graduates, or teaching activities, the applicant may request the *MUC Preference via the new program pathway*.

To apply for the MUC Preference as a new program, an applicant must submit a brief narrative entitled “New Program MUC Preference Request” in Attachment 4 that will:

- Describe how their program meets at least four of the seven criteria mentioned above;
- State the year the program was established and include a justification of eligibility if the program was closed for at least 3 years, as described above; and
- Provide the total number of graduates for each year, including the current year, since the training program began or resumed activity after a temporary closure as described above.

As mentioned above, new “tracks,” such as primary care or rural tracks within existing institutions DO NOT qualify under either the Medical Underserved Community or the New Program funding preference qualification. Programs that have been significantly changed or improved with a new focus also DO NOT qualify for the New Program qualification.

Funding Special Considerations

This program includes special consideration. A special consideration is defined as the favorable consideration of an application by HRSA funding officials, based on the extent to which the application addresses the specific area of special consideration. It is anticipated that of the total funds available, at least \$1,800,000 will be awarded to programs that provide training to physician assistant students, faculty, or practicing physician assistants.

In making the PCTE awards, geographic distribution will be taken into consideration when granting awards. HRSA anticipates funding at least one awardee in each of the ten HHS regions. Applications that do not receive special consideration will be given full and equitable consideration during the review process.

Please Note: HRSA may elect not to fund applicants with management or financial instability that directly relate to the organization’s ability to implement statutory, regulatory or other requirements ([45 CFR § 75.205](#)). 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 agency, official, or board.

3. Anticipated Announcement and Award Dates

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

VI. Award Administration Information

1. Award Notices

The Notice of Award will be sent prior to the start date of July 1, 2016. See Section 5.4 of HRSA's [SF-424 R&R Application Guide](#) for additional information.

2. Administrative and National Policy Requirements

See Section 2 of HRSA's [SF-424 R&R Application Guide](#).

3. Reporting

The successful applicant under this FOA must comply with Section 6 of HRSA's [SF-424 R&R Application Guide](#) and the following reporting and review activities:

1) **Progress Report(s).** The recipient must submit a progress report to HRSA on an **annual** basis. The Bureau of Health Workforce (BHW) will verify that approved and funded applicants' proposed objectives are accomplished during each year of the project.

The BHW Progress Report has two parts. The first part demonstrates recipient progress on program-specific goals. Recipients will provide performance information on project objectives and accomplishments, project barriers and resolutions, and will identify any technical assistance needs.

The second part collects information providing a comprehensive overview of recipient overall progress in meeting the approved and funded objectives of the project, as well as plans for continuation of the project in the coming budget period. The recipient should also plan to report on dissemination activities in the annual progress report.

Further information will be provided in the NoA.

2) **Performance Reports.** The recipient must submit a Performance Report to HRSA via the EHBs on a semi-annual basis. All BHW recipients are required to collect and report performance data so that HRSA can meet its obligations under the Government Performance and Results Modernization Act of 2010 (GPRA). Performance Reporting for BHW programs was newly implemented in Fiscal Year 2012. The required performance measures for this program are outlined in the Project Narrative Section IV's Impact Sub-section (a). Further information will be provided in the NoA.

The semi-annual performance reports will cover the following reporting periods:

Semi Annual Report #1 covers activities between July 1 and December 31. The report must be submitted by January 31 of the following year.

Semi Annual Report #2 covers activities between January 1 and June 30. The report must be submitted by July 31 of the same year.

3) **Final Report.** A final report is due within 90 days after the project period ends. The Final Report must be submitted online by recipients in the Electronic Handbook system at <https://grants.hrsa.gov/webexternal/home.asp>.

The Final Report is designed to provide BHW with information required to close out a grant after completion of project activities. Every recipient is required to submit a final report at the end of their project. The Final Report includes the following sections:

- Project Objectives and Accomplishments - Description of major accomplishments on project objectives.
- Project Barriers and Resolutions - Description of barriers/problems that impeded project's ability to implement the approved plan.
- Summary Information:
 - Project overview.
 - Project impact.
 - Prospects for continuing the project and/or replicating this project elsewhere.
 - Publications produced through this grant activity.
 - Changes to the objectives from the initially approved grant.

Further information will be provided in the NoA.

4) **Federal Financial Report.** A Federal Financial Report (SF-425) is required according to the schedule in the SF-424 R&R Application Guide. The report is an accounting of expenditures under the project that year. Financial reports must be submitted electronically through the EHB system. More specific information will be included in the NoA.

5) **Attribution.** HRSA requires recipients to use the following acknowledgement and disclaimer on all products produced by HRSA grant funds:

“This project is/was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number and title for grant amount (specify grant number, title, total award amount and percentage financed with nongovernmental sources). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.”

Recipients are required to use this language when issuing statements, press releases, requests for proposals, bid solicitations, and other HRSA supported publications and forums describing projects or programs funded in whole or in part with HRSA funding, including websites. Examples of HRSA-supported publications include, but are not limited to, manuals, toolkits, resource guides, case studies and issues briefs.

VII. Agency Contacts

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

Kimberly Ross, Grants Management Specialist
HRSA Division of Grants Management Operations, OFAM
Parklawn Building, Room 18-105
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 443-2353
Fax: (301) 443-6452
Email: kross@hrsa.gov

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

Anthony Anyanwu, Project Officer
Attn: Primary Care Training and Enhancement program
Bureau of Health Workforce, HRSA
Parklawn Building, Room 12C-06
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 443-8437
Fax: (301) 443-1945
Email: aanyanwu@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, 7 days a week, excluding federal holidays at:

Grants.gov Contact Center
Telephone: 1-800-518-4726 (International Callers, please dial 606-545-5035)
Email: 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. A logic model is a visual diagram that demonstrates an overview of the relationships between the 1) resources and inputs, 2) implementation strategies and activities, and 3) desired outputs and outcomes in a project. Information on how to distinguish between a logic model and work plan can be found at the following website:
<http://www.cdc.gov/healthyouth/evaluation/pdf/brief5.pdf>.

Technical Assistance: Call/Webinar

A technical assistance call has been scheduled for applicants as follows:

Date: Nov. 5, 2015
Time: 3-4:30 p.m. (ET)
Call-In Number: 1-800-369-1882
Participant Code: 1847935
Web link: https://hrsa.connectsolutions.com/pcte_foa/

A recorded replay of the webinar will be available after the call, through the closing date of the funding opportunity. The information for the webinar recording will be placed on our website:
<http://bhw.hrsa.gov/grants/medicine/pcte.html>.

Program Definitions

The following definitions apply to the PCTE program for FY 2016.

Accredited – The term “accredited” means a school or program that is accredited by a recognized body or bodies approved for such purpose by the Secretary of Education. In general, the relevant accrediting bodies are the Liaison Committee on Medical Education (LCME) for allopathic medical schools, American Osteopathic Association (AOA) for osteopathic medical schools and osteopathic residency programs, Accreditation Council for Graduate Medical Education (ACGME) for allopathic residency programs, and the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) for physician assistant programs.

Collaborative Project – For the purpose of this FOA, a collaborative project must include activities targeted at more than one training level or at least two (student, resident, faculty development, and practicing primary care physician or physician assistants) and more than one or at least two primary care professions. The lead applicant must be from one of the following professions disciplines: family medicine, general internal medicine, general pediatrics, medical students, physician assistant students, or faculty in any of these areas. All collaborative projects must include at least two of the following professions: primary care physicians, physician assistants, nurse practitioners, dentists, mental health providers, pharmacists, and other allied health professionals.

Disadvantaged Background – An individual from a disadvantaged background is defined as someone who comes from an environmentally *or* economically disadvantaged background.

- 1) **Environmentally disadvantaged** means an individual comes from an environment that has inhibited him/her from obtaining the knowledge, skills, and abilities required to enroll in and graduate from a health professions school.
- 2) **Economically disadvantaged** means an individual comes from a family with an annual income below a level based on low-income thresholds, according to family size established by the U.S. Census Bureau, adjusted annually for changes in the Consumer Price Index, and adjusted by the Secretary of the U.S. Department of Health and Human Services, for use in all health professions programs. The Secretary updates these [income levels in the Federal Register annually](#).

The Secretary defines a “low income family/household” for various health professions programs included in Titles III, VII and VIII of the Public Health Service Act, as having an annual income that does not exceed 200 percent of the Department’s poverty guidelines. A *family* is a group of two or more individuals related by birth, marriage, or adoption who live together. A *household* may be only one person.

2015 HRSA Poverty Guidelines (200% of HHS Poverty Guidelines)			
Size of parents’ family*	Income Level**		
	48 Contiguous States and D.C.	Alaska	Hawaii
1	\$23,540	\$29,440	\$27,100
2	\$31,860	\$39,840	\$36,660
3	\$40,180	\$50,240	\$46,220
4	\$48,500	\$60,640	\$55,780
5	\$56,820	\$71,040	\$65,340
6	\$65,140	\$81,440	\$74,900
7	\$73,460	\$91,840	\$84,460
8	\$81,780	\$102,240	\$94,020
For each additional person, add	\$8,320	\$10,400	\$9,560

* Includes only dependents listed on federal income tax forms. Some programs will use the student’s family rather than his or her parents’ family.

** Adjusted gross income for calendar year 2014.

SOURCE: *Federal Register*, Vol. 80, No. 51, March 17, 2015, pp. 13879-13880.

The following are provided as **examples** of a disadvantaged background. **These examples are for guidance only and are not intended to be all-inclusive. Each academic institution defines the below mentioned “low” rates based on its own enrollment populations. It is the responsibility of each applicant to clearly delineate the criteria used to classify student participants as coming from a disadvantaged background.** The most recent annual data available for the last four examples below can be found on your state’s Department of Education website under your high school’s report card.

- The individual comes from a family that receives public assistance (e.g., Temporary Assistance to Needy Families, Supplemental Nutrition Assistance Program, Medicaid, and public housing).
- The individual is the first generation in his or her family to attend college.
- The individual graduated from (or last attended) a high school with low SAT scores, based on most recent annual data available.
- The individual graduated from (or last attended) a high school that—based on the most recent annual data available— had either a:
 - low percentage of seniors receiving a high school diploma; or
 - low percentage of graduates who go to college during the first year after graduation.
- The individual graduated from (or last attended) a high school with low per capita funding.
- The individual graduated from (or last attended) a high school where—based on the most recent annual data available— many of the enrolled students are eligible for free or reduced-price lunches.

Diversity - refers to the multiplicity of human differences among groups of people or individuals. Increasing diversity means enhancing an individual's, group's, or organization's cultural competence; in other words, the ability to recognize, understand, and respect the differences that may exist between groups and individuals. Increasing diversity in the health care workforce requires recognition of many other dimensions including, but not limited to, sex, sexual orientation and gender identity, race, ethnicity, nationality, religion, age, cultural background, socio-economic status, disability, and language.

Health disparity population - a population that has a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates in the population, as compared to the health status of the general population. It further includes populations for which there is a significant disparity in the quality, outcomes, cost, use of, access to, or satisfaction with health care services, as compared to the general population.

Integrated health care delivery system – a delivery system which provides or aims to provide a coordinated continuum of services to a defined population and are willing to be held clinically and fiscally accountable for the outcomes and the health status of the population served. At a minimum the proposed system must include collaborative practice across disciplines, mechanisms to improve care coordination, and system level initiatives, such as integrated electronic health records or care protocols, to improve the quality of care provided.

Interprofessional education - occurs when two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes (WHO, 2010). The goals of interprofessional collaboration and education are to encourage increased knowledge of the roles and responsibilities of other disciplines, and to improve communication and collaboration among disciplines in future work settings.

Medically Underserved Community (MUC) - a geographic location or population of individuals that is eligible for designation by the federal government as a Health Professional Shortage Area, Medically Underserved Area, Medically Underserved Population, or Governor's Certified Shortage Area for Rural Health Clinic purposes. As an umbrella term, MUC also includes populations such as homeless individuals, migrant or seasonal workers, and residents of public housing. More information on HRSA shortage designations is available at: <http://www.hrsa.gov/shortage/>.

Organization - defined by having a unique Employer Identification Number (EIN). Only one application per Federal tax identification number can be submitted to the PCTE Program competition.

Primary Care – the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.¹²

Rural – a geographical area that is not part of a Metropolitan Statistical Area (MSA) To determine if a specific geographical area is considered rural, go to <http://datawarehouse.hrsa.gov/RuralAdvisor/RuralHealthAdvisor.aspx>.

Social Determinants of Health - The social determinants of health are the circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.¹³

Stipend – a payment made to an individual under a fellowship or training grant in accordance with established levels to provide for the individual's living expenses during the period of training. A stipend is not considered compensation for the services expected of an employee.

Team-Based care is delivered by intentionally created work groups of at least three types of health providers, who are recognized by others as well as by themselves as having a collective identity and shared responsibility for a patient, group of patients, their families, and/or communities to improve health outcomes. Characteristics of team-based care include: respect for diversity of skills and knowledge of team members, an open environment in which to raise concerns and make suggestions, an emphasis on comprehensive patient care and quality improvement, and team member willingness to take on additional roles and responsibilities.

Traineeship – funds for tuition, books, fees, and stipends that are awarded by the applicant to individuals.

Underrepresented minority – an individual from a racial and/or ethnic group that is considered inadequately represented in a specific profession relative to the numbers of that racial and/or

¹² Donaldson MS, Yordy KD, Lohr KN, Vanselow NA, Editors. Primary Care: America's Health in a New Era. Committee on the Future of Primary Care, Division of Health Care Services. Institute of Medicine. National Academy Press. Washington, D.C. 1996: p. 31.

¹³ World Health Organization: Social determinants of health. 2010. Retrieved August 17, 2015, from http://www.who.int/social_determinants/en/

ethnic group in the general population. For purposes of this program, the term “racial and ethnic minority group” means American Indians (including Alaska Natives, Eskimos, and Aleuts); Native Hawaiians and other Pacific Islanders; Blacks; and Hispanics. The term “Hispanic” means individuals whose origin is Mexican, Puerto Rican, Cuban, Central or South American, or any other Spanish-speaking country.

IX. Tips for Writing a Strong Application

See Section 4.7 of HRSA’s [*SF-424 R&R Application Guide*](#).

In addition, BHW has developed a number of recorded webcasts with information that may assist applicants in preparing a competitive application. These webcasts can be accessed at: <http://bhw.hrsa.gov/grants/technicalassistance/index.html>