U.S. Department of Health and Human Services

HRSA

Health Resources & Services Administration

Federal Office of Rural Health Policy

Community-Based Division

Small Health Care Provider Quality Improvement Program

Funding Opportunity Number: HRSA-22-093

Funding Opportunity Type: New

Assistance Listings (CFDA) Number: 93.912

NOTICE OF FUNDING OPPORTUNITY

Fiscal Year 2022

Application Due Date: March 21, 2022

Ensure your SAM.gov and Grants.gov registrations and passwords are current immediately!

HRSA will not approve deadline extensions for lack of registration.

Registration in all systems may take up to 1 month to complete.

Issuance Date: December 21, 2021

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Authority: Public Health Service Act, Title III, Section 330A(g) (42 U.S.C. 254c(g))

508 COMPLIANCE DISCLAIMER

Note: Persons using assistive technology may not be able to fully access information in this file. For assistance, please email or call one of the HRSA staff listed in Section VII. Agency Contacts.

EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA) is accepting applications for the fiscal year (FY) 2022 Small Health Care Provider Quality Improvement Program. The purpose of this program is to provide support to rural primary care providers, such as a critical access hospital, a rural health clinic, or a network of rural health providers, for the planning and implementation of quality improvement activities providing services to residents of rural areas.

Funding Opportunity Title:	Small Health Care Provider Quality Improvement Program
Funding Opportunity Number:	HRSA-22-093
Due Date for Applications:	March 21, 2022
Anticipated Total Annual Available FY 2022 Funding:	$8,000,000 subject to the availability of appropriated funds
Estimated Number and Type of Awards:	Up to 40 awards
Estimated Award Amount:	Up to $200,000 per year
Cost Sharing/Match Required:	No
Period of Performance:	August 1, 2022 through July 31, 2026 (4 years)

Eligible Applicants:	Eligible applicants must: • be a domestic rural public or rural nonprofit private health care provider or provider of health care services, such as a critical access hospital, a rural health clinic; • or be another rural provider or network of small rural providers identified by the Secretary as a key source of local or regional care; and • not previously have received an award under this subsection for the same or similar project. See Section III of this notice of funding opportunity (NOFO) for complete eligibility information.

Application Guide

You (the applicant organization/agency) are responsible for reading and complying with the instructions included in HRSA's *SF-424 Application Guide,* available online at http://www.hrsa.gov/grants/apply/applicationguide/sf424guide.pdf, except where instructed in this NOFO to do otherwise.

Technical Assistance

HRSA has scheduled the following technical assistance:

Webinar

Day and Date: Wednesday, January 26, 2022
Time: 2 – 3 p.m. ET
Call-In Number: 1-833-568-8864
Participant Code: 45653299
Weblink: https://hrsa-gov.zoomgov.com/j/1608411479?pwd=MDdBclFTTm8zK25ZWTZ2SDZPWHhadz09

NOTE: The webinar will be recorded and playback information can be requested at kpongsiri@hrsa.gov

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I. Program Funding Opportunity Description

1. Purpose

This notice announces the opportunity to apply for funding under the Small Health Care Provider Quality Improvement Program. The purpose of this program is to support the planning and implementation of quality improvement activities for rural primary care providers or providers of health care services, such as critical access hospitals (CAH), rural health clinics (RHC), or a network of rural health providers, serving rural residents.

The goal of the Small Health Care Provider Quality Improvement Program is to promote the development of a quality improvement culture and the delivery of cost-effective, coordinated, culturally appropriate, and equitable health care services in rural primary care settings. Specifically, program objectives include increased care coordination, enhanced chronic disease management, and improved health outcomes for patients. An additional program goal is to prepare rural health care providers for quality reporting and pay-for-performance programs. In order to achieve these goals and objectives, applicants are required to use an evidence-based model or promising practice to demonstrate the following **impact areas**, by the end of the four-year period of performance:

1) **Improved health outcomes**,
2) **Expanded capacity for essential health care services**, and
3) **Increased financial sustainability**.

Program activities include, but are not limited to, providing clinical health services for rural residents and conducting community health and prevention efforts for rural communities. Applicants are highly encouraged to address the underlying factors that are driving growing rural health disparities related to the five leading causes of avoidable death[1], which are heart disease, cancer, unintentional injury/substance use, chronic lower respiratory disease, and stroke. Previous award recipients implemented a range of activities, such as coordinating care among network members, leveraging use of new Centers of Medicare & Medicaid (CMS) billing codes under standard fee-for-service Medicare supporting chronic care management, and integrating mental/behavioral health services into the rural primary care setting. Refer to the program's Sourcebook and Grantee Directory for a summary of previously funded programs.

Although it is not a requirement, HRSA strongly encourages applicants to form a network and to consider including a RHC as a member in their proposal. Meeting the needs of rural communities relies on expanding our partnerships, expanding the reach of our impact on rural communities. For more details, see Program Requirements and Expectations.

[1] Garcia MC, Rossen LM, Bastian B, et al. Potentially Excess Deaths from the Five Leading Causes of Death in Metropolitan and Nonmetropolitan Counties — United States, 2010–2017. MMWR Surveill Summ 2019;68(No. SS-10):1–11. DOI: http://dx.doi.org/10.15585/mmwr.ss6810a1external icon.

2. Background

This program is authorized by the Public Health Service Act, Title III, Section 330A(g) (42 U.S.C. 254c(g)) and permits HRSA to support awards to rural primary care providers, such as critical access hospitals (CAH), rural health clinics (RHC), or a network of rural health providers, serving rural residents, for the planning and implementation of quality improvement activities.

The Institute of Medicine defines quality health care as care that is "safe, effective, patient-centered, timely, efficient, and equitable."[2] Engaging in ongoing quality improvement is essential for rural providers and communities to improve the health outcomes of the rural population, reduce the overall cost of care, and address the growing rural health disparities. Compared to their urban counterparts, rural residents are more likely to die from the five leading avoidable causes of death: heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke.[2,3,4] Rural residents have generally poorer health outcomes compared to their urban counterparts with higher prevalence of chronic diseases and mental illnesses.[5,6] Many of these challenges are longstanding and finding sustainable solutions have often lie beyond the clinical setting. Overcoming these challenges takes a collaboration of public health stakeholders and their partners to address a broader range of social determinants of health. The Federal Office of Rural Health Policy (FORHP) envisions its grant programs, such the Small Health Care Provider Quality Improvement Program, to support capacity building at the local level to improve health care delivery and health outcomes as part of the FORHP's ongoing Healthy Rural Hometown Initiative (HRHI). This effort intends to use grant funding to help rural communities develop successful and sustainable quality improvement strategies that target the five leading causes of avoidable death of heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke, address the underlying factors and social determinants of health, and ultimately overcome long-standing rural health disparities.

In addition to the growing rural health disparities between rural and urban areas, racial and ethnic minority populations in rural areas face even more challenges in terms of access to care and related health care challenges that are often overlooked.[7] Recognizing the link between health disparities and the five leading causes of avoidable death in rural communities, it is important to bridge the gap between social determinants of health[8] and other systemic issues that contribute to achieving health equity related to excess death. The Small Health Care Provider Quality Improvement Program supports creative programs that aim to confront these important public

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[2] CDC Center for Surveillance, Epidemiology, and Laboratory Services (CSELS). (2017). Leading Causes of Death in Rural America. Available at: https://www.cdc.gov/ruralhealth/cause-of-death.html.
[3] Moy E, Garcia MC, Bastian B, et al. Leading Causes of Death in Nonmetropolitan and Metropolitan Areas — United States, 1999–2014. MMWR Surveill Summ 2017. Available at: https://www.cdc.gov/mmwr/volumes/66/ss/ss6601a1.htm.
[4] Garcia MC, Rossen LM, Bastian B, et al. Potentially Excess Deaths from the Five Leading Causes of Death in Metropolitan and Nonmetropolitan Counties — United States, 2010–2017. MMWR Surveill Summ 2019;68(No. SS-10):1–11. DOI: http://dx.doi.org/10.15585/mmwr.ss6810a1external icon.
[5].Alfero C, Coburn A, Lundblad J, MacKinney A, McBride T, Mueller K, Weigel, P. (2015). Care Coordination in Rural Communities Supporting the High Performance Rural Health System. Rural Policy Research Institute. Available at: http://www.rupri.org/wp-content/uploads/2014/09/Care-Coordination-in-Rural-Communities-Supporting-the-High-Performance-Rural-Health-System.-RUPRl-Health-Panel.-June-2015.pdf.
[6] Rural Health Information Hub. (2019). Rural Health Disparities. Available at: https://www.ruralhealthinfo.org/topics/rural-health-disparities.
[7] James, C. V., R. Moonesinghe, S. M. Wilson-Frederick, J. E. Hall, A. Penman-Aguilar, and K. Bouye. 2017. "Racial/Ethnic Health Disparities Among Rural Adults -United States, 2012-2015." MMWR Surveill Summ66 (23): 1-9. https://doi.org/10.15585/mmwr.ss6623a1.
[8] Rural Health Information Hub, 2020. Social Determinants of Health for Rural People [online]. Rural Health Information Hub. Available at: https://www.ruralhealthinfo.org/topics/social-determinants-of-health.

health issues and address the needs of target population groups who have historically suffered from poorer health outcomes, health disparities and other inequalities. Applicants are encouraged to give special consideration to populations that have historically suffered from poorer health outcomes or health disparities, as compared to the rest of the rural population. Examples of these populations include, but are not limited to, Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; and persons otherwise adversely affected by persistent poverty or inequality.

II. Award Information

1. Type of Application and Award

Type of applications sought: New.

HRSA will provide funding in the form of a grant.

2. Summary of Funding

HRSA estimates approximately $8,000,000 to be available annually to fund up to 40 recipients. The actual amount available will not be determined until enactment of the final FY 2022 federal appropriation. You may apply for a ceiling amount of up to $200,000 total cost (includes both direct and indirect, facilities and administrative costs) per year. This program notice is subject to the appropriation of funds, and is a contingency action taken to ensure that, should funds become available for this purpose, HRSA can process applications and award funds appropriately.

The period of performance is August 1, 2022 through July 31, 2026 (4 years). Funding beyond the first year is subject to the availability of appropriated funds for the Small Health Care Provider Quality Improvement Program in subsequent fiscal years, satisfactory recipient progress, and a decision that continued funding is in the best interest of the Federal Government.

All HRSA awards are subject to the Uniform Administrative Requirements, Cost Principles, and Audit Requirements at 45 CFR part 75.

III. Eligibility Information

1. Eligible Applicants

Eligible applicants must:

- be a domestic rural public or rural nonprofit private health care provider or provider of health care services, such as a critical access hospital, a rural health clinic;
- or be another rural provider or network of small rural providers identified by the Secretary as a key source of local or regional care; and
- not previously have received an award under this subsection for the same or similar project (see Section 3. Other below for further details about HRSA Funding History).

The applicant organization must be located in a rural area.

2. Cost Sharing/Matching

Cost sharing/matching is not required for this program.

3. Other

HRSA may not consider an application for funding if it contains any of the non-responsive criteria below:

- Exceeds the ceiling amount
- Fails to satisfy the deadline requirements referenced in Section IV.4
- Exceeds the page limit.
- Fails to propose a service area that is entirely rural, as defined by the Rural Health Grants Eligibility Analyzer. All activities supported by the Small Health Care Provider Quality Improvement Program must exclusively occur in HRSA-designated rural areas. Please reference the Program Requirements and Expectations section for additional guidance.

HRSA Funding History

The applicant must not previously have received an award under this subsection for the same or similar project. Current and former award recipients of any HRSA/FORHP programs are eligible to apply if the proposed project is a new proposal for an entirely new project. Proposals that are an expansion or enhancement of a previously awarded project are only eligible if the applicant's proposal was previously awarded under a HRSA/FORHP program other than the Small Health Care Provider Quality Improvement Program. The proposal should differ significantly from previous projects by expanding the service area of the project, serving a new population, providing a new service or expanding the scope of the previous award activities. Project proposals submitted to supplant an existing program are not eligible and will not be accepted.

For organizations that are funded by HRSA's Health Center Program through Bureau of Primary Health Care (Section 330 of the Public Health Service Act (42 U.S.C. 254b)) and/or receiving support for the HRSA Accreditation and Patient-Centered Medical Home (APCMH) Recognition Initiative, any activities and personnel supported under this award must not be duplicative. Failure to explain how the funds will be managed and allocated separately to avoid duplicate funding may affect the score of your application. You are encouraged to develop innovative approaches to help your rural communities improve the health of your local population while including the community served in the development and ongoing operations of the program. See Attachment 11: Current and Previous HRSA Funding History Information for additional details and instructions.

Tribal Exception

HRSA is aware that tribes and tribal governments may have an established infrastructure without separation of services recognized by filing for EINs. In case of tribes and tribal governments, only a single EIN located in a HRSA-designated rural area is necessary to form a network/consortium, if applicable. Refer to *Attachment 10* for additional information on this exception.

Multiple EIN Exception

In general, multiple applications associated with the same DUNS number and/or EIN are not allowable. However, HRSA recognizes a growing trend towards greater consolidation within the health care industry and the possibility that health care organizations may share the same EIN as its parent organization. As a result, at HRSA's discretion, multiple health care organizations that share the same EIN as its parent organization or, organizations within the same consortium (if applicable) who are proposing different projects are eligible to apply by requesting an exception. Refer to *Attachment 10* for additional information on this exception.

Multiple Submissions

HRSA will only accept your **last** validated electronic submission, under the correct funding opportunity number, before the Grants.gov application due date as the final and only acceptable application.

Notifying Your State Office of Rural Health (SORH)

You are required to notify your SORH of your intent to apply to this program. A list of all National Organization for State Offices of Rural Health can be accessed at https://nosorh.org/nosorhmembers/nosorh-members-browse-by-state/. A copy of the letter or email sent to your SORH, and any response received to your letter or email submitted to your SORH describing your proposed project, is required to be included in *Attachment 3: Required Documentation from State Office of Rural Health (SORH) Letter.*

Applicants located in Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, American Samoa, the U.S. Virgin Islands, the Federated States of Micronesia, the Republic of the Marshall Islands, or the Republic of Palau that do not have the functional equivalent of a SORH are nevertheless eligible to apply.

IV. Application and Submission Information

1. Address to Request Application Package

HRSA ***requires*** you to apply electronically. HRSA encourages you to apply through Grants.gov using the SF-424 workspace application package associated with this notice of funding opportunity (NOFO) following the directions provided at Grants.gov: HOW TO APPLY FOR GRANTS.

The NOFO is also known as “Instructions” on Grants.gov. You must select “Subscribe” and provide your email address for HRSA-22-093 in order to receive notifications including modifications, clarifications, and/or republications of the NOFO on Grants.gov. You will also receive notifications of documents placed in the RELATED DOCUMENTS tab on Grants.gov that may affect the NOFO and your application. *You are ultimately responsible for reviewing the For Applicants page for all information relevant to this NOFO.*

2. Content and Form of Application Submission

Application Format Requirements

Section 4 of HRSA’s *SF-424 Application Guide* provides general instructions for the budget, budget narrative, staffing plan and personnel requirements, assurances, certifications, etc. You must submit the information outlined in the HRSA *SF-424 Application Guide* in addition to the program-specific information below. You are responsible for reading and complying with the instructions included in HRSA’s *SF-424 Application Guide* except where instructed in the NOFO to do otherwise. You must submit the application in the English language and in the terms of U.S. dollars (45 CFR § 75.111(a)).

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

Application Page Limitation

The total size of all uploaded files included in the page limit may not exceed the equivalent of **80 pages** when printed by HRSA. The page limit includes the project and budget narratives, and attachments required in the *Application Guide* and this NOFO.

Please note: Effective April 22, 2021, the abstract is no longer an attachment that counts in the page limit. The abstract is the standard form (SF) "Project Abstract Summary.” Standard OMB-approved forms included in the workspace application package do not count in the page limit. If you use an OMB-approved form that is not included in the workspace application package for HRSA-22-093, it may count against the page limit. Therefore, we strongly recommend you only use Grants.gov workspace forms associated with this NOFO to avoid exceeding the page limit. Indirect Cost Rate Agreement and proof of non-profit status (if applicable) do not count in the page limit. **It is therefore important to take appropriate measures to ensure your application does not exceed the specified page limit. Any application exceeding the page limit of 80 will not be read, evaluated, or considered for funding.**

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

Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification

1) You certify on behalf of the applicant organization, by submission of your proposal, that neither you nor your principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.

2) Failure to make required disclosures can result in any of the remedies described in 45 CFR § 75.371, including suspension or debarment. (See also 2 CFR parts 180 and 376, and 31 U.S.C. § 3354).

3) If you are unable to attest to the statements in this certification, you must include an explanation in *Attachment 13: Other Relevant Documents.*

Program Requirements and Expectations

Applicants for the Small Health Care Provider Quality Improvement Program must meet all of the requirements stated below. Failure to respond to the requirements below may impact your application's score.

Applicant Organization:

If the applicant is a nonprofit entity, one of the following documents must be included in *Attachment 1: Proof of Nonprofit or Public Status* to document nonprofit status *(will **not** count toward the page limit)*:

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

If the applicant is a public entity, proof of nonprofit status is not necessary. The applicant must submit an official signed letter on city, county, state or tribal government letterhead identifying them as a public entity in *Attachment 1: Proof of Nonprofit or Public Status.*

Management Requirements

The applicant should have the staffing and infrastructure necessary to oversee program activities, serve as the fiscal agent for the award, and ensure that local control for award is vested in the targeted rural communities. The organization must:

- Exercise administrative and programmatic direction over award-funded activities;
- Be responsible for hiring and managing award-funded staff;
- Demonstrate administrative and accounting capabilities to manage award funds;

- Have an Employer Identification Number (EIN) from the Internal Revenue Service; and
- Identify a Project Director who will have administrative and programmatic direction over award-funded activities.

All award recipients are encouraged to allocate adequate time, qualifications and expertise to successfully support the project's proposed data collection, tracking and analysis efforts, and effectively demonstrate the proposed project outcomes at the end of the four-year period of performance. HRSA strongly encourages award recipients to:

- Have at least one permanent staff at the time an award is made; and
- Have a minimum total equal to 2.0 full-time equivalent (FTE) allocated for implementation of project activities, met across two or more staffing positions, including the project director position.
- Refer to Evaluation and Technical Support Capacity narrative section under *Resources/Capabilities*, and *Attachment 7: Staffing Plan and Position Descriptions for Key Personnel,* for additional guidance.

Geographic Requirements

The applicant must be located in a HRSA-designated rural area, which is a non-metropolitan county or in a rural census tract of a metropolitan county.

- To determine rural eligibility, refer to the Rural Health Grants Eligibility Analyzer at https://data.hrsa.gov/tools/rural-health. This webpage allows potential applicants to search by county or street address to determine your rural eligibility. The applicant organization's county name must be filled in on the SF-424 Box 8, Section d. address. If the applicant is eligible by census tract, the census tract number must also be included next to the county name.

- In addition to the 50 states, only organizations in Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, American Samoa, the U.S. Virgin Islands, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau are eligible.

- If your organization is owned by or affiliated with an urban entity or health care system, the rural component may still apply as long as the rural entity has its own Employer Identification Number (EIN) and can directly receive and administer the funds in the rural area. The rural entity must be responsible for the planning, program management, financial management and decision making for the project, and the urban parent organization must assure HRSA in writing that, for the award, they will exert no control over or demand collaboration with the rural entity. This letter must be included in *Attachment 2: Letter from Urban Parent Organization.* If the applicant organization shares the same EIN as its parent organization or organizations within the same network/consortium (if applicable) are proposing different projects, and the applicant is eligible, then the applicant may request an exception in *Attachment 10*. Please see Multiple EIN Exception for additional details.

All activities and services supported by this program must exclusively target populations residing in HRSA-designated rural counties or rural census tracts. Proposed rural counties should be fully rural. For partially rural counties, please include the rural census tract(s) in the Project Abstract. Include a map of service area in *Attachment 8*.

Network Partnerships

The Small Health Care Provider Quality Improvement Program strongly encourages the establishment of a network or consortium to encourage relationships among service providers in rural areas. Examples of network member entities include rural and critical access hospitals, public health departments, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), home health providers, primary care service providers, social service agencies, community and migrant health centers, and civic organizations.

Technical Assistance

All award recipients will have the opportunity to work closely with technical assistance (TA) providers throughout the four-year period of performance. The targeted TA will assist award recipients with achieving desired project outcomes, sustainability and strategic planning, and will ensure alignment of the awarded project with the program goals. The TA is provided to award recipients at no additional cost. This support is an investment made by HRSA in order to ensure the success of the awarded projects. HRSA has found that most award recipients benefit greatly from the support provided through these collaborations. If funded, award recipients will learn more about the targeted technical assistance and evaluation support.

See Section 4.1 viii of HRSA's *SF-424 Application Guide* for additional information on all certifications.

Program-Specific Instructions

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

i. *Project Abstract*

Use the Standard OMB-approved Project Abstract Summary Form 2.0 that is included in the workspace application package. Do not upload the abstract as an attachment or it will count toward the page limitation. Please use the guidance below. It is most current and differs slightly from that in Section 4.1.ix of HRSA's *SF-424 Application Guide.*

Provide a summary of the application in the Project Abstract box of the Project Abstract Summary Form using 4,000 characters or less.

Because the abstract is often distributed to provide information to the public and Congress, prepare this so that it is clear, accurate, concise, and without reference to other parts of the application. It must include a brief description of the proposed project including the needs to be addressed, the proposed services, and the population group(s) to be served. If the application is funded, your project abstract information (as submitted) will be made available to public websites and/or databases including USAspending.gov.

ABSTRACT HEADER CONTENT
Applicant Organization Information: Organization Name, Address, Facility/Entity Type (e.g., CAH, tribal organization, FQHC, RHC, public health department, etc.) and Website
Designated Project Director Information: Project Director Name & Title, Contact Phone Numbers and E-Mail Address
Quality Improvement Project: Project Title and Goal(s), Requested award amount for each project year (Years 1-4)
ABSTRACT BODY CONTENT
Service Area Brief description of the service area, including a list of rural counties served o Entirely Rural Counties (list county names) o Partially Rural Counties (list city, state, zip code, and census tract). Applicants should specify whether the area is in a HRSA-designated rural county or rural census tract in an urban county. To ascertain whether a particular county or census tract is rural, refer to https://data.hrsa.gov/tools/rural-health.
Target Population Brief description of the target population the project proposes to serve and track
Network Partnerships *(if applicable)* Briefly describe the network including name and goals, Total number and facility/entity type of partner(s) comprising named collaboration
Quality Improvement Model(s) Brief description of the project's proposed quality improvement model approach(es) and application
Project Activities/Services Brief description of the proposed project activities and/or services
Expected Outcomes Brief description of the proposed expected outcomes. Clearly label and organize these expected outcomes by the Small Health Care Provider Quality Improvement Program's key **impact areas**: 1) Improved health outcomes, 2) Expanded capacity for essential health care services, and 3) Increased financial sustainability. Refer to the Logic Model section and Impact section for guidance.
Funding Preference If requesting a funding preference, ***place request for funding preference at the bottom of the abstract.*** Applicants must explicitly request a qualifying funding preference and cite the qualification that is being met. HRSA highly recommends you include this language: "***Applicant's organization name*** is requesting a funding preference based on ***qualification X***. *County Y is in a designated HPSA*" at the bottom of the abstract if requesting funding preference. If applicable, you need to provide supporting documentation in *Attachment 9: Funding Preference.*

NARRATIVE GUIDANCE

To ensure that you fully address the review criteria, the table below provides a crosswalk between the narrative language and where each section falls within the review criteria. Any forms or attachments referenced in a narrative section may be considered during the objective review.

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

ii. *Project Narrative*

This section provides a comprehensive description of all aspects of the proposed project. It should be succinct, self-explanatory, consistent with forms and attachments, and organized in alignment with the sections and format below so that reviewers can understand the proposed project.

Use the following section headers for the narrative: Introduction, Needs Assessment, Methodology, Work Plan, Resolution of Challenges, Evaluation and Technical Support Capacity, Organizational Information, and Budget.

- **INTRODUCTION -- Corresponds to Section V's** Review Criterion 1: NEED

Provide a brief overview of the target population and service area and the network members (if applicable) involved in the project. This section should clearly outline the purpose of the proposed project. It should summarize the project's goals, activities and expected outcomes as they relate to each of the Small Health Care Quality Improvement Program key impact areas: improved health outcomes, expanded capacity for essential health care services, and increased financial sustainability.

- **NEEDS ASSESSMENT -- Corresponds to Section V's Review Criterion 1: NEED**

Outline the community's need for the proposed project, and how the local community will be involved in the ongoing operations of the project. Describe how the target population was involved in determining the need and relevant barriers the project intends to overcome, and provide a geographical snapshot of the service area. A list of resources is located in Appendix B.

Use the following sub-headings for this section: *1.Target Population, 2. Barriers/Challenges, 3. Geographic Details of Service Area, and 4. Health Care in Service Area.*

1) Target Population

a. Identify and describe the target population and service area, including a list of rural county names that will receive the intervention services. If the target population and service area are the same, this must be stated and reflected in the description provided in response to this section. Refer to Program Requirements and Expectations: Geographic Requirements for rural service area requirements.

b. Use the following guidance in providing descriptions of the **target population** and **service area** in response to this section:
   - Social determinants of health and health disparities impacting the target population that include considerations to disparities based on race, ethnicity, gender identity, sexual orientation, geography, socioeconomic status, disability status, primary language, health literacy, access to transportation, and any other relevant elements;
   - Inclusion and selection criteria for the service area and target population should be clearly stated and should remain consistent across the four-year period of performance to minimize service and measurement disruptions should patients move, change or become deceased during project implementation;
   - Any relevant available local, state, federal and/or national data or rankings in describing unique patient population needs; and
   - Health care needs, including the identification of needs and how they will be met.
   - If applicable, relationship to project goals, which should include considerations to relationships with project focus on at least one of the five leading causes of avoidable death (heart disease, cancer, unintentional injury/substance use, chronic lower respiratory disease, and stroke).

c. ***Health Inequity among Target Population**:* Describe the population you propose to serve includes subpopulations who have historically suffered from poorer health outcomes, health disparities, and other inequities among the target population. These populations may include, but are not limited to: Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; and persons otherwise adversely affected by persistent poverty or inequality. Also, include information regarding the social determinants of health and health disparities affecting the population or communities served. Refer to Appendix C for the NOFO's definitions of equity and underserved communities.

d. Specify how the patients will be served, measured and tracked across the four-year period of performance.

2) Barriers/Challenges

Describe any barriers or challenges relevant to project implementation that the proposed project hopes to overcome. Socioeconomic, linguistic, cultural, ethnic or other relevant barriers should be discussed. Some examples in rural communities include, but are not limited to, access to health care services, Health Information Technology (HIT) interoperability, and health care professional shortages. Your response must include a plan to overcome any barriers identified. This should also, include any pertinent challenges and/or barriers related to project data, as well as steps that will be taken to resolve any challenges or barriers identified.

3) Geographic Details of Service Area

Describe geographical features for the proposed project service area. Description must include a map that clearly shows the entire service area and indicates any relevant geographic barriers (e.g., mountainous terrain). Ensure maps in Attachment 8 included are clear and are easily reproducible in black and white, as this is what reviewers will see.

4) Health Care in Service Area

Identify and describe any other existing health care services available in or near the proposed service area. This includes: 1) a rationale for why the existing health care services do not sufficiently meet the need of the service area and target population; 2) how the proposed project will address any health care service gap(s) for the service area; and 3) how this grant program is the best and most appropriate opportunity to address identified gap(s), including how other grant programs and/or resources are unable to fulfill these gaps, as appropriate.

Any potential adverse effects are particularly important to include in response to this section, as well as any estimates for how the project might augment and enhance any existing capabilities in the service area.

▪ METHODOLOGY -- Corresponds to Section V's Review Criteria 2: RESPONSE and 3: EVALUATIVE MEASURES

Propose methods that will be used to address the stated needs and meet each of the previously described program requirements and expectations in this NOFO.

Use the following sub-headings in responding to this section: *1. Goals & Objectives, 2. Quality Improvement Model(s), 3. Sustainability Approach and 4. Data Methodology Approach.*

1. ***Goals & Objectives***
    a. Define the specific goals and objectives of the proposed project. These goals and objectives should directly relate to the information presented in the *Introduction* and *Needs Assessment* narrative sections. The stated goals and objectives should be specific, measurable, realistic, and achievable in a specific timeframe.

    b. Align the goals with the Centers for Disease Control and Prevention (CDC)'s Healthy People 2030 Initiative, as may be feasible and applicable to do so. It is strongly encouraged that project goals and objectives align with the national initiatives, including alignment with additional quality improvement initiatives such as, but not limited to, the National Quality Strategy, Centers for Medicare & Medicaid (CMS) Rural Strategy, CDC Million Hearts, and the HHS Healthy Rural Hometown Initiative among others.

    c. ***Addressing Health Inequity*:** Describe how the project will address health inequity among target population and/or any subsets of the target population you propose to serve. Refer to Appendix C for the NOFO's definitions of equity and underserved communities.

    d. If applicable, discuss how the project plans to address at least one of the five leading causes of avoidable death (heart disease, cancer, unintentional injury/substance use, chronic lower respiratory disease, and stroke)

2. ***Quality Improvement Model(s)***
    a. Propose projects based on an evidence-based, effective, and/or promising practice quality improvement (QI) model(s) shown to be effective in addressing improvements to health care quality and patient health outcomes.

    b. Explicitly identify the proposed QI model(s), describe how the identified model(s) will contribute to improvements in patient health and care delivery, and detail how the model(s) framework will be applied, including how staff will be trained, the roles of staff in model(s) implementation and, if applicable, any network partner roles.

    c. Provide rationale for choosing the identified QI model(s) and justification for why the selected model(s) serves as the best selection for meeting project's proposed goals should also be included. All quality improvement model(s) identified should effectively align with the proposed project and clearly link to the proposed goals, objectives, activities and target population.

    d. Include a thorough rationale supporting how the proposed model(s), and any necessary adaptations, if appropriate and relevant to the identified model(s) application to the proposed project. Applicants must clearly explain the extent identified model(s) are tailored and/or modified and describe how the tailored model(s) are effective in meeting project goals, as applicable. HRSA recognizes few evidence-based QI models specific to rural communities exist. Given that rural communities differ across the country, non-rural specific evidence- based QI models may be utilized and adapted to fit for proposed projects. To best fit rural adaptation needs, effective or promising practices, as defined by the Rural Health Information (RHIhub) level of evidence criterion, will also be accepted when proposed with a comprehensive rationale and justification that is supportive to the

effective utilization of the identified proposed approach, as an alternative to utilization of an evidence based model approach. Refer to the [RHIhub's evidence-based toolkits] for additional program approaches that applicants can adapt to fit their community.

e. Align quality improvement initiatives, such as the Patient-Centered Medical Homes (PCMH), Value-Based Care (VBC), and HRSA/FORHP Healthy Rural Hometown Initiative (HRHI). Describe how the project's proposed quality improvement model(s) align with any relevant quality improvement initiatives and detail how alignments will be incorporated into project implementation, as applicable. In aligning with value-based care efforts, applicants are highly encouraged to look at all relevant payers (Medicare, Medicaid, tribal, private, etc.) and their specific value-based models. Toward that end, applicants are encouraged to engage payers early in the application phase to identify how the proposed QI approach can align with the value-based models.

3. Sustainability Approach

a. Develop a sustainability plan that addresses how the proposed project will continue after the Small Health Care Provider Quality Improvement Program federal funding has ended. HRSA strongly encourages applicants to focus on approaches that emphasize value across public and private insurers as an approach to sustainability. For example, leveraging use of new CMS billing codes under standard fee-for-service Medicare supporting chronic care management and population health and other resources can be a strategy for continuing proposed project activities after any award funding ends. For applicants serving Medicare Advantage (MA) enrollees, MA plans may see benefit in partnering with award recipients with a strong quality improvement focus. All MA organizations must have a Quality Improvement (QI) program as described in 42 CFR 422.152, and the primary goal of these QI programs is to sustain improvement in patient outcomes. Additionally, these QI programs must include a chronic care improvement program, and applicants that emphasize care coordination and population health could be seen as particularly valued partners by MA organizations.

b. For applicants serving Medicaid populations, develop a plan to engage with state Medicaid officials to explore how proposed project activities may align with state efforts to focus on value within the Medicaid population, both in standard fee-for-service and in Medicaid Managed Care, is also an encouraged consideration to sustainability strategies for applicants. Similarly, engagement with private payers is also an encouraged approach to consider for the maintenance of proposed project activities after award funding. Refer to the [Community Health Workers (CHW) Toolkit] and [Rural Diabetes Prevention Toolkit] on Implementing Sustainable Payment Models and Working with Policymakers and Payers.

c. Describe a sustainability plan that includes strategies and action steps to achieve sustainability and demonstrate a cohesive plan for sustaining the program impact and services. Applicants should include a description of potential sources of support for achieving sustainability.

- Sources of support could include, but are not limited to financial, in-kind, or the absorption of activities by network/consortium members. Examples of successful sustainable project impacts, activities and services achieved by previously funded Small Health Care Provider Quality Improvement Program projects include continuation of quality improvement strategies, ongoing work of consortia partners, policy change, changes in practice and culture within health institutions and communities, payment models, and the continued use of award-funded assets, among other strategies.

- Most successful sustainability strategies include a variety of sources of support and do not depend on federal funding to maintain program activities. Historically, successful award recipients have incorporated diverse funding strategies that include absorption of some activities by network/consortia partners (i.e., a partner takes on an award funded activity beyond the period of performance as part of their standard practice), earned income through third-party reimbursement or fees for services rendered, and other awards and charitable contributions. Refer to the Sustainability Planning Tools on how to better position your program for long-term sustainability.

d. Include a description addressing the feasibility of the proposed sustainability plan and the prospective implementation of the plan's action steps. HRSA understands sustainability plans may evolve as projects are implemented.

e. Consider participation in incentive programs and to leverage reimbursement strategies as a means for project sustainability. Incentives refer to improving the way providers are paid and offering incentive payments for providing high quality health care. This includes participation in value-based payment systems, such as accountable care organizations (ACO), patient centered medical homes (PCMH), bundled payments, and other shared savings models. Such incentives offer opportunities that can contribute to project sustainability. Similarly, reimbursement strategies leverage payment reimbursements for certain services to qualified patient populations. Many of the Centers for Medicare & Medicaid (CMS) programs, such as the Chronic Care Management and Diabetes Prevention Program, incentivize provision of preventive services and chronic disease management for Medicare patients, offering reimbursements when services are provided. For sustainability strategies involving participation in incentive programs and/or leveraging reimbursement strategies, applicants are asked to provide response to this section that also details the use of these approaches, as applicable, for project sustainability.

   Note: As part of receiving the award, award recipients are required to submit a final sustainability plan during the four year of the period of performance. Further information will be provided upon receipt of the award for those who are funded.

4. Data Methodology Approach

a. Utilize the Small Health Care Provider Quality Improvement Program measures, also referred to as Performance Improvement Measurement System (PIMS) measures, to demonstrate project outcomes and complete annual program and progress reporting requirements. All successful applicants are required to ensure capacity (i.e. staff time) and capability for PIMS reporting. A draft list of tentative PIMS measures can be referenced under *Appendix A*.

b. Provide a full list of any proposed project-specific measures for measurement of the project's ability to successfully meet project goals and objectives. Organize all the measures using the Small Health Care Provider Quality Improvement Program's key **impact areas**: 1) Improved health outcomes, 2) Expanded capacity for essential health care services, and 3) Increased financial sustainability. Strong measures include both process and outcome measures and consider patient health care needs and service delivery in a manner that minimizes burden, maximizes efficiencies for optimal patient and quality care outcomes. Strong measures are also trackable, measurable and capable of demonstrating improvements to patient health, quality and delivery of care. Alignment to national, state and local QI initiatives and/or available data sets, including health information exchanges, should also be considered for any project specific measures identified. Provide a list of project-specific measures as *Attachment 12: List of Project-Specific Measures*.

c. Address what health outcomes will be used to measure the proposed project's resulting improvements to patient health for the identified target population.

d. Describe how the proposed project will demonstrate improvements to the quality of care and delivery of services resulting from project implementation.

e. Describe how the target population are tracked for the purposes of completing the annual PIMS reporting requirement for this program. Additional guidelines and details regarding the service area and target population can be found under the *Needs Assessment* narrative section.

f. Describe the data methodology approach proposed for project data collection, tracking, measurement and utilization. Provide a plan for how data will be collected, tracked, analyzed, used and shared over the four-year period of performance. This should include plans for:

- Use of any available data, such as, but not limited to, patient disease registries, clinical quality measures, hospital utilization data, emergency department (ED) visits and/or 30-day readmission data, as appropriate.
- Plans for implementation of the data methodology approach (e.g., processes, workflows and other relevant operational elements);
- Staff capacity, capability and needs;
- Use of any HIT platforms, modules and/or system(s).
- Any pertinent local state and/or federal partnerships, collaborations and/or initiatives (including QI initiatives);
- Plans for how data will be shared with key stakeholders and HRSA, including providers of health care services and/or other health care professionals for clinical decision making, organizational staff and leadership, network/consortium and/or community partners (as applicable), and patients and rural community members.
- How the approach aligns with the proposed project's goals, QI model(s) and plans for sustainability.
- Plans for how data will be use to address health disparities.

g. Incorporate the use of Health Information Technology (HIT), if applicable, to support demonstration of overall proposed project impact. HIT is a critical component for improving the quality of care and patient health outcomes as HIT makes it is possible to generate and distribute timely and meaningful data and information to help providers and patients track and plan care. Some examples of HIT utilization from historically funded Small Health Care Provider Quality Improvement Program projects include use of HIT for assistance with the tracking, assessment and measurement of patient health outcomes, to participate in statewide Health Information Exchange or population health initiatives, to enhance mechanisms for participation in quality reporting programs and for the overall implementation and application of quality improvement intervention efforts.

- **WORK PLAN -- Corresponds to Section V's Review Criterion** 2: RESPONSE**,** 3: EVALUATIVE MEASURES**, and** 4: IMPACT

Describe and detail the implementation of proposed project activities for the duration of the four-year period of performance. For responses to this section, use the following sub-headings: *1. Work Plan, 2. Impact, 3. Replicability, 4. Dissemination Plan, and 5. Economic Impact Analysis.*

1. Work Plan

a. Submit a detailed work plan, in a narrative format, that clearly details the planned activities and steps necessary to accomplish each proposed project goal. Applicants must describe the proposed project work plan by providing a description that details the steps of proposed project implementation that will be used to achieve each project activity proposed for each year of four-year period of performance.

b. Provide a work plan narrative description that discusses, at minimum:
   - Proposed plans for project implementation (including actions steps for implementation);
   - Timeframes assigned for execution of the work plan for each year of the four-year period of performance;
   - Key personnel and/or partners responsible for implementing project activities;
   - Performance benchmarks for measuring progress and success of project implementation; and
   - A clear description of how the work plan output will be measured.

c. Use of a tabular format that uses rows and columns to display this information is strongly encouraged to applicants for effective organization of the work plan information. The table should include, and clearly illustrate, the project's goals, objectives, strategies, activities, outputs and outcomes, performance benchmarks for measuring progress of each activity and for measuring project outputs/outcomes, information on how project outputs will be measured, timeframes assigned for work plan execution during project implementation, and the individuals, organizational representatives, etc. responsible for carrying out each work plan activity. All work plans are required to **include a timeline for all 4 years of the period of performance**.

d. Clearly and coherently align with the proposed project goals and objectives and be time-bound, assigning appropriate timelines for project activity implementation for each year of the four-year period of performance. Responsible staff and/or network/consortium members should also be identified on the work plan for each project activity and/or activities.

e. ***Potential Impact on Health Inequity***: A description of any meaningful support and/or collaboration with key stakeholders in planning, designing and implementing all activities, the development of the application and the extent to which these contributors reflect the cultural, racial, linguistic and geographic diversity of the populations and communities served should be included.

f. The narrative description provided in response to this section should clearly align with the descriptions provided in response to your application's *Methodology* narrative section.

Note that HRSA is aware that work plans may change as projects are implemented; however, a project's likelihood of success is increased if there is a thorough and detailed work plan in the planning stages. Work plans provided in response to this section should also be included in response to *Attachment 4: Work Plan*.

2. Impact

a. Include a description that details the following impacts expected to result from the proposed project work plan implementation in response to this section:

- Expected impact on the health outcomes identified target population's health outcomes, social determinants of health, and health disparities. Include any impact or implications for the service area (local, state and national impacts/implications may also be included here); and;
- Expected impact on service area health care delivery and services; and
- Expected impact on the program's overall sustainability;

Note that all the expected impacts should be organized using the Rural Quality Program's key **impact areas**: 1) Improved health outcomes, 2) Expanded capacity for essential health care services, and 3) Increased financial sustainability.

This information should align with the content provided in the *Logic Model* narrative section and *Attachment 5: Logic Model and Narrative Description.*

b. Describe the expected or potential long-term changes and/or improvements in health status due to the program. HRSA recognizes that there are external factors attributing the effects of an activity or program to the long-term health outcome of a community. Examples of potential long-term impact could include, but are not limited to:

- Changes in morbidity and mortality;
- Maintenance of desired behavior;
- Policy implications;
- Reductions in social and/or economic burdens;
- Mitigation to access to care barriers; and/or
- Improvements to the quality and delivery of care, among others.

Note that all the expected impacts should be organized into the Small Health Care Provider Quality Improvement Program's key **impact areas**: 1) Improved health outcomes, 2) Expanded capacity for essential health care services, and 3) Increased financial sustainability.

3. Replicability

Describe the how the proposed project expected impact on the patient population may potentially be extended for use in similar communities with comparable needs. Applicants should also include any project results that may be nationally relevant and/or have relevant local or state implications regarding replicability. Response descriptions should include the degree to which the project activities may also be expanded to be used for larger scale implementation or for similar purposes for other relevant contexts or environments should also be included in this section, if applicable.

4. Dissemination Plan

Describe the plans and methods for dissemination of project results. Applicants must articulate a clear approach that addresses relevant targeted and broad audiences for dissemination of project information and results. The description should include a plan detailing how project information collected will be shared with varying stakeholders and an outline of the strategies and activities planned for informing respective target audiences and stakeholders (i.e., policymakers, research community, etc.), including the general public. How project results will be tailored to appropriate audiences for effective dissemination should also be included in the response described under this section.

5. Economic Impact Analysis

Provide a description in response to this section that identifies the anticipated impact the proposed project will have on the local rural economy. Note that all award recipients will be required to report on the proposed projects' economic impact at the end of the four-year period of performance using the Economic Impact Analysis Tool (EIA) as part of the annual PIMS reporting requirement. Using specially designed calculations of categories such as project spending, populations served and service locations, the EIA tool is able to provide an estimate for the impact of project spending. If awarded, all recipients will be required to apply the use of this tool to their respected grant project for successful completion of this reporting requirement.

- **RESOLUTION OF CHALLENGES -- Corresponds to Section V's Review Criterion 2: RESPONSE**

Discuss anticipated challenges to the proposed project design and implementation of activities described in the Work Plan and describe the approaches that will be used for resolving the anticipated challenges identified. Some challenges to consider include, but are not limited to:

- Designing and implementing the activities described in the work plan;
- Data collection capacity at each clinical site and how data will be shared linked, and de-identified among network partners and shared with the HRSA; the treatment of data and the corresponding legal and privacy considerations; and the corresponding staffing resources necessary for each network partner and the applicant organization to support successful data collection.
- External challenges such as staff turnover, geographic limitations, health workforce shortages, insurance, provider reimbursement, telehealth, support and/or adoption of new health IT platforms, technological barriers in data collection and documentation, and/or others.

- How to ensure the services provided address the cultural, linguistic, religious, and social differences of the target population.
- If applicable, keeping the network actively engaged throughout the period of performance; in particular maintaining communication and collaboration with the state Medicaid agency.

- **EVALUATION AND TECHNICAL SUPPORT CAPACITY -- Corresponds to Section V's Review Criteria 3: EVALUATIVE MEASURES, 4: IMPACT, and 5: RESOURCES/CAPABILITIES.**

Include a description of the proposed project plans for a performance self-assessment that contributes to attaining the proposed project goals, objectives and activities described in the narrative responses. Use the following sub-headings in responding to this section: *1. Performance Self- Assessment, 2. Logic Model, 3. Project Monitoring, and 4. Resources/Capabilities.*

This section should demonstrate your organizational capacity to assess and document progress towards your project goals, objectives and activities. Note that the Small Health Care Provider Quality Improvement Program award recipients will have an opportunity to work with a HRSA-funded technical assistance provider during the period of performance. HRSA will provide additional guidance on the technical assistance throughout the period of performance.

1. Performance Self-Assessment

a. Include ongoing performance self-assessment processes to document progress towards proposed project goals and objectives. Descriptions detailing inputs (e.g., organizational profile, collaborative partners, key staff, budget, and other resources), key processes, and expected outcomes of proposed project activities should be included in response to this section.

b. Provide a description which details the systems and processes planned to support management of project performance, including ability of the project to effectively track of performance outcomes, how data will be collected and managed (e.g., assigned skilled staff, data management software, etc.). Descriptions provided in response to this section should clearly align with project description responses provided under *Data Methodology Approach* section in the Methodology narrative section, and reference, as appropriate, the data collection strategies planned for the collection, analysis and tracking of project data to measure project process, outcomes and impact. Any potential obstacles identified for implementation of the proposed project's performance self-assessment, including how potential obstacles will be addressed should be provided in the description response to this section. HRSA will be conducting an independent program-wide self-assessment so applicants should focus their efforts under this review criterion solely to assessing and improving their own processes toward achieving the goals of the program.

2. Logic Model

a. Submit a logic model that illustrates the inputs, activities, outputs, outcomes, and impact of the project. The logic model submitted should be consistent with responses provided under *Data Methodology Approach* section, the *Impact* section, and Attachment 5: Logic Model and Narrative Description. A logic model is a simplified picture of a program, initiative, or intervention that presents the conceptual framework for project implementation. It should illustrate logical relationships among invested resources, activities implemented and the benefits or changes that result. An "outcomes approach" logic model attempts to logically connect program resources to strategic approaches and desired results, and hence is useful in evaluating a program. Applicants are required to include the project's logic model and narrative description in Attachment 5: Logic Model and Narrative Description.

b. Organize the expected program impacts into the Small Health Care Provider Quality Improvement Program's key **impact areas**: 1) Improved health outcomes, 2) Expanded capacity for essential health care services, and 3) Increased financial sustainability.

c. Based on your proposed activities, indicate which activities provide **a direct short-term outcome**, increasing the financial sustainability of your program. For example, your proposed activity is to apply for your state financial incentive payment through the State Recruitment Assistance Program after hiring an eligible health care professional. As a short-term outcome, your organization would receive an incentive payment amount for each qualifying physician, dentist, and any other qualified providers. Include this information in *Attachment 5: Logic Model and Narrative Description.*

The logic model provided must clearly include the following column headings*: inputs, activities, outputs, direct short-term outcomes, long-term outcomes, and key* ***impact areas****.* It is recommended that logic models should use a table format.

Note: Although there are similarities, a logic model is not a work plan. A work plan is an "action" guide with a timeline used during program implementation; the work plan provides the "how to" steps. Information on how to develop logic models can be found on the CDC Program Performance and Evaluation Office website.

3. Project Monitoring

Describe the proposed approaches to monitoring effective implementation of project activities. This description should also include details on the processes planned for prompt identification and assessment of potential inefficiencies or ineffective efforts as well as the strategies for resolving any unsuccessful project implementation efforts, including strategies for quality assurance and plans for the development and testing of any needed project modifications and/or adaptations. The responsible personnel and resources intended for the roles of leading and conducting project monitoring described in this section should also be identified and described.

4. Resources/Capabilities

Allocate adequate time, qualifications and expertise to successfully support the project's proposed data collection, tracking and analysis efforts, and effectively demonstrate the proposed project outcomes at the end of the four-year period of performance. In response to this section, provide a project staffing list and plan that align with these expectations. The following outlines what should be included for each of these items:

a. *Project Staffing List*

Include a full list of project positions that provides 1) position titles, 2) descriptions of the position roles and responsibilities, 3) associated personnel assigned to each respective position (if known) or the personnel experience desired (if unknown,) and 4) anticipated salary and FTE allocation.

HRSA **strongly recommends a team of at least three staff**, which includes: 1) a Project Director, 2) a provider or clinician (e.g., physician, nurse, nurse practitioner, physician assistant, etc.), and 3) a data/evaluation specialist. The Project Director role is expected to manage day-to-day responsibility for the project, including administrative and programmatic direction over award-funded activities and completion of grant program reporting requirements. The provider or clinician is expected to provide clinical technical expertise for the grant project and knowledgeable of the project's patient population. The data/evaluation specialist role should provide expertise and support for the collection, tracking, documentation, analysis, reporting, and utilization of project data. Additional roles and expertise recommended for consideration are skills and expertise in HIT and practice facilitation for quality improvement and operations.

HRSA strongly recommends that projects will have at least one permanent staff, if awarded, at the time award awards are made, whether or not this is the Project Director or interim Project Director Position. Refer to *Attachment 7: Staffing Plan and Position Descriptions for Key Personnel,* and Program Requirements and Expectations.

b. *Project Staffing Plan*

Complete a project staffing plan and include it under *Attachment 7: Staffing Plan and Position Descriptions for Key Personnel.* This plan should describe a clear and coherent plan for managing and staffing the proposed project, addressing the staffing requirements necessary to run the project that clearly and directly links staffing needs to the activities proposed in the applicant's project narrative and budget section responses. System and processes in place to address staff turnover in the event it should occur should also be included in this plan.

Specifically, the staffing plan should include the following:

- Job descriptions for key personnel listed in the application;
- Number and types of staff, respective qualifications, and FTE; and
- Information necessary to illustrate both the capabilities (current experience, skills, knowledge, and experience with previous work of a similar nature) of key staff already identified and the requirements that the applicant has established to fill other key positions if the award is received.

c. *Project Director*

Ensure the assigned Project Director possesses the appropriate management experience and will allot adequate time to the project. This should be evidenced and addressed as part of the description provided in this section. Provide information on the individual who will serve as the Project Director (or interim) for administrative and programmatic management and direction of the proposed project. In the event the applicant organization has an interim Project Director, also discuss the process and timeline for hiring a permanent project director for this award. Refer to *Attachment 7:*

Staffing Plan and Position Descriptions for Key Personnel and Program Requirements and Expectations under Management Requirements, as needed.

Note: It is preferred, not required, for the applicant organization to identify a permanent Project Director prior to receiving award funds.

- **ORGANIZATIONAL INFORMATION -- Corresponds to Section V's Review Criterion 5: RESOURCES/CAPABILITIES**

Use the following sub-headings when responding to this section: *1. Applicant Organization and 2. Network (if applicable).*

1. Applicant Organization

a. Provide a brief overview of the applicant organization and include information regarding mission, structure, and current primary activities.

b. Describe the organizational ability to manage the project and include information which describes an overview of the associated personnel responsible for supporting project implementation and any relevant executive-level oversight planned (e.g., CEO, CFO, etc.).

c. Provide an organizational chart of for the applicant organization and any relevant project partners, if applicable, under *Attachment 6: Applicant Organizational Chart and List.*

2. Network **(if applicable)**

a. If applicable, identify and briefly describe the contributions of the proposed network to the project in response to this section. Applicants should also include details regarding history of previous collaborations with named network, if applicable. How communication and coordination will occur between network members for the proposed project should also be clearly detailed.

b. If applicable, provide a list of all network partners proposed for direct involvement of proposed project implementation, along with any formal established signed Memorandum of Understanding/Agreement (MOU/A) documentation and/or letter of commitment among named network partners. If applicable, this information should be included under *Attachment 6: Applicant Organizational Chart and List*, and *Attachment 13: Other Relevant Documents* respectively.

c. If applicable, consider including a RHC as a member for this program. A RHC is a special certification given to health care practices in underserved rural areas by the Centers for Medicare & Medicaid Services (CMS). More than 4,600 Rural Health Clinics (RHCs) in 45 states make up a key part of the rural health care infrastructure and help address health equity gaps in medically underserved rural communities to improve health outcomes for rural residents.[9]

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[9] Centers for Medicare & Medicaid Services, 2019. Rural Health Clinic Fact Sheet. Available at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/RuralHlthClinfctsht.pdf

iii. *Budget*

The directions offered in the SF-424 Application Guide may differ from those offered by Grants.gov. Follow the instructions in Section 4.1.iv of HRSA's *SF-424 Application Guide* and the additional budget instructions provided below. A budget that follows the *Application Guide* will ensure that, if HRSA selects your application for funding, you will have a well-organized plan and, by carefully following the approved plan, may avoid audit issues during the implementation phase.

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

In addition, the Small Health Care Provider Quality Improvement Program requires the following:

Travel: You must allocate travel funds for up to two (2) program staff to attend an annual 2.5-day technical assistance workshop in Washington, DC and include the cost in this budget line item.

Contractual: You are responsible for ensuring that your organization or institution has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring all contracts. Consistent with 45 CFR 75, you must provide a clear explanation of the purpose of each contract, how the costs were estimated, and the specific contract deliverables.

As required by the Consolidated Appropriations Act, 2021 (P.L. 116-260), Division H, § 202 and Division A of the Further Continuing Appropriations Act, 2022 (P.L. 117-70), "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." See Section 4.1.iv Budget – Salary Limitation of HRSA's *SF-424 Application Guide* for additional information. Note that these or other salary limitations may apply in the following fiscal years, as required by law.

iv. *Budget Narrative*

See Section 4.1.v. of HRSA's *SF-424 Application Guide*.

In addition, the Small Health Care Provider Quality Improvement Program requires the following:

This notice invites applications for periods of performance up to four years. The budget narrative should describe expected spending for all four years of the project and align with the timeline in the work plan.

Competitive FY 2022 awards will be for a 1-year budget period, although periods of performance may be for four years. Budget period renewal and release of subsequent year funds are based on the award recipient's submission and HRSA approval of Progress Report(s) and any other required submissions or reports.

Funding beyond the first year is subject to the availability of appropriated funds for the Small Health Care Provider Quality Improvement Program in subsequent fiscal years, satisfactory progress, and a decision that continued funding is in the best interest of the Federal Government. You must allocate the award funding across each year of the four-year period of

performance. Applicants are required to submit 1-year budgets for each of the subsequent budget periods within the requested period of performance at the time of application.

Reminder: The Budget, SF-424A, and Budget Narrative amounts must align and cannot exceed the budget ceiling amount.

v. *Attachments*

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 limitation.** Your indirect cost rate agreement and proof of non-profit status (if applicable) will not count toward the page limitation. **Clearly label each attachment**. You must upload attachments into the application. Any *hyperlinked* attachments will *not* be reviewed/opened by HRSA.

Attachment 1: Proof of Nonprofit or Public Status *(If applicable)*

Applicant must include a letter from the IRS or eligible state entity that provides documentation of nonprofit status. In place of the letter documenting nonprofit status, public entities may indicate their type of public entity (state or local government) and include it here**.** Refer to Eligibility Information for more information. **This attachment will not count towards the 80-page limit.**

Attachment 2: Letter from Urban Parent Organization *(If applicable)*

If your organization is owned by an urban parent, the urban parent must assure HRSA/FORHP, in writing, that for this project, they will exert no control over the rural organization. If applicable, a letter stating this should be submitted in this attachment. **This attachment will not count towards the 80-page limit.**

Attachment 3: Documentation from State Office of Rural Health (SORH) Letter *(Required)*

Applicants are required to notify your respective SORH early in the application process of your intent to apply and request an email or letter confirming the contact with your SORH. At their own discretion, SORHs may also offer to write letters of support for your project. A copy of the letter or email confirming your contact with your SORH must be included with *Attachment 3*. If you do not receive a response from your SORH, you must submit a copy of your letter or email notifying your SORH of your intent to apply. **This attachment will count towards the 80-page limit.**

Attachment 4: Work Plan *(Required)*

Applicant must submit a Work Plan for the project that includes all information detailed in the content provided in the Work Plan narrative section as *Attachment 4*. Use of a tabular format that uses rows and columns to display this information is strongly encouraged to applicants for effective organization of the information. **This attachment will count towards the 80-page limit.**

Attachment 5: Logic Model and Narrative Description *(Required)*

Applicant must submit a logic model that illustrates the following column headings *inputs, activities, outputs, direct short-term outcomes, long-term outcomes, and key impact areas* of the project. Organize and clearly label the desired program impacts by the Small Health Care Provider Quality Improvement Program's key impact areas: 1) Improved health outcomes, 2) Expanded capacity for essential health care services, and 3) Increased financial sustainability. Based on your proposed activities, clearly indicate which activities provide **a direct short-term outcome** for sustainability. For example, your proposed activity is to apply for your state financial incentive payment through the State Recruitment Assistance Program after hiring an eligible

health care professional. The direct short-term outcome would be your organization receiving an incentive payment amount for each qualifying physician, dentist, and any other qualifying providers.

It is recommended that the logic model use a table format. This attachment should align with the content provided in the Logic Model and Impact narrative sections. **This attachment will count towards the 80-page limit.**

Attachment 6: Applicant Organizational Chart and List *(Required)*

Applicants are required to submit an organizational chart, a one-page figure that depicts organizational structure of the project. This attachment should align with the content provided in the Organizational Information narrative section. **This attachment will count towards the 80-page limit.**

If applicable, the network organizational chart should depict the structure of the network for the project and should describe how authority will flow from your organization receiving the federal funds to the network members.

If applicable, the network member organizational list should include each member of the existing network starting with the applicant organization first. It is recommended the list should use a table format and include the following column headings: *member name, member address, primary point of contact at organization, member Employer Identification Number (EIN), facility type (i.e., hospital, RHC, FQHC, etc.), sector (i.e., healthcare, public health, education, transportation, etc.), list of each member organizations' roles/responsibilities/contribution to the project, and specify (yes/no) whether member is located in a HRSA-designated rural area.*

Attachment 7: Staffing Plan and Position Descriptions for Key Personnel *(see Section 4.1. of HRSA's SF-424 Application Guide)* ***(Required)***

Applicants are required to submit a staffing plan and position descriptions of key personnel listed in the application for the proposed project. Minimum total assigned FTE allocation no less than 2.0 FTE for implementation of project activities met through two or more staffing positions, including the project director position is strongly encouraged. HRSA *strongly recommends* a team of *at least three staff*, which includes: 1) a *Project Director,* 2) a *provider or clinician* (i.e., physician, nurse, nurse practitioner, physician assistant, etc.), and 3) a *data/evaluation specialist*.

This plan should describe a clear and coherent plan for managing and staffing the proposed project (including FTE allocations) and include the job descriptions for key personnel listed in the application that describes the specific roles, responsibilities, and qualifications for each proposed position. Keep each position description to one page, if possible. For the purposes of this NOFO, key personnel is defined as persons funded by this award or persons conducting activities central to this program. Responses should align with the content in the Resources/Capabilities narrative section. **This attachment will count towards the 80-page limit.**

Attachment 8: Map of Service Area *(Required)*

Applicant must include a legible map that clearly shows the location of applicant organization and network members (if applicable), the geographic area that will be served by the project, and any other information that will help reviewers visualize and understand the scope of the proposed project activities. This attachment should align with the content provided in the Project Abstract

and *Needs Assessment* narrative sections. Note: Maps should be legible and in black and white. **This attachment will count towards the 80-page limit.**

Attachment 9: Proof of Funding Preference Designation/Eligibility *(if applicable*)

If requesting a funding preference, applicant must include a proof of funding preference designation or eligibility. Include a printout or screenshot that displays the HPSA and/or MUC/P designation and respective score: https://data.hrsa.gov/tools/shortage-area/by-address. The printout or screenshot of HPSA designation can also be found at: http://hpsafind.hrsa.gov and; MUAS/P designation can also be found at: http://muafind.hrsa.gov. **This attachment will not count towards the 80-page limit.**

Attachment 10: Exception Request *(if applicable)*

For Tribal Exception and Multiple EIN Exception requests, the following **must** be included:

- Names, titles, email addresses, and phone numbers for points of contact at each of the applicant organizations and the parent organization.
- Proposed project focus and service area for each applicant organization with the same EIN (these should not overlap) (applicable to Multiple EIN exception requests only).
- Justification for why each applicant organization within the same EIN must apply to this funding opportunity separately as the applicant organization, as opposed to serving as members on other applications (applicable to Multiple EIN exception request only).
- Assurance that the applicant organizations will each be responsible for the planning, program management, financial management, and decision making of their respective projects, independent of each other and/or the parent organization.
- Signatures from the points of contact at each applicant organization and the parent organization.

This attachment will not count towards the 80-page limit.

Attachment 11: Current and Previous HRSA Funding History Information *(if applicable)*

Current and former award recipients of any HRSA community-based programs from the last five (5) years who apply must include: dates of any prior award(s) received; grant number assigned to the previous project(s); and a copy of the abstract or project summary that was submitted with the previously awarded application(s). Note that funding under this program must be used for quality improvement (QI) activities that are not otherwise supported by other federal entities funding. For instance, Federally Qualified Health Center (FQHC) applicants must propose a project that is unique and separate from that being funded by the HRSA/BPHC Health Center Program operational funding. **This attachment will not count towards the 80-page limit.**

Attachment 12: List of Project-Specific Measures *(Required)*

Applicant must provide a full list of any proposed project-specific measures that will be used to measure resulting project improvements to patient health and delivery of care. Organize all the measures into the Small Health Care Provider Quality Improvement Program's key **impact areas**: 1) Improved health outcomes, 2) Expanded capacity for essential health care services, and 3) Increased financial sustainability. Strong measures are also trackable, measurable and capable of demonstrating improvements to patient health, quality and delivery of care. Alignment to national, state and local QI initiatives and/or available data sets, including health information exchanges, should also be considered for any project specific measures identified. Use of a tabular format that uses rows and columns to display this information is strongly encouraged to applicants for effective organization of the information. This attachment should align with the

content provided in the Methodology narrative section under *Data Methodology Approach*. **This attachment will count towards the 80-page limit.**

Attachments 13-15: Other Relevant Documents *(Optional)*

In this section, provide any other documents that are relevant to the application, including letters of support, letters of commitment, Memorandums of Understanding/Agreement (MOU/A), and data sharing agreements. Documentation regarding project support, collaboration and/or partnerships, such as the letters of support, must be dated, signed and indicate specific support and/or agreement for the project/program. All documentation such as MOU/A, data sharing agreements, contractual agreements, etc., must also include a designated timeframe for which the agreement is deemed active. **This attachment will count towards the 80-page limit.**

3. Dun and Bradstreet Data Universal Numbering System (DUNS) Number Transition to the Unique Entity Identifier (UEI) and System for Award Management (SAM)

You must obtain a valid DUNS number, also known as the Unique Entity Identifier (UEI), and provide that number in the application. In April 2022, the *DUNS number will be replaced by the UEI, a "new, non-proprietary identifier" requested in, and assigned by, the System for Award Management (SAM.gov). For more details, visit the following webpages: Planned UEI Updates in Grant Application Forms and General Service Administration's UEI Update.

You must register with SAM and continue to maintain active SAM registration with current information at all times during which you have an active federal award or an application or plan under consideration by an agency (unless you are an individual or federal agency that is exempted from those requirements under 2 CFR § 25.110(b) or (c), or you have an exception approved by the agency under 2 CFR § 25.110(d)). For your SAM.gov registration, you must submit a notarized letter appointing the authorized Entity Administrator.

If you are chosen as a recipient, HRSA will not make an award until you have complied with all applicable SAM requirements. If you have not fully complied with the requirements by the time HRSA is ready to make an award, you may be deemed not qualified to receive an award, and HRSA may use that determination as the basis for making an award to another applicant.

If you have 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.

*Currently, the Grants.gov registration process requires information in three separate systems:

- Dun and Bradstreet (https://www.dnb.com/duns-number.html)
- System for Award Management (SAM) (https://sam.gov/content/home | SAM.gov Knowledge Base)
- Grants.gov (https://www.grants.gov/)

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

In accordance with the Federal Government's efforts to reduce reporting burden for recipients of federal financial assistance, the general certification and representation requirements contained in the Standard Form 424B (SF-424B) – Assurances – Non-Construction Programs, and the Standard Form 424D (SF-424D) – Assurances – Construction Programs, have been standardized. Effective January 1, 2020, the forms themselves are no longer part of HRSA's application packages instead, the updated common certification and representation requirements will be stored and maintained within SAM. Organizations or individuals applying for federal financial assistance as of January 1, 2020, must validate the federally required common certifications and representations annually through SAM.gov.

If you fail to allow ample time to complete registration with SAM or Grants.gov, you 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 NOFO is *March 21, 2022 at 11:59 p.m. ET*. HRSA suggests submitting applications to Grants.gov at least **3 calendar days before the deadline** to allow for any unforeseen circumstances. See Section 8.2.5 – Summary of emails from Grants.gov of HRSA's *SF-424 Application Guide* for additional information.

5. Intergovernmental Review

The Small Health Care Provider Quality Improvement Program is a program subject to the provisions of Executive Order 12372, as implemented by 45 CFR part 100.

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

6. Funding Restrictions

You may request funding for a period of performance of up to 4 years, at no more than $200,000 per year (inclusive of direct **and** indirect costs). This program notice is subject to the appropriation of funds, and is a contingency action taken to ensure that, should funds become available for this purpose, HRSA can process applications and award funds appropriately. 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.

The General Provisions in Division H of the Consolidated Appropriations Act, 2021 (P.L. 116-260) and Division A of the Further Continuing Appropriations Act, 2022 (P.L. 117-70) apply to this program. See Section 4.1 of HRSA's *SF-424 Application Guide* for additional information. Note that these or other restrictions will apply in following fiscal years, as required by law.

You cannot use funds under this notice for the following purposes:

i. To build or acquire real property, or
ii. For construction or major renovation or alteration of any space; (see 42 U.S.C. 254c(h)).

You are required to have the necessary policies, procedures, and financial controls in place to ensure that your organization complies with all legal requirements and restrictions applicable to the receipt of federal funding including statutory restrictions on use of funds for lobbying, executive salaries, gun control, abortion, etc. Like all other applicable grants requirements, the effectiveness of these policies, procedures, and controls is subject to audit.

All program income generated as a result of awarded funds must be used for approved project-related activities. Any program income earned by the recipient must be used under the addition/additive alternative. You can find post-award requirements for program income at 45 CFR § 75.307.

Funding under this program must be used for quality improvement (QI) activities that are not otherwise supported by other federal entities funding. For instance, Federally Qualified Health Centers (FQHCs) applicants must propose a project that is unique and separate from that being funded by the Health Center Program operational funding or Quality Improvement Awards (QIA). You are encouraged to develop innovative approaches to help your rural communities improve the health of your local population while including the community served in the development and ongoing operations of the program.

V. Application Review Information

1. Review Criteria

HRSA has procedures for assessing the technical merit of applications to provide for an objective review and to assist you in understanding the standards against which your application will be reviewed. HRSA has critical indicators for each review criterion to assist you in presenting pertinent information related to that criterion and to provide the reviewer with a standard for evaluation.

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

Six (6) review criteria are used to review and rank the Small Health Care Provider Quality Improvement Program applications. Below are descriptions of the review criteria and their scoring points.

Review Criterion	Number of Points
1. Need	25
2. Response	25
3. Evaluative Measures	15
4. Impact	20
5. Resources/Capabilities	10
6. Support Requested	5
TOTAL POINTS	**100**

Criterion 1: NEED (25 points) – Corresponds to Section IV's INTRODUCTION and NEEDS ASSESSMENT

Sub-Criterion One: Introduction and Target Population (6 points)

a) The extent to which the applicant is able to provide an effective explanation justifying the reasons why federal funding is required to carry out the project.

b) The extent to which the applicant clearly describes project goals and objectives to address relevant health care, community, and target population needs.

c) The extent to which the applicant clearly describes the population (including the target population and service area, as applicable) for this project, including:
   i. Clear identification, definition, and inclusion criteria;
   ii. Details for how selection was determined;
   iii. Defined service area available to receive project services upon award, if funded;
   iv. Ability of the project to serve and meet the needs of the target population;
   v. Description and feasibility of the expected results for the target population; and
   vi. Description and appropriateness of how the local community and target population will be engaged in the proposed project.

Sub-Criterion Two: Health Inequity among Target Population (7 points)

d) The extent to which applicant clearly identifies and describes any subsets of the target population in the service area who have historically suffered from poorer health outcomes.

e) The extent in which applicant includes any relevant health disparities and social determinants of health, and other health inequities among the target population.

Sub-Criterion Three: Barriers/Challenges (6 points)

f) The extent to which the applicant uses and cites relevant local, state, national and/or federal data or rankings to further illustrate demographics, health care utilization and health status needs of target population proposed to be served.

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

Sub-Criterion Four: Geographic Details of Service Area, Health Care in Service Area (6 points)

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

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

j) The extent to which the applicant clearly identifies, defines and describes the quality improvement, patient health and health care services needs in alignment with the overarching proposed project purpose, goals, objectives, activities and expected outcomes.

Criterion 2: RESPONSE (25 points) – Corresponds to Section IV's METHODOLOGY, WORK PLAN, and RESOLUTION OF CHALLENGES

Sub-Criterion One: Goals & Objectives, QI Model(s), Work Plan, and Resolution of Challenges (10 points)

a) The extent to which the proposed project responds to the Small Health Care Provider Quality Improvement Program *Purpose* identified in the program description. This includes the extent to which the proposed applicant is able to describe project proposals with the potential to effectively:
   i. Expand and enhance the delivery of health care services in rural areas, including the expansion of access, coordination and quality of essential health care services;
   ii. Supports rural primary care providers;
   iii. Applies an appropriate evidence-based, effective or promising practice QI model(s) for project implementation;
   iv. If applicable, incorporate QI initiatives such as Patient-Centered Medical Home and Value Based Care;
   v. If applicable, address at least one of the five leading causes of avoidable death (heart disease, cancer, unintentional injury/substance use, chronic lower respiratory disease, and stroke); and
   vi. Show demonstrated improvements to rural patient health, quality and delivery of care as a result of the project at the end of the four-year period of performance.

b) The extent to which the applicant identifies and describes the project's Quality Improvement (QI) Model(s), including:
   i. Clear identification, description, and citation of project's QI model(s);
   ii. Appropriate rationale supporting why QI model(s) identified is the best selection for proposed project and will be effective in meeting project goals and objectives. ***Note:*** *If model(s) identified are not evidence-based, applicants should provide an appropriate rationale justifying model(s) as best approach for project and evaluated with consideration to this description provided, if applicable;*

iii. How the QI model(s) will be implemented, including description of any model modifications and/or rural adaption needs and how staff will be trained to use the QI model(s);
iv. How the QI model(s) will contribute to the improvement of care delivery and; and
v. If applicable, description of any network members' roles for implementation of QI model(s).

c) The extent to which the applicant is able to describe and clearly define specific, measurable, achievable, realistic, and time-bound goals for the project.

d) The extent to which the applicant discusses anticipated challenges to project implementation and the approaches for resolution.

e) The extent to which the applicant describes how project will improve care delivery, including how the project will engage patients and reduce real or perceived barriers to care.

Sub-Criterion Two: Addressing Health Inequity (5 points)

f) The extent to which the applicant describes how the project will address health equity among target population and/or any subsets of the target population in the service area who have historically suffered from poorer health outcomes.

Sub-Criterion Three: Sustainability Approach and Data Methodology Approach (10 points)

g) The extent to which the applicant identifies and describes the sustainability strategy plan in Sustainability Plan, including:
   i. Description of project activities to be sustained after the four-year period of performance ends;
   ii. Description of the action steps for sustainability plan implementation; and
   iii. Feasibility of the proposed sustainability plan;

h) The extent to which the applicant identifies and describes the project's data methodology approach, including:
   i. How data will be collected, tracked, assessed, utilized and shared;
   ii. How data will be utilized to address social determinants of health and health disparities;
   iii. How project staff will be trained to utilize the identified approach;
   iv. Description of any relevant collaborations or partnership engagement; and
   v. How well approach supports ability to track target population and demonstrate meaningful outcomes to improvements to patient health, quality and delivery of care.

i) If applicable, the extent to which the applicant describes plans to use Health Information Technology (HIT), including the description of the system for data collection (e.g., registry, electronic health record or other HIT), how HIT will be utilized during project implementation, description of any HIT personnel or training needs and description of any existing data sharing partner agreement(s) or plans to establish HIT data sharing partner agreement(s).

Criterion 3: EVALUATIVE MEASURES (15 points) – Corresponds to Section IV's METHODOLOGY, WORK PLAN, and EVALUATION AND TECHNICAL SUPPORT CAPACITY

Sub-Criterion One: Data Methodology Approach, Project Monitoring, Performance Self-Assessment (6 points)

a) The strength and effectiveness of the method(s) proposed for monitoring project performance and assessing implementation of project activities.

b) Evidence that the evaluative measures will be able to assess: 1) to what extent program objectives have been met and 2) to what extent these measures can be attributed to the project.

c) The extent to which the applicant lists and describes identified process and outcome project measures that will be used to evaluate effectiveness and measure success of project results.

d) The extent to which applicant describes how project plans to use data to measure, track and demonstrate project results to show improvements to health status, quality of care and delivery of services.

e) The extent to which the target population identified can effectively be used for measuring success of the project.

Sub-Criterion Two: Work Plan - Dissemination Plan and Replicability (5 points)

f) The extent to which the applicant describes the plans and strength of methods for disseminating project results which includes:

   i. How and with whom project information will be shared, including how project results will be tailored for relevant project audiences such as, but not limited to, providers of health care services and/or other health care professionals to inform clinical decision making, organizational leadership, community partners, patients, and network partners, if applicable.

g) The extent to which the applicant describes the potential extension or expansion of the proposed project to be used in similar communities with comparable needs or for other relevant context or environments.

Sub-Criterion Three: Resources/Capabilities (4 points)

h) The extent to which the applicant describes feasible and appropriate organizational, technical and personnel capacity to adequately track, collect and report data relating to all project performance measure categories, including HRSA PIMS requirements and any project-specific measures identified in *Attachment 12: List of Project-Specific Measures*.

Criterion 4: IMPACT (20 points) – Corresponds to Section IV's WORK PLAN and EVALUATION AND TECHNICAL SUPPORT CAPACITY

Sub-Criterion One: Work Plan and Logic Model (10 points)

a) The extent to which the applicant's work plan clearly describes the project goals, objectives, activities, outputs, outcomes, and timeframe for effective project implementation, including assignment of responsible staff and/or, if applicable, network members to each project work plan activity.

b) The extent to which the applicant provides an outcomes approach logic model that connects program resources with desired results/outcomes/impacts in Attachment 5: Logic Model and Narrative Description.

c) The extent to which the proposed project in the logic model connects the desired results/outcomes/impacts to the Small Health Care Provider Quality Improvement Program's *key* ***impact areas*** identified in the program.

d) If applicable, indicate in the logic model if any of these activities provide a direct short-term outcome, increasing the financial sustainability of your program.

Sub-Criterion Two: Impacts expected to result from the proposed project work plan implementation*, including potential impact on Health Inequity (5 points)*

e) The extent to which applicant clearly describes the potential impact on any subsets of the target population in the service area who have historically suffered from poorer health outcomes.

f) The extent in which applicant clearly describes the potential impact on any relevant health disparities and social determinants of health, and other inequities among the target population.

Sub-Criterion Three: Performance Self-Assessment and Project Monitoring (5 points)

g) The extent to which the applicant is able to clearly demonstrate how project measures described will effectively measure project impact on community, services and patient population needs.
h) The extent to which the applicant describes how the execution of project implementation is capable of achieving project goals.

i) The extent to which the applicant describes how delivery of health care will be improved as a result of the project.
   - If applicable, this may include addressing at least one of the five leading causes of avoidable death in rural areas (heart disease, cancer, unintentional injury/substance use, chronic lower respiratory disease, and stroke).

Criterion 5: RESOURCES/CAPABILITIES (10 points) – Corresponds to Section IV's EVALUATION AND TECHNICAL SUPPORT CAPACITY and ORGANIZATIONAL INFORMATION

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

b) Project personnel are qualified by training and/or experience to implement and carry out their roles described in the Staffing Plan as evidenced by Staffing Plan and Position Descriptions for Key Personnel (*Attachment 7*) that document the education, experience, and skills necessary for successfully carrying out the proposed project.

c) Adequate FTE time and effort are allocated with the appropriate skills and qualifications for designated project personnel to feasibly implement the proposed project.

d) The extent to which the project personnel are qualified and staffing capacity is adequate to successfully implement proposed project data collection, tracking and analysis efforts and support demonstration of indicated outcomes at the end of the four-year period of performance.

Criterion 6: SUPPORT REQUESTED (5 points) – Corresponds to Section IV's BUDGET AND BUDGET NARRATIVE

a) The reasonableness of the proposed budget for each year of the period of performance in relation to the objectives, the complexity of the activities, and the anticipated results. This includes:

   i. The extent to which costs, as outlined in the budget and required resources sections, are reasonable given the scope of work;
   ii. The extent to which the budget narrative demonstrates how the expected spending aligns with the timeline and work plan;
   iii. The extent to which key personnel have adequate time devoted to the project to achieve project objectives, and the application's budget provides sufficient detail about the role, responsibilities, FTE of each award-supported staff position; and
   iv. The extent to which key personnel have adequate time devoted to support the project's proposed data collection, tracking and analysis efforts for effective demonstration of indicated outcomes at the end of the four-year period of performance.

2. Review and Selection Process

The objective review process provides an objective evaluation of applications to the individuals responsible for making award decisions. The highest ranked applications receive consideration for award within available funding ranges. HRSA may also consider assessment of risk and the other pre-award activities described in Section 3 below. See Section 5.3 of HRSA's *SF-424 Application Guide* for more details.

For this program, HRSA will use funding preferences.

Funding Preferences

This program provides a funding preference for some applicants, as authorized by Section 330A(h)(3) of the Public Health Service (PHS) Act (42 U.S.C. 254c(h)(3). Applicants receiving the preference will be placed in a more competitive position among applications that can be funded. Applications that do not receive a funding preference will receive full and equitable consideration during the review process. HRSA staff will determine the funding factor and will grant it to any qualified applicant that demonstrates they meet the criteria for the preference(s) as follows:

Qualification 1: Health Professional Shortage Area (HPSA)

You can request this funding preference if the service area of the applicant is located in an officially designated health professional shortage area (HPSA). Applicants must include a screenshot or printout from the HRSA Shortage Designation website, which indicates if a particular address is located in a HPSA: https://data.hrsa.gov/tools/shortage-area in Attachment 9.

Qualification 2: Medically Underserved Community/Populations (MUC/MUPs)

You can request this funding preference if the applicant is located in a medically underserved community (MUC) or serves medically underserved populations (MUPs). Applicants must include a screenshot or printout from the HRSA Shortage Designation website that indicates if a particular address is located in a MUC or serves an MUP: https://data.hrsa.gov/tools/shortage-area in Attachment 9.

Qualification 3: Focus on primary care and wellness and prevention strategies

You can request this funding preference if their project focuses on primary care and wellness and prevention strategies. This focus must be evident throughout the project narrative in Attachment 9.

If requesting a funding preference, indicate which qualifier is being met in the ***Project Abstract*** **and** ***Attachment 9*****.** HRSA highly recommends that the applicant include this language to identify their funding preference request*:*

> *"Applicant's organization name is requesting a funding preference based on qualification X. County Y is in a designated HPSA; or in a MUC/MUP; or is focusing on primary care, and wellness and prevention strategies."*

If a funding preference is requested, documentation of funding preference must be included in ***Attachment 9: Funding Preference.*** Label documentation as *Proof of Funding Preference Designation/Eligibility*. If you do not provide appropriate documentation in Attachment 9, as described, you will not receive the funding preference.

Provide documentation of funding preference and label documentation as "Proof of Funding Preference Designation/Eligibility." See page 44 of the HRSA SF-424 Application Guide. You only have to meet **one** of the qualifications stated above to receive the preference. Meeting more than one qualification **does not** increase an applicant's competitive position.

3. Assessment of Risk

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

HRSA reviews applications receiving a favorable objective review for other considerations that include past performance, as applicable; cost analysis of the project/program budget; assessment of your management systems, ensuring continued applicant eligibility; and compliance with any public policy requirements, including those requiring just-in-time submissions. HRSA may ask you to submit additional programmatic or administrative information (such as an updated budget or "other support" information) or to undertake certain activities (such as negotiation of an indirect cost rate) in anticipation of an award. However, even at this point in the process, such requests do not guarantee that HRSA will make an award. Following review of all applicable information, HRSA's approving and business management officials will determine whether HRSA can make an award, if special conditions are required, and what level of funding is appropriate.

Award decisions are discretionary and are not subject to appeal to any HRSA or HHS official or board.

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

HRSA will report to FAPIIS a determination that an applicant is not qualified (45 CFR § 75.212).

VI. Award Administration Information

1. Award Notices

HRSA will release the Notice of Award (NOA) on or around the start date of August 1, 2022.

See Section 5.4 of HRSA's *SF-424 Application Guide* for additional information.

2. Administrative and National Policy Requirements

See Section 2.1 of HRSA's *SF-424 Application Guide*.

If you are successful and receive a NOA, in accepting the award, you agree that the award and any activities thereunder are subject to:

- all provisions of 45 CFR part 75, currently in effect or implemented during the period of the award,

- other federal regulations and HHS policies in effect at the time of the award or implemented during the period of award, and
- applicable statutory provisions.

Accessibility Provisions and Non-Discrimination Requirements

Should you successfully compete for an award, recipients of federal financial assistance (FFA) from HHS must administer their programs in compliance with federal civil rights laws that prohibit discrimination on the basis of race, color, national origin, disability, age and, in some circumstances, religion, conscience, and sex (including gender identity, sexual orientation, and pregnancy). This includes ensuring programs are accessible to persons with limited English proficiency and persons with disabilities. The HHS Office for Civil Rights (OCR) provides guidance on complying with civil rights laws enforced by HHS. See Providers of Health Care and Social Services and HHS Nondiscrimination Notice.

- Recipients of FFA must ensure that their programs are accessible to persons with limited English proficiency. For guidance on meeting your legal obligation to take reasonable steps to ensure meaningful access to your programs or activities by limited English proficient individuals, see Fact Sheet on the Revised HHS LEP Guidance and Limited English Proficiency.
- For information on your specific legal obligations for serving qualified individuals with disabilities, including reasonable modifications and making services accessible to them, see Discrimination on the Basis of Disability.
- HHS-funded health and education programs must be administered in an environment free of sexual harassment. See Discrimination on the Basis of Sex.
- For guidance on administering your program in compliance with applicable federal religious nondiscrimination laws and applicable federal conscience protection and associated anti-discrimination laws, see Conscience Protections for Health Care Providers and Religious Freedom.

Please contact the HHS Office for Civil Rights for more information about obligations and prohibitions under federal civil rights laws or call 1-800-368-1019 or TDD 1-800-537-7697.

The HRSA Office of Civil Rights, Diversity, and Inclusion (OCRDI) offers technical assistance, individual consultations, trainings, and plain language materials to supplement OCR guidance and assist HRSA recipients in meeting their civil rights obligations. Visit OCRDI's website to learn more about how federal civil rights laws and accessibility requirements apply to your programs, or contact OCRDI directly at HRSACivilRights@hrsa.gov.

Executive Order on Worker Organizing and Empowerment

Pursuant to the Executive Order on Worker Organizing and Empowerment, HRSA strongly encourages applicants to support worker organizing and collective bargaining and to promote equality of bargaining power between employers and employees. This may include the development of policies and practices that could be used to promote worker power. Applicants can describe their plans and specific activities to promote this activity in the application narrative.

Requirements of Subawards

The terms and conditions in the NOA apply directly to the recipient of HRSA funds. The recipient is accountable for the performance of the project, program, or activity; the appropriate expenditure of funds under the award by all parties; and all other obligations of the recipient, as cited in the NOA. In general, the requirements that apply to the recipient, including public policy requirements, also apply to subrecipients under awards, and it is the recipient's responsibility to monitor the compliance of all funded subrecipients. See 45 CFR § 75.101 Applicability for more details.

Data Rights

All publications developed or purchased with funds awarded under this notice must be consistent with the requirements of the program. Pursuant to 45 CFR § 75.322(b), the recipient owns the copyright for materials that it develops under an award issued pursuant to this notice, and HHS reserves a royalty-free, nonexclusive, and irrevocable right to reproduce, publish, or otherwise use those materials for federal purposes, and to authorize others to do so. In addition, pursuant to 45 CFR § 75.322(d), the Federal Government has the right to obtain, reproduce, publish, or otherwise use data produced under this award and has the right to authorize others to receive, reproduce, publish, or otherwise use such data for federal purposes, e.g., to make it available in government-sponsored databases for use by others. If applicable, the specific scope of HRSA rights with respect to a particular grant-supported effort will be addressed in the NOA. Data and copyright-protected works developed by a subrecipient also are subject to the Federal Government's copyright license and data rights.

3. Reporting

Award recipients must comply with Section 6 of HRSA's *SF-424 Application Guide* **and** the following reporting and review activities:

1) **Federal Financial Status Report (FFR).** A Federal Financial Report (FFR) is required at the end of each budget period. The report is an accounting of expenditures under the project that year. Financial reports must be submitted electronically through the HRSA Electronic Handbook System (EHB). More specific information will be included in the Notice of Award.

2) **Data Dashboard**. Award recipients will be expected to establish and submit a data dashboard of key project measures and resulting outcomes at the end of the first year of their period of performance and within 30 days of the end of year three or four of the period of performance. Data dashboards identify key project data to support the ongoing data collection, documentation and tracking across the four-year period of performance as well as resulting project outcome data. Further information will be provided upon receipt of the award.

3) **Sustainability Plan**. As part of receiving the award, award recipients are required to submit a final Sustainability Plan during the third or fourth year of their period of performance. Further information will be provided upon receipt of the award.

4) **Progress Report**. Award recipients must submit a progress report to HRSA on an **annual basis**. *Submission and HRSA approval of your Progress Report(s) triggers the budget period renewal and release of subsequent year funds.* This report demonstrates award recipient progress on program-specific goals. Further information will be provided in the award notice.

5) **Annual Performance Measures Report**. An annual performance measures report is required after the end of each budget period in the Performance Improvement Measurement System (PIMS). As part of the PIMS reporting during the fourth year of the period of performance, award recipients will also be expected to provide reporting on the economic impact of the project using the Economic Impact Analysis Tool. Upon award, award recipients will be notified of specific performance measures required for reporting.

6) **Closeout Report**. A draft closeout report is due within 30 days of the end of period of performance year four report and a final closeout within 90 days after the period of performance ends. The closeout report collects program-specific goals and progress on strategies; core performance measurement data; impact of the overall project; the degree to which the award recipient achieved the mission, goal and strategies outlined in the program; award recipient objectives and accomplishments; barriers encountered; and responses to summary questions regarding the award recipient's overall experiences over the entire period of performance. Further information will be provided in the award notice.

7) **Integrity and Performance Reporting.** The NOA will contain a provision for integrity and performance reporting in FAPIIS, as required in 45 CFR part 75 Appendix XII.

Note that the OMB revisions to Guidance for Grants and Agreements termination provisions located at 2 CFR § 200.340 - Termination apply to all federal awards effective August 13, 2020. No additional termination provisions apply unless otherwise noted.

VII. Agency Contacts

You may request additional information and/or technical assistance regarding business, administrative, or fiscal issues related to this NOFO by contacting:

Benoit Mirindi
Grants Management Specialist,
Division of Grants Management Operations, OFAM
Health Resources and Services Administration
5600 Fishers Lane, Mailstop 10SWH03
Rockville, MD 20857
Telephone: (301) 444-6606
Email: bmirindi@hrsa.gov

You may request additional information regarding the overall program issues and/or technical assistance related to this NOFO by contacting:

Kanokphan Mew Pongsiri
Public Health Analyst,
Attn: Small Health Care Provider Quality Improvement Program
Federal Office of Rural Health Policy
Health Resources and Services Administration
5600 Fishers Lane, Room 17W10D
Rockville, MD 20857
Telephone: (301) 443-2752
Email: kpongsiri@hrsa.gov

You may need assistance when working online to submit your application forms electronically. 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 dial 606-545-5035)
Email: support@grants.gov
Self-Service Knowledge Base

Successful applicants/recipients may need assistance when working online to submit information and reports electronically through HRSA's Electronic Handbooks (EHBs). Always obtain a case number when calling for support. For assistance with submitting in the EHBs, contact the HRSA Contact Center, Monday–Friday, 7 a.m. to 8 p.m. ET, excluding federal holidays at:

HRSA Contact Center
Telephone: (877) 464-4772 / (877) Go4-HRSA
TTY: (877) 897-9910
Web: http://www.hrsa.gov/about/contact/ehbhelp.aspx

VIII. Other Information

Technical Assistance

HRSA has scheduled following technical assistance:

Webinar

Day and Date: Wednesday, January 26, 2022
Time: 2 – 3 p.m. ET
Call-In Number: 1-833-568-8864
Participant Code: 45653299
Weblink: https://hrsa-gov.zoomgov.com/j/1608411479?pwd=MDdBclFTTm8zK25ZWTZ2SDZPWHhadz09

NOTE: The webinar will be recorded and playback information can be requested at kpongsiri@hrsa.gov

Tips for Writing a Strong Application

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

Appendix A: Performance Measures

Small Health Care Provider Quality Improvement Program Performance Improvement and Measurement System (PIMS)

For the purposes of this funding opportunity, FORHP has included a draft of the program measures. The final performance measures will be shared upon grant award and award recipients will be required to report on the performance measures annually.

1. **ACCESS TO CARE**: Number of unique individuals from target population who received direct services, type of direct service encounters provided.
2. **POPULATION DEMOGRAPHICS**: Number of people served by ethnicity, race, sex, sexual orientation, gender identity, age group (Children (0-12), Adolescents (13-17), Adults (18-64), Elderly (65 and over)) and insurance status/coverage.
3. **SUSTAINABILITY**: Sources of sustainability, additional program revenue and ratio for economic impact (use the HRSA's Economic Impact Analysis tool at https://www.ruralhealthinfo.org/econtool to calculate ratio).
4. **NETWORK**: Identify types and number of nonprofit organizations in the network, if applicable
5. **QUALITY IMPROVEMENT IMPLEMENTATION STRATEGIES**: Health Technology, Patient Care / Service Delivery, Provider Performance, Quality Improvement Methodology, Organizational Positioning and Accreditation
6. **UTILIZATION**: Emergency department (ED) rate and 30- day hospital readmission rate
7. **TELEHEALTH**: Number of Patient Care Sessions and Total number of miles saved
8. **CLINICAL MEASURES**: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease, Comprehensive Diabetes Care, Body Mass Index (BMI) Screening and Follow-Up, Controlling High Blood Pressure, Tobacco Use: Screening & Cessation Intervention, Screening for Clinical Depression and Follow-Up Plan
9. **OPTIONAL MEASURES**: Weight Assessment and Counseling for Children/Adolescents, Alcohol and Other Drug (AOD) Dependence Treatment, Hospital-Wide All-Cause Unplanned Readmission, Medication Reconciliation Post Discharge, Chronic Obstructive Pulmonary Disease (COPD) Inhaled Bronchodilator Therapy

Appendix B: Resources for Applicants

These sources may offer data and information that help you in preparing the application. Note that this list of resources is current as of December 2021.

Resources for Health Care Quality Improvement

- HHS Rural Action Plan: https://www.hhs.gov/sites/default/files/hhs-rural-action-plan.pdf
- Centers for Medicare and & Medicaid (CMS) Electronic Clinical Quality Improvement (eCQI) Measure Set https://ecqi.healthit.gov/
- CMS Quality Payment Program (QPP) Measures https://qpp.cms.gov/
- CMS Chronic Care Management (CCM) Measures: https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/chronic-care-management
- Healthcare Effectiveness Data and Information Set (HEDIS) http://www.ncqa.org/hedis-quality-measurement/hedis-measures
- National Quality Forum (NQF) Measures Set http://www.qualityforum.org/Measures_Reports_Tools.aspx
- NQF MAP Rural Healthcare Workgroup http://www.qualityforum.org/MAP_Rural_Health_Workgroup.aspx
- U.S. Preventive Services Task Force Clinical Guideline Recommendations https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations
- Centers for Medicare & Medicaid (CMS) Rural Strategy: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf
- Agency for Healthcare Research and Quality (AHRQ) Data: https://www.ahrq.gov/data/index.html
- HRSA Data Warehouse: https://data.hrsa.gov/
- National Center for Health Statistics: http://www.cdc.gov/nchs/
- AHRQ EvidenceNOW Advancing Heart Health in Primary Care https://www.ahrq.gov/evidencenow/index.html
- Health Resources and Services Administration (HRSA) Quality Toolkit https://www.ruralcenter.org/resource-library/hrsa-quality-improvement-toolkit
- Agency for Healthcare Research and Quality (AHRQ) Quality and Patient Safety: http://www.ahrq.gov/qual/qualix.htm
- Institute for Healthcare Improvement: http://www.ihi.org/Pages/default.aspx
- Office of the National Coordinator for Health Information Technology (ONC) Continuous Quality Improvement Strategies: https://www.healthit.gov/sites/default/files/tools/nlc_continuousqualityimprovementprimer.pdf
- ONC Health Information Technology Health IT Playbook: https://www.healthit.gov/playbook
- AHRQ Innovation Exchange http://www.innovations.ahrq.gov/
- Centers for Disease Control and Prevention (CDC) Guide to Community Preventive Services: https://www.cdc.gov/tobacco/stateandcommunity/comguide/index.htm
- Association of State and Territorial Health Officials: http://www.astho.org/Programs/Prevention/
- Care Management and Medicare Reimbursement Strategies for Rural Providers https://www.ruralhealthinfo.org/care-management
- CMS Connected Care: The Chronic Care Management Resource: https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/chronic-care-management

Resources for Mental/Behavioral Health Care Services

- HRSA Behavioral Health Website: https://www.hrsa.gov/behavioral-health
- SAMHSA Evidence-Based Practices Resource Center https://www.samhsa.gov/ebp-resource-center
- Rural Prevention and Treatment of Substance Abuse Toolkit https://www.ruralhealthinfo.org/toolkits/substance-abuse
- Rural Services Integration Toolkit https://www.ruralhealthinfo.org/toolkits/services-integration

General Resources

- National Area Health Education Center (AHEC) Organization: https://www.nationalahec.org/
- National Association of County and City Health Officials (NACCHO): http://archived.naccho.org/topics/infrastructure/mapp/
- Primary Care Associations (PCAs): http://www.nachc.org/about-nachc/state-affiliates/state-regional-pca-listing/
- State Rural Health Associations (SRHAs) https://www.ruralhealthweb.org/programs/state-rural-health-associations
- Kellogg Foundation Logic Model Development Guide: https://www.wkkf.org/resource-directory/resources/2004/01/logic-model-development-guide
- Centers for Disease Control and Prevention (CDC) Program Evaluation Resources https://www.cdc.gov/eval/index.htm

HRSA Resources

- Office of Regional Operations (ORO) https://www.hrsa.gov/about/organization/bureaus/oro/index.html
- Bureau of Primary Health Care (BPHC) Health Center Program https://bphc.hrsa.gov/
- National Health Service Corps (NHSC) https://nhsc.hrsa.gov/nhsc-sites/contacts/regional-offices-state-contacts.html

FORHP Resources

- Small Health Care Provider Quality Improvement Program Grantee Directory https://www.ruralhealthinfo.org/resources/15416
- Rural Health Information Hub (RHIhub) https://www.ruralhealthinfo.org/
- Community Health Gateway https://www.ruralhealthinfo.org/community-health
- Rural Health Research Gateway http://www.ruralhealthresearch.org/
- National Organization for State Offices of Rural Health (NOSORH) https://nosorh.org/nosorh-members/nosorh-members-browse-by-state/
- NOSORH Factsheet: https://nosorh.org/wp-content/uploads/2018/01/SORH-CBD-Factsheet-Final.pdf
- Community Organization Collaboration Video: https://www.youtube.com/watch?v=Tk3hGs6Btpc
- Quality Improvement Basics: A Collection of Helpful Resources for Rural Health Care Organizations https://mcrh.msu.edu/programs/CAH/Quality-Improvement-Basics-Rural-Health-Care-Professionals_Final_December%202016.pdf

Appendix C: Small Health Care Provider Quality Improvement Program Glossary

Culturally appropriate: Culturally and Linguistically Appropriate Services (CLAS) is services that are respectful of and responsive to each person's culture and communication needs. CLAS is a way to improve the quality of services provided to all individuals, which will ultimately help reduce health disparities and achieve health equity. Providing CLAS is one strategy to help eliminate health inequities. By tailoring services to an individual's culture and language preferences, health professionals can help bring about positive health outcomes for diverse populations. For more resources, visit https://thinkculturalhealth.hhs.gov/clas/what-is-clas

Equitable or Equity: "[T]he consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality."[10] Addressing issues of equity should include an understanding of intersectionality and how multiple forms of discrimination impact individuals' lived experiences. Individuals and communities often belong to more than one group that has been historically underserved, marginalized, or adversely affected by persistent poverty and inequality. Individuals at the nexus of multiple identities often experience unique forms of discrimination or systemic disadvantages, including in their access to needed services.[11]

Evidence-based model: An evidence-based QI model provides a framework to improve patient care and processes. QI models can help an organization or team to focus on changes that have already proven to be effective, and also provide guidance on different ways to approach change. Examples of evidence-based QI models that have been used historically by Small Health Care Provider Quality Improvement Program award recipients include models such as the Chronic Care Model, Lean Model, Lean Sigma Six and Model for Improvement, among others. These models have targeted efforts that have included QI outcomes, such as, transformation of health care delivery, improved patient safety, implementation of patient-centered care, establishment and utilization of integrated care teams, improvements to the coordination and continuum of care services, improvements to service delivery efficiencies, workflows, and coordination among clinical care teams, positioning for participation in QI incentive programs and improvements to care transitions, among others. Evidenced-based model must meets the following criteria: 1) a review study of the approach has been published in a peer- reviewed publication, 2) approach has been tried in more than

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[10] Executive Order 13985 on Advancing Racial Equity and Support for Underserved Communities through the Federal Government, 86 FR 7009, at § 2(a) (Jan. 20, 2021), https://www.govinfo.gov/content/pkg/FR-2021-01-25/pdf/2021-01753.pdf.

[11] Executive Order 13988 on Preventing and Combating Discrimination on the Basis of Gender Identity or Sexual Orientation, 86 FR 2023, at § 1 (Jan. 20, 2021), https://www.govinfo.gov/content/pkg/FR-2021-01-25/pdf/2021-01761.pdf.

one location or setting demonstrating overall positive results, and 3) though may vary by setting or location, approach has proven useful in all formal contexts.

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

Health Information Technology: For the purposes of this grant program, HIT may include, but is not limited to HIT systems such as, patient registries, electronic health record (EHR) system and/or other Health IT platforms, modules, portals, dashboards and/or interfaces. Though this program does not support funding for an EHR system, awarded organizations may use funds to develop or purchase a module, interface or other similar technology to customize reports for support of data collection, to advance interoperability and/or support improvements to the quality and delivery of services. Applicants who propose any allocation of award funds as described are required to provide an additional response under this section that addresses how the respective proposed use of award funds for HIT is essential to the achievement of proposed project goals. This justification should also align with the applicant's budget narrative response. Applicants are strongly encouraged to utilize EHR products certified by the Office of the National Coordinator for Health Information Technology (https://chpl.healthit.gov). Engagement in efforts to improve health information exchange and interoperability, including any statewide HIT efforts are also strongly encouraged.

Impact Areas: A set of expected short-term and long-term outcomes proposed by the applicants. For the purposes of this grant program, applicants are asked that their proposed program expected outcomes fall under or are organized by these three key impact areas: 1) improved health outcomes, 2) expanded capacity for essential health care services, and 3) increased financial sustainability.

Here are the Small Health Care Provider Quality Improvement Program's key impact areas and examples of their measures and expected outcomes:

2) IMPACT AREA: Improved patient health outcomes
    - Measure: percentages of clinical quality measures
    - Expected outcome: By the end of Year 4, my program will increase the number of patients with controlled high blood pressure from 30% to 50%.

3) IMPACT AREA: Expanded capacity of essential rural health care services
    - Measure: number of patients that receive direct services; integration of additional services such as mental/behavioral health into primary care setting; rate of care coordination among multiple providers; inclusion of telehealth service into existing practice
    - Expected outcome: By the end of Year 1, my program will increase the numbers of patients that receive direct services from 50 to 100.

4) IMPACT AREA: Increased financial sustainability
    - Measure: number of partnerships; sustainability monetary amount through a partnership with payers, leveraging value-based payments, reimbursement structures, and potential savings.
    - Expected outcome: By the end of Year 2, my team will engage with a state Medicaid official through an in-person meeting to explore how my proposed project activities may align with state efforts to focus on value within the Medicaid population, both in standard fee-for-service and in Medicaid Managed Care.

Network/Consortium: A formal organizational arrangement among separately owned health care providers or other entities that provide or support the delivery of health care services. The purpose of a network/consortium is to foster collaboration and integration of functions among network/consortium entities to strengthen the rural health care system**.**

Promising Practice: A model with at least preliminary evidence of effectiveness in small-scale interventions or for which there is potential for generating data that will be useful for making decisions about taking the intervention to scale and generalizing the results to diverse populations and settings."[12] An example of a promising practice is a small-scale pilot program that generates positive outcome results and justifies program expansion to new access points and/or service populations.

Rural Area: Project area determined rural as defined by HRSA Rural Health Grants Eligibility Analyzer: https://data.hrsa.gov/tools/rural-health?tab=Address

Service Area*:* The service area can be the same or different from the identified target population; this will depend on the nature of the proposed project, the specific services to be provided and the outcomes intended to be measured and tracked. The service area population identified must be able to serve as an effective measurement for the proposed project and will be the patient population that is reported in the annual PIMS reporting requirement. Service area population descriptions should be accompanied with justifications evident throughout the service area population narrative provided in response to this section.

Social Determinants of Health - Healthy People 2030: The Department of Health and Human Services (HHS) is committed to improving the health and well-being of the nation through Healthy People 2030 (HP2030). HP2030 establishes national health objectives with targets and monitors and catalyzes progress over time to measure the impact of research and prevention efforts. HHS defines social determinants of health as the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Social determinants of health can be grouped into 5 domains: economic stability; education access and quality; health care access and quality; neighborhood and built environment; social and community context. You can explore

[12] Department of Health and Human Services Administration for Children and Families Program Announcement. Federal Register, Vol. 68, No. 131, (July 2003), p. 40974.

evidence-based resources at the following link: Browse Evidence-Based Resources.

- CDC: CDC: Social Determinants of Health: Know What Affects Health
- CDC Social Vulnerability Index (SVI) County Maps: CDC's Social Vulnerability Index (SVI): County Maps
- HHS National Partnership to End Health Disparities: https://www.minorityhealth.hhs.gov/assets/pdf/npa/NPA_Toolkit.pdf
- Opportunity Zones: Guidance and Examples of language

Target Population: The target population is the population to be served by the project. It is usually a subset of the entire service area population, but in some cases, may include all residents of the service areas. Project proposals must identify a target population that is either the same or comparative to the service area identified for the project. Specifically, this requires you to identify a target population and a service area that effectively serve as measurements for proposed project goals and with the ability to demonstrate impact on improvements to patient health, quality and delivery of care. While some applicants may choose to select a target population that reflects the service area more broadly, others may choose to select a target population and service area that are the same population. Under either approach, applicants are expected to clearly describe the requested information to describe the target population in response to this section.

Underserved Communities: [The] populations sharing a particular characteristic, as well as geographic communities that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life, as exemplified by the list in the preceding definition of 'equity.[13]

[13] Executive Order 13985 on Advancing Racial Equity and Support for Underserved Communities through the Federal Government, 86 FR 7009, at § 2(b) (Jan. 20, 2021), https://www.govinfo.gov/content/pkg/FR-2021-01-25/pdf/2021-01753.pdf.