

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES



Federal Office of Rural Health Policy
Community-Based Division

Small Health Care Provider Quality Improvement Program
Funding Opportunity Number: HRSA-19-018
Funding Opportunity Type: New

Catalog of Federal Domestic Assistance (CFDA) No. 93.912

NOTICE OF FUNDING OPPORTUNITY

Fiscal Year 2019

Application Due Date: April 22, 2019

*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, including SAM.gov and Grants.gov,
may take up to 1 month to complete.*

Issuance Date: February 20, 2019

Katherine Lloyd, MPH
Public Health Analyst, Federal Office of Rural Health Policy
Telephone: 301-443-2933
Fax: 301-443-2803
Email: Klloyd@hrsa.gov

Authority: Public Health Service Act, Title III, Section 330A(g) (42 U.S.C. 254c(g)), as amended;
P.L. 115-245.

EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA) is accepting applications for the fiscal year (FY) 2019 Small Health Care Provider Quality Improvement Program (Rural Quality Program). The purpose of this program is to provide support to rural primary care providers, such as a critical access hospital or a rural health clinic, 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-19-018
Due Date for Applications:	April 22, 2019
Anticipated Total Annual Available FY2019 Funding:	\$6,400,000
Estimated Number and Type of Awards:	Up to 32 grants
Estimated Award Amount:	Up to \$200,000 per year
Cost Sharing/Match Required:	No
Period of Performance:	August 1, 2019 through July 31, 2022 (3 years)
Eligible Applicants:	<ul style="list-style-type: none">• Must be a rural public or rural nonprofit private health care provider or provider of health care services, such as a critical access hospital or a rural health clinic; and• Must not previously have received an award under this subsection for the same or similar project. <p>[See Section III-1 of this notice of funding opportunity announcement (NOFO) for complete eligibility information.]</p>

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: Tuesday, March 5, 2019

Time: 2:30-3:30 p.m. ET

Call-In Number: 1-800-593-7188

Participant Code: 4206450

Weblink: https://hrsa.connectsolutions.com/fy19_small_health_care_provider/

Webinar Recording: <https://www.mymeetings.com/mm/ims/d.php?o=8555765>

Playback Number: 800-310-4931

Passcode: 8468

Table of Contents

I. Program Funding Opportunity Description.....	1
1. Purpose.....	1
2. Background	2
II. Award Information.....	3
1. Type of Application and Award.....	3
2. Summary of Funding	3
III. Eligibility Information.....	3
1. Eligible Applicants	3
2. Cost Sharing/Matching	7
3. Other.....	7
IV. Application and Submission Information.....	8
1. Address to Request Application Package	8
2. Content and Form of Application Submission	8
i. Project Abstract.....	9
ii. Project Narrative.....	10
iii. Budget.....	28
iv. Budget Narrative	29
v. Attachments	29
3. Dun and Bradstreet Universal Numbering System Number and System for Award Management.....	32
4. Submission Dates and Times	32
5. Intergovernmental Review.....	33
6. Funding Restrictions	33
V. Application Review Information	33
1. Review Criteria.....	33
2. Review and Selection Process.....	38
3. Assessment of Risk and Other Pre-Award Activities	39
4. Anticipated Announcement and Award Dates.....	40
VI. Award Administration Information.....	40
1. Award Notices.....	40
2. Administrative and National Policy Requirements.....	40
3. Reporting	41
VII. Agency Contacts	42
VIII. Other Information.....	43
Appendix A.....	44
Appendix B.....	45

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 (Rural Quality Program). The purpose of the Rural Quality Program is to support planning and implementation of quality improvement activities for rural primary care providers or providers of health care services, such as a critical access hospital or a rural health clinic, serving rural residents. These activities include providing clinical health services to residents of rural areas by funding projects that coordinate, expand access, contain costs, and improve the quality of essential health care services.

The program goal is to promote the development of an evidence-based quality improvement culture and to promote the delivery of cost-effective, coordinated health care services in primary care settings. Successfully funded projects will enhance the delivery of health care in rural areas and demonstrate improvements in: 1) patient health outcomes for the rural communities served and 2) the delivery and quality of essential rural health care services by the end of the three-year period of performance. Additional objectives of the program include enhanced chronic disease management and increased engagement of patients and their caregivers.

In alignment with the Department of Health and Human Services' (HHS) and Health Resources and Services (HRSA) priorities and current rural health care needs, the FY 2019 Rural Quality Program additionally requests project proposals focus on rural chronic disease management and/or the integration of mental/behavioral health services into the rural primary care setting. You are also strongly encouraged to incorporate quality improvement initiatives that align with [Patient-Centered Medical Home](#) (PCMH) and [Value-Based Care Delivery](#) (VBC) approaches to care. Both PCMH and VBC apply the concepts of systematic and continuous quality improvement and will help position award recipients to provide high quality, affordable and accessible patient-centered health care services.^{1, 2}

Although it is not a requirement, HRSA strongly encourages applicants to form a consortium or network for this program. As health care delivery becomes an increasingly collaborative environment, HRSA finds the formation of partnerships for community-based projects an effective way to meet rural community needs, enhance organizational roles, and expand critical health care services and rural delivery systems. Further, consortia and networks can contribute great value to quality improvement initiatives through leveraging shared resources, information, and participation in incentive programs rewarding health care professionals for the provision of preventive and quality care services.

Funding under this program may be used to provide start-up funds for quality improvement initiatives that allow recipients to develop the necessary capacity and ability to obtain funding from other sources. Awarded organizations are not required to, but are permitted, to use funds to obtain or maintain nationally recognized

¹ Agency for Healthcare Research and Quality Patient Center Medical Home Resource Center. *Defining PCMH*. Accessed June 1, 2018 from: <https://pcmh.ahrq.gov/page/defining-pcmh>.

² New England Journal of Medicine. January 1, 2017. *What is Value-Based Healthcare?* Accessed June, 2018 from: <https://catalyst.nejm.org/what-is-value-based-healthcare/>.

quality improvement accreditation such as, PCMH by the National Committee for Quality Assurance (NCQA), among others. Applicants that are health departments and/or partner with health departments are particularly encouraged to pursue such accreditation. HRSA also recognizes how the focus on value among public and private insurers may further serve strategies for post-funding project sustainability. You are encouraged to consider leveraging value-based payment and reimbursement structures for maintaining proposed projects at the conclusion of federal funding, if awarded. Please refer to this NOFO's Project Narrative Methodology section [A. Goals and Objectives](#) and [C. Sustainability Approach](#) for more information and additional guidance on this topic.

HRSA recognizes rural health care organizations often provide a variety of essential health care services and, if awarded, does not restrict applicants from expanding or replicating proposed project activities as part of implementation efforts during the three-year period of performance. For additional information and guidance, please refer to the instructions included in the [Project Narrative](#) section.

2. Background

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

The Rural Quality Program FY 2019 NOFO will continue to include the program's overarching purpose and historical programmatic components, while also including additional focus on: 1) rural chronic disease management, 2) the integration of mental/behavioral health care services in rural primary care settings, and 3) the delivery of high-quality, affordable, patient-centered care through quality improvement initiatives.

The Role of Primary Care in Quality Improvement

Quality improvement in the primary care environment provides a valuable opportunity to address rural-specific quality and health improvement needs and is well positioned to address the many health risk factors disproportionately affecting rural populations, such as, cigarette smoking, hypertension, obesity, physical inactivity and poor nutrition; all of which largely contribute to the leading chronic disease conditions present among rural populations. Through timely disease treatment and management, primary care not only improves patient health, but also decreases health care costs associated with chronic disease, such as preventable emergency and inpatient hospital utilization, by coordinating care and helping patients to better understand and manage their health.^{3,4,5,6}

Integration of Mental/Behavioral Health into Primary Care Settings

Mental/behavioral health services for chronic disease conditions, mental health conditions, and substance use disorders help to connect patients with care and services

³ Centers for Disease Control and Prevention. January 13, 2017. *Reducing Potentially Excess Deaths from the Five Leading Causes of Death in the Rural United States*. Accessed June, 2018 from: https://www.cdc.gov/mmwr/volumes/66/ss/ss6602a1.htm?s_cid=ss6602a1_w

⁴ <https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/chartbooks/qdr-ruralhealthchartbook-update.pdf>

⁵ Centers for Disease Control and Prevention. January 13, 2017. *Leading Causes of Death in Nonmetropolitan and Metropolitan Areas-United States, 1999–2014*. Accessed June, 2018 from: https://www.cdc.gov/mmwr/volumes/66/ss/ss6601a1.htm?s_cid=ss6601a1_w

⁶ Agency for Healthcare Quality and Research. October, 2017. *National Healthcare Quality and Disparities Report Chartbook on Rural Healthcare*. Retrieved June, 2018 from: <https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/chartbooks/qdr-ruralhealthchartbook-update.pdf>.

that encompass patient health care needs more broadly, improving overall patient health and wellness. Research on rural patient health suggest the integration of mental/behavioral health care services into primary care settings addresses major mental/behavioral health needs disproportionately affecting rural populations, strengthening the health care delivery system and leading to improved patient outcomes.

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 expects approximately \$6,400,000 available annually to fund up to 32 recipients. 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. The period of performance is August 1, 2019 through July 31, 2022 (3 years). Funding beyond the first year is dependent on the availability of appropriated funds for the Small Health Care Provider Quality Improvement Program in subsequent fiscal years, satisfactory recipient performance, and a decision that continued funding is in the best interest of the Federal Government.

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

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

A. Organization Requirements

Eligible applicants must be a rural public or rural nonprofit private health care provider or provider of health care services, such as a critical access hospital or a rural health clinic; or network of small rural providers; and must not previously have received an award under this subsection for the same or similar project. For the purposes of this program, "health care provider" may include, but is not limited to, entities such as black lung clinics, hospitals, public health agencies, home health providers, mental health centers and providers, substance abuse service providers, rural health clinics, primary care providers, oral health providers, social service agencies, health profession schools, local school districts, emergency services providers, community health centers/federally qualified health centers, tribal health programs, churches, and civic organizations that are providing health care services.

- i. 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.
- ii. If the applicant is a public entity, proof of nonprofit status is not necessary. The applicant must submit an official signed letter on city, county, state or tribal government letterhead identifying them as a public entity in [Attachment 1](#). Applicants may include supplemental information such as documentation of the law that created the organization or documentation showing that the state or a political subdivision of the state controls the organization. Tribal government entities should verify their federally recognized status via the Bureau of Indian Affairs: <http://www.indianaffairs.gov/>.
- iii. The Rural Quality Program strongly encourages the establishment of a consortium to encourage relationships among service providers in rural areas. Examples of consortium 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.
- iv. Organizations and/or consortia are **not eligible** if they have previously received an award for the Small Health Care Provider Quality Improvement Program (Rural Quality Program) for the same or a similar project. This program will **not** award projects for the same or similar projects previously awarded under the Rural Quality Program. This includes proposals considered an expansion or enhancement of previously awarded Rural Quality Program projects. **Current and former award recipients** of any HRSA community-based 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 program *other than* the Rural Quality 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. Please provide a one-page synopsis for all previously funded HRSA projects in **Attachment 12: Other Relevant Documents**.

- v. For organizations that are also funded by [HRSA's Health Center Program](#) (Section 330 of the Public Health Service Act (42 U.S.C. 254b)) and/or receiving support for the [HRSA Patient-Centered Medical Home \(PCMH\) Recognition Initiative](#), please be advised that activities and personnel supported under this award **must not be duplicative** of those funded by the HRSA Health Center Program. Failure to thoroughly explain how the funds will be managed and allocated separately to avoid duplicate payment between Section 330A awards and this NOFO may affect the score of your application.
- vi. Foreign entities are not eligible for HRSA awards, unless the authorizing legislation specifically authorizes awards to foreign entities or the award is for research. This exception does not extend to research training awards or construction of research facilities.

B. Geographic Eligibility Requirements

The applicant organization must be located in a non-metropolitan county or in a rural census tract of a metropolitan county and all services must be provided in a non-metropolitan county or rural census tract.

- i. If the applicant organization's headquarters are located in a metropolitan or urban county, that also serves or has branches in a non-metropolitan or rural county, the applicant organization is not eligible solely because of the rural areas they serve, and must meet all other eligibility requirements.
- ii. To ascertain rural eligibility, please refer to data.hrsa.gov. 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.
- iii. 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.
- iv. 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](#).

- v. In determining eligibility for this funding, HRSA realizes there are some metropolitan areas that would, otherwise be considered, non-metropolitan if the core, urbanized area population count did not include federal and/or state prison populations. Consequently, HRSA has created an exception process whereby applicants from metropolitan counties in which the combined population of the core-urbanized area is more than 50,000 can request an exception by demonstrating that through the removal of federal and/or state prisoners from that count, they would have a population total of less than 50,000. You must present documented evidence of total population for the core urbanized area and demonstrate through data from the United States Census Bureau and state, Federal Bureaus of Prisons, or Corrections Departments that show the total core urbanized area population (which is not the county or town population), minus any state and/or federal prisoners, results in a total population of less than 50,000. Any data submitted that does not take the total core urbanized area population into consideration will not be eligible. For further information, please visit the [United States Census Bureau](#). Prisoners held in local jails cannot be removed from the core urbanized area population.

This exception is only for the purpose of eligibility for HRSA award programs. To find out if you are eligible for a reclassification, please contact Steve Hirsch at 301-443-7322. If eligible, you will be required to request the exception and present the data in [Attachment 10: Exception Request](#), which will be verified by HRSA.

Applications from organizations that do not meet the above criteria will not be considered under this notice of funding opportunity.

C. Management Requirements

If awarded, the applicant will be the award recipient of record and must have financial management systems in place as well as the capability to manage the award. 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.

HRSA strongly encourages award recipients to:

- devote at least 0.25 FTE to the project director position;
- have at least one permanent staff at the time an award is made; and
- have a minimum total equal to 2.0 FTE allocated for implementation of project activities, met across two or more staffing positions, including the project director position.

2. Cost Sharing/Matching

Cost sharing/matching is not required for this program.

3. Other

HRSA will consider any application that exceeds the ceiling amount as non-responsive and will not consider it for funding under this notice.

HRSA will consider any application that fails to satisfy the deadline requirements referenced in *Section IV.4* as non-responsive and will not consider it for funding under this notice.

NOTE: Multiple applications from an organization are not allowable.

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

Notifying Your State Office of Rural Health (SORH)

You are required to notify your SORH of your intent to apply to this program. A list of all SORHs, including all SORH contact information, can be accessed on the [National Organization for State Offices of Rural Health](#) website. 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: State Office of Rural Health Letter](#).

HRSA recommends contacting your SORH entity early in the application process to advise them of your intent to apply. The SORH may be able to provide you with some consultation and technical assistance. You should make every effort to seek consultation from the SORH at least three weeks in advance of the application due date and, as feasible, provide the SORH with a simple summary of your proposed project. If no response is received, please include the original letter of intent requesting the support.

Applicants located in Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, American Samoa, the U.S. Virgin Islands, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau do not have a designated SORH. Therefore, applicants from these areas can request an email or letter confirming the contact from the National Organization of State Offices of Rural Health (NOSORH). The email address is: donnap@nosorh.org. For more information on how SORHs can be helpful in supporting rural community organizations, please visit the [NOSORH website](#) and check out the [Community Based Division \(CBD\) Factsheet](#) and community organization collaboration [video](#) highlight.

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](https://www.grants.gov) using the SF-424 workspace application package associated with this NOFO following the directions provided at <http://www.grants.gov/applicants/apply-for-awards.html>.

If you're reading this notice of funding opportunity (NOFO) (also known as "Instructions" on Grants.gov) and reviewing or preparing the workspace application package, you will automatically be notified in the event HRSA changes and/or republishes the NOFO on Grants.gov before its closing date. Responding to an earlier version of a modified notice may result in a less competitive or ineligible application. *Please note you are ultimately responsible for reviewing the [For Applicants](#) page for all information relevant to desired opportunities.*

2. Content and Form of Application Submission

Section 4 of HRSA's [SF-424 Application Guide](#) provides instructions for the budget, budget narrative, staffing plan and personnel requirements, assurances, certifications, and abstract. You must submit the information outlined in the Application Guide in addition to the program-specific information below. 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 HRSA's [SF-424 Application Guide](#) for the Application Completeness Checklist.

Application Page Limit

The total size of all uploaded files may not exceed the equivalent of **80 pages** when printed by HRSA. The page limit includes the abstract, project and budget narratives, attachments, and letters of commitment and support required in the *Application Guide* and this NOFO. Standard OMB-approved forms that are included in the application package do not count in the page limitation. Indirect Cost Rate Agreement and proof of non-profit status (if applicable) do not count in the page limit. **We strongly urge you to take appropriate measures to ensure your application does not exceed the specified page limit.**

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

Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification

1. The prospective recipient certifies, by submission of this proposal, that neither it nor its principals is 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. 3321).

3. Where the prospective recipient is unable to attest to the statements in this certification, an explanation shall be included in [Attachment 12: Other Relevant Documents](#).

See Section 4.1 viii of HRSA’s [SF-424 Application Guide](#) for additional information on all certifications.

i. Project Abstract

See Section 4.1.ix of HRSA’s [SF-424 Application Guide](#). Please use the following outline to complete the requested abstract content described below. The project abstract must be **single-spaced** and limited to **one page in length**.

ABSTRACT HEADING CONTENT
Applicant Organization Information Organization Name, Address, Facility/Entity Type and Website Address <i>(if applicable)</i>
Designated Project Director Information Project Director Name & Title, Contact Phone Numbers <i>(Voice, Fax)</i> and E-Mail Address
Quality Improvement Project: Project Title and Goal
ABSTRACT BODY CONTENT
Target Patient Population Brief description of the service area and target patient population the project proposes to serve and track.
Network/Consortium Partnerships <i>(if applicable)</i> <ul style="list-style-type: none"> ○ Brief description of the name and purpose of the identified collaboration ○ 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 project’s expected outcomes.
Funding Preference If requesting a funding preference, <i>please place request for funding preference at the bottom of the abstract.</i> Applicants must explicitly request a qualifying funding preference and cite the qualification that is being met (see 42 U.S.C. 254c(h)(3)). HRSA highly recommends you include this language: <i>“Applicant’s organization name is requesting a funding preference based on qualification X. County Y is in a designated HPSA”</i> at the bottom of the abstract if requesting funding preference. If applicable, you need to provide supporting documentation in Attachment 9: Funding Preference . Please refer to Section V.2 for further information.

ii. **Project Narrative**

This section provides a comprehensive framework and description for all aspects of the proposed project. It should be succinct, self-explanatory and well organized so that reviewers can understand the proposed project clearly.

Successful applications will contain the information below. Use the following section headers for the narrative: Introduction, Needs Assessment, Methodology, Work Plan, Evaluation and Technical Support Capacity, and Organizational Information.

- **INTRODUCTION** -- Corresponds to Section V's [Review Criterion 1: NEED](#)

Provide an overview introducing the fundamental elements of the proposed project. Use the following sub-headings: Purpose/Overview and Patient Health Outcome and Clinical Quality Measure Overview.

A. Purpose/Overview

Briefly describe the purpose, goals, and expected outcomes of the proposed project, summarizing the needs the project proposal will address. In addition: 1) briefly discuss applicable project approaches related to incorporating alignment of quality improvement initiatives such as PCMH or VBC approaches to care, 2) identify project focus plans to address chronic disease management and/or the integration of mental/behavioral health into the primary care setting, and 3) identify and briefly describe the proposed project's evidence-based, effective and/or promising practice quality improvement (QI) model(s) planned for project implementation. QI model(s) descriptions should explicitly address how the identified model(s) will be applied to meet project goals. Further details regarding the evidence-based, effective and/or or promising practice QI model(s) should be included under your response to the NOFO's [Methodology](#) narrative section. Please see the [Methodology](#) narrative section for further instructions.

B. Patient Health Outcome & Clinical Quality Measure Overview

All awardees will be required to report and utilize Rural Quality Program measures, also referred to as Performance Improvement Measurement System (PIMS) measures, to help 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 Rural Quality Program PIMS measures can be referenced under [Appendix A](#).

In addition to the PIMS measures, applicants are also strongly encouraged to identify project-specific measures for measurement of the project's ability to successfully meet project goals and objectives.

Responses in this section should cite both **PIMS measure** requirements and any project-specific measures identified and briefly describe the capacity and capability to respond to these measures. All responses to this section should effectively address: 1) what health outcomes will be used to measure the proposed project's resulting improvements to patient health for the identified target patient population(s), 2) how health outcomes will be tracked over the three-year period of

performance, and 3) how the proposed project will demonstrate improvements to the quality of care and delivery of services resulting from project implementation.

Note: The patient population required to be applied for the purposes of completing the annual PIMS reporting requirement for this program is intended to be the **full patient panel** identified for the proposed project. Additional guidelines and details regarding the full patient panel can be found under the [Needs Assessment](#) narrative section. Please refer to this section for further instructions.

Additional details about proposed project measures must also be included in responses to the [Methodology](#) and the [Evaluation & Technical Support Capacity](#) narrative sections. Please refer to these sections for further instructions.

▪ **NEEDS ASSESSMENT** -- Corresponds to Section V's [Review Criterion 1: NEED](#)

This section outlines the community and organizational needs for the proposed project, including how the target patient population will be served, approaches to implementation of project services and activities and how local partnership organizations (if applicable) and the local community will be involved in the ongoing operations of the project. Content included in this section should be able to clearly communicate and help reviewers understand the proposed project's community and target population and how they will be served.

Responses to this section should include the following sub-headings: Target Population, Barriers/Challenges, Geographic Details of Service Area and Health Care in Service Area.

A. Target Population

You are expected to identify and have in place a target patient population and full patient panel available and ready to receive project services at beginning of the award period of performance, if awarded.

In response to this section, the proposed project's target patient population and full patient panel that will receive the intervention services, must be clearly identified and described. Plans and outcome indicators for the measurement, tracking and demonstration of improvements to patient health, quality and delivery of care resulting from the implementation of the proposed project should also be included and clearly addressed in this description. If the target patient population and full patient panel are the same, this must be stated and reflected in the description provided in response to this section. Inclusion criteria for the full patient panel and target patient population should be clearly stated and should remain consistent across the three-year period of performance to minimize service and measurement disruptions should patients move, change or become deceased during project implementation. This section should help reviewers understand the specifics of the patients that will be served, measured and tracked across the three-year period of performance, if awarded. Please see notes below for additional guidance regarding this NOFO's full patient panel and target patient population requirements.

Note: Full Patient Panel

The full patient panel can be the same or different from the identified target patient 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 full patient panel 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. Full patient panel descriptions should be accompanied with justifications evident throughout the full patient panel narrative provided in response to this section.

Note: Target Patient Population

Project proposals must identify a target patient population that is either *the same or comparative* to the full patient panel identified for the project. Specifically, this requires you to identify a target patient population and a full patient panel 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 patient population that reflects the full patient panel more broadly, others may choose to select a target patient population and full patient panel that are the same population. Under either approach, applicants are expected to clearly describe the requested information to describe the target patient population in response to this section.

Please use the following guidance in providing descriptions of the **target patient population and full patient panel** in response to this section:

1. Inclusion criteria and selection methodology;
2. Specific characteristics, which should include:
 - a. Use and citation of any available demographic data, as possible;
 - b. Citation and use of any relevant health status or social-related data factors such as specific health status indicators, age, insurance coverage, etc.;
 - c. Socio-cultural determinants of health and health disparities impacting the target patient 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; and
 - d. Where relevant, statistics regarding crime, substance use and other potentially relevant social challenges
3. Health care needs, including the identification of needs and how they will be met;
4. Health outcome improvements expected;
5. Relationship to project goals, which should include considerations to relationships with:
 - a. Quality improvement initiatives such as PCMH and VBC and
 - b. Project focus including chronic disease management and/or the integration of mental/behavioral health into primary care settings.
6. Plans for how potential changes in the patient population(s) will be handled (e.g., patient relocation, death, etc.);
7. Baseline health status/outcome indicators, which should include comparison of patient population(s) baseline health status/outcome indicators to:

The general community patient population as a whole, and

- a. Any relevant available local, state, federal and/or national data or rankings in describing unique patient population needs.
8. Involvement of the patient population(s) in project development;
9. Plans to ensure effective response to patient population(s) needs; and
10. Capacity to expand services beyond patient population(s) to serve rural community needs more broadly.

B. Barriers/Challenges

Please 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.

C. Geographic Details of Service Area

A description of geographical features for the proposed project service area should be included under this section. Description must include a map that clearly shows the entire service area and indicates any relevant geographic barriers (e.g., mountainous terrain). Please ensure maps included are clear and are easily reproducible in black and white, as this is what reviewers will see.

D. Health Care in Service Area

You should identify and describe any other existing health care services available in or near the proposed target 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 patient 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.

Your response to this section must clearly describe 1) how the proposed project would not provide any duplicative services and 2) any potential impacts the proposed project may have on the community (e.g., economic impact etc.) and/or other existing programs, organizations or health care facilities in the service area. This should include a description of any potential impacts on existing providers, including providers directly involved with the project, as well as those not involved. Potential impacts such as changes in referral patterns, practice patterns and provider performance, among others, should be specifically addressed.

- **METHODOLOGY** -- Corresponds to Section V's Review [Criterion 2: RESPONSE](#) and [Criterion 3: EVALUATIVE MEASURES](#)

In narrative format, 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.

Please use the following sub-headings in responding to this section: Goals & Objectives, Quality Improvement Model(s), Sustainability Approach and Data Methodology Approach.

A. Goals & Objectives

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.

Goal Alignment

The goals of the award-funded activities are strongly encouraged to align with the Centers for Disease Control and Prevention (CDC) [Healthy People Initiative](#), as may be feasible and applicable to do so.

It is strongly encouraged that project goals and objectives align with the goals for PCMH and VBC approaches to care, including alignment with additional quality improvement initiatives such as, but not limited to, the [National Quality Strategy](#), [Centers for Medicare and Medicaid \(CMS\) Rural Strategy](#), [Million Hearts](#), among others.

Accreditation

Applicants should consider attainment or maintenance of nationally recognized quality improvement accreditation, such as PCMH by the National Committee for Quality Assurance (NCQA), among others, as part of quality improvement award activities. If the attainment or maintenance of quality improvement accreditation or certification is a part of proposed project goals and objectives, applicants should include this information, including description of these activities, if applicable, in the response to this section. Applicants who are health departments and/or partner with health departments, are particularly encouraged to include the pursuit or maintenance of such accreditation as part of proposed project activities.

Telehealth, Telemedicine and/or Mobile Technology

For applicants proposing use of telehealth, telemedicine, and/or mobile technology as part of proposed project activities and/or services, applicants should identify and explicitly describe the proposed goals, objectives and activities involving telehealth, telemedicine, and/or mobile technology for project implementation in response to this section. For the purposes of this NOFO, use of any remote technologies, including remote home/patient monitoring, is considered a qualifying approach for inclusion in this section. All applicants who are proposing the use of telehealth, telemedicine, mobile technology and/or any of the above named technologies for project proposals are required to meet all of the

requirements and expectations for the full patient panel and target population described in this NOFO.

Descriptions provided should detail the approach for the identified technology utilization and clearly state the need, rationale, equipment, staffing capacity, and implementation plans. Implementation plan details should include, but is not limited to, the collection, tracking and analysis of full patient panel and target population data, the coordination of any pertinent referral, billing and/or clinical workflows, plans for provision of patient care delivery and coordination of care, anticipated barriers and plans to overcome any identified barriers. To the extent applicants are focusing on the Medicare population, HRSA encourages awareness and application of billing for any appropriate Medicare telehealth billing codes, as a number of new services related to both chronic disease and behavioral health integration have been added in recent years. Considerations to billing for these services are encouraged as each State Medicaid program has its own unique telehealth coverage policies, as do private insurers. The ability to bill for these services supports many aspects of successful technology utilization and may also contribute to sustainability of services after any awarded grant funding ends.

Chronic Disease Management

Projects focusing on the management of chronic disease conditions are asked to ensure project goals are aligned to be able to adequately demonstrate improvements to the management of the named chronic disease or chronic disease conditions as a result of the proposed project by the end of the three-year period of performance, if awarded. This includes improvements to the quality and delivery of related health care services as well as improvements to patient health outcomes for the related chronic disease management identified.

In addition to focusing on how to improve quality and enhance outcomes for rural patients, applicants should also focus on how to fully leverage public and private insurers to emphasize value. For example, the [Centers for Medicare and Medicaid Services](#) have added a range of new billing codes that can help support chronic care management and population health. This included a national campaign to focus on these issues for providers and patients in rural and underserved areas. For applicants focusing on the Medicare population, these new billing codes and other resources could create a key part of project sustainability strategy for maintaining proposed projects at the conclusion of award funding, if awarded.

There are other resources that focus on these new billing codes in rural practice settings available at the [Rural Health Information Hub](#). This emerging emphasis on linking payment to quality extends to other payers. Applicants serving the Medicaid population should engage their state Medicaid officials on how the activities within this award may align with their state's efforts to focus on value within the Medicaid population, both in standard fee-for-service and in Medicaid Managed Care. Similarly, many private insurers are engaging in similar value-focused efforts related to chronic care management and applicants are encouraged to engage their private payers in this effort to obtain additional support to keep the project going in perpetuity.

Integration of Mental/Behavioral Health into Primary Care Settings

Projects focusing on approaches working to integrate mental/behavioral health care services into primary care settings should be explicit in the alignment of goals tied to this effort. Goals should be able to adequately demonstrate improvements to the quality and delivery of health care services and patient health outcomes as a direct result of service integration project activities by the end of the three-year period of performance, if awarded. Applicants are also expected to consider utilization of best practices, models and/or approaches proven effective in accomplishing integration successfully. Rural-specific evidence-based toolkits are available on [RHlhub](#), and includes toolkits on topics such as [Rural Services Integration](#), [Rural Prevention and Treatment of Substance Use Disorder](#), among others.

B. Quality Improvement Model(s)

All applicants are required to propose projects based on an evidence-based, effective, and/or or promising practice quality improvement (QI) model(s) shown to be effective in addressing improvements to health care quality and patient health outcomes. Responses to this section must 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 consortium or network partner roles. 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 patient population. Though not a requirement, applicants may propose use of more than one quality improvement model. All responses to this section are expected to address completed responses for each model identified. References and/or citations should be included in the description provided with this section.

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 Rural Quality 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.

Patient-Centered Medical Homes and Value-Based Care

With this funding opportunity's encouragement to align quality improvement initiatives with PCMH and VBC approaches to care, applicants are asked to 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.

Rural Model Adaptations

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. This section should include a thorough rationale supporting how the proposed model(s), and any necessary adaptations, are 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.

Note: For the purposes of this program, an evidenced-based model 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 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.

To best fit rural adaptation needs, Effective or Promising Practices, as defined by the [Rural Health Information Hub](#) 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.

C. Sustainability Approach

Applicants are expected to develop sustainable projects and have in place a sustainability plan that addresses how the proposed project will continue after Rural Quality Program federal funding has ended, if awarded. HRSA strongly encourages applicants to focus on approaches to emphasizing value across public and private insurers as an approach to sustainability and leverage use of new CMS billing codes supporting chronic care management and population health and other resources as a strategy for continuing proposed project activities after any award funding ends. For applicants serving Medicaid populations, the engagement 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, if awarded. Helpful related resources are available on the CMS Chronic Care Management and RHHub websites. Please also see the [Incentive Programs and Reimbursement Strategies](#) section below for additional related information.

For responses to this section, applicants should describe a sustainability plan that includes strategies and action steps to achieve sustainability. 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 consortium members.

Examples of successful sustainable project impacts, activities and services achieved by previously funded Rural Quality 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 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.

Feasibility

HRSA understands sustainability plans may evolve as projects are implemented. As such, applicants are also asked to include a description addressing the feasibility of the proposed sustainability plan and the prospective implementation of the plan's action steps.

Incentive Programs and Reimbursement Strategies

Applicants are encouraged to 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 and 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 third year of the period of performance. Further information will be provided upon receipt of the award for those who are funded.

D. Data Methodology Approach

As described in the [Introduction](#) narrative section [C. Patient Health Outcomes & Clinical Quality Measure Overview](#), successful applicants will be required to report annually on the HRSA Rural Quality Program PIMS measures and are also encouraged to utilize project-specific measures to measure the ability of the project to meet project goals. For this section, applicants are requested to elaborate on the response presented in the [Introduction](#) narrative section [C. Patient Health Outcome & Clinical Quality Measure Overview](#) and further detail any proposed project-specific measures described. Specifically, responses to this

section will be reviewed on the applicant's ability to successfully: 1) provide a full list of relevant proposed project specific measures, if applicable, 2) describe the data methodology approach proposed for project data collection, tracking, measurement and utilization, and 3) address considerations for effective application of Health Information Technology (HIT) for the data methodology approach identified. Further details pertaining to these section requirements can be found in the proceeding paragraphs:

1. *List of Project-Specific Measures*

As applicable, please 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 in response to this section. 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.

2. *Data Methodology Approach Description*

Successful applicants will propose a data methodology approach which effectively is able to support: 1) successful tracking of relevant health outcome indicators for the identified patient population(s) over the three-year period of performance, 2) demonstration of meaningful health outcomes for the patient population(s) directly resulting from proposed project implementation, and 3) demonstration of improvements to the quality of care and delivery of services specific to the proposed project's focus and achieved as a result of proposed project implementation.

Responses to this section should specifically include the following details in describing the proposed project's data methodology approach:

1. Plans for how data will be collected, tracked, analyzed, used and shared over the three-year period of performance. This should include plans for:
 - a. Use of any available patient 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.
2. Plans for implementation of the data methodology approach (*e.g., processes, workflows and other relevant operational elements*);
3. Any relevant quality control protocols;
4. Personnel capacity, capability and needs;
5. Timeline for implementation, including timeline or timelines for any related project data collection, measurement, utilization, etc.;
6. Use of any HIT platforms, modules and/or system(s). This should include description which clearly detail:
 - a. How the use of any HIT platforms, modules and/or system(s) will be applied (*e.g., use of HIT system(s) for project implementation, data collection, distribution of project information, HIT personnel and/or training needs, and any relevant HIT specific data processes related*

- to project data), and
 - b. Any established data sharing partner agreements and/or plans for establishing data sharing partner agreements related to the proposed project's utilization of HIT, if applicable.
 - 7. Any pertinent local state and/or federal partnerships, collaborations and/or initiatives (including QI initiatives);
 - 8. Plans for how information and data will be shared with:
 - a. Providers of health care services and/or other health care professionals for clinical decision making;
 - b. Organizational staff and leadership;
 - c. Consortium and/or community partners (as applicable); and
 - d. Patients and rural community members.
 - 9. How the approach aligns with the proposed project's goals, QI model(s) and plans for sustainability.
3. *Application of Health Information Technology*
- 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. Proposed projects are expected to incorporate use of HIT, to the extent possible, to support demonstration of overall proposed project impact. Some examples of HIT utilization from historically funded Rural Quality 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.

Applicants should include details regarding the application of HIT under item number six in the above table provided under [Section D. Data Methodology Approach](#)

Note: 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.

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

All applicants are required to describe and detail the implementation of proposed project activities for the duration of the three-year period of performance. For responses to this section, please use the following sub-headings: Work Plan, Impact, Replicability, Dissemination Plan and Economic Impact Analysis.

A. Work Plan

Applicants must 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 three-year period of performance. In response to this section, applicants should include the following:

1. 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 three-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.
2. 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 3 years of the period of performance.**

All work plans should 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 three-year period of performance. Responsible staff and/or consortium members should also be identified on the work plan for each project activity and/or activities. 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. 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.

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](#).

B. Impact

Please include a description that details the following impact expected to result from the proposed project work plan implementation in response to this section:

- Expected impact on the identified target patient population/full patient panel;
- Expected impact on service area health care delivery and services; and
- Expected impact or implications for rural community service area (local, state and national impacts/implications may also be included here).

Although HRSA recognizes the influence of external factors when attributing the effects of an activity or program to the long-term health outcome of a community, applicants should still describe the expected or potential long-term changes and/or improvements in health status due to the program. 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.

C. 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.

D. 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.

E. Economic Impact Analysis

Applicants must provide a description in response to this section that identifies the anticipated impact the proposed project will have on the local rural economy.

Please note that all award recipients will be required to report on the proposed projects' economic impact at the end of the three-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:

- collaboration and coordination among staff members;
- data sharing;
- project support and/or buy-in from key project stakeholders (e.g., organizational leaders, project partners, clinical providers, health care staff, etc.);
- implementation;
- support and/or adoption of new health IT platforms;
- modules and/or systems;
- technological barriers in data collection and/or documentation; or
- staff turnover, among others.

▪ **EVALUATION AND TECHNICAL SUPPORT CAPACITY** -- Corresponds to Section V's [Review Criterion 3: EVALUATIVE MEASURES](#), [Review Criterion 4: IMPACT](#) and [Review Criterion 5: RESOURCES/CAPABILITIES](#)

In response to this section, applicants are asked to include a description of the proposed project plans for program performance evaluation that contributes to attaining the proposed project goals, objectives and activities described in the narrative responses. Please use the following sub-headings in responding to this section: Performance Evaluation, Logic Model, Project Monitoring, and Resources/Capabilities.

A. Performance Evaluation

The program performance evaluation should be inclusive of ongoing performance evaluation processes able 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.

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.) should also be included in response to this section. Descriptions provided in response to this section should clearly align with project description responses provided to [section D. Data Methodology Approach](#) under 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 evaluation, 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 evaluation 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.

Note: Applicants are *not* expected to allocate major resources towards a comprehensive project evaluation.

B. Logic Model

Applicants are required to 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 section [D. Data Methodology Approach](#) of the [Methodology](#) narrative Section. 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](#).

The logic model provided must clearly include the following elements: inputs, outputs, short-term outcomes, long-term outcomes, and impacts. Logic models should use a chart format with 10-pitch fonts.

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 distinguish between a logic model and work plan can be found at the following [Centers for Disease Control and Prevention \(CDC\) Program Evaluation](#) website. Additional information on developing logic models can be found on the [CDC Program Performance and Evaluation Office](#) website.

C. Project Monitoring

In an effort to maximize allocation of award funds towards project activities, applicants are asked to 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.

D. Resources/Capabilities

You are expected 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 three-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:

Project Staffing List

This should 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. 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* (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**, as needed.

Project Staffing Plan

Completion of a project staffing plan is required and requested for inclusion 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 equivalents; 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.

Note: Applicants proposing projects to address the integration of mental/behavioral health care services into the primary care setting are expected to identify and describe staffing plans in response to this section that appropriately utilize staffing plans and/or models proven effective in accomplishing the proposed integration successfully.

Project Director

Applicants are responsible for ensuring 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. Please 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, please also discuss the process and timeline for hiring a permanent project director for this award. Refer to **Attachment 7: Staffing Plan**, as needed.

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

Resumes/Biographical Sketches of Key Personnel

To be included under [Attachment 8: Biosketches of Key Personnel](#). Please reference [Section V. Attachments](#) for additional instructions for completing resumes/ biographical sketches of key personnel attachment.

- **ORGANIZATIONAL INFORMATION** -- Corresponds to Section V's [Review Criterion 5: RESOURCES/CAPABILITIES](#)

Please use the following three sub-headings when responding to this section: Applicant Organization and Consortium/Network.

A. Applicant Organization

Provide a brief overview of the applicant organization and include information regarding mission, structure, and current primary activities. The applicant organization description should address the organizational ability to manage the grant 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.). The financial practices and systems which assure the applicant organization's capacity to manage federal funds must also be identified and detailed in this description, as well as information detailing the applicant organization's ability to support achievement of project goals including implementation of project activities, provision of services planned for

meeting target patient population needs, implementation of quality improvement model(s) and the tracking, collection, analysis and utilization of project data and results. Applicants will be required to provide documentation that the applicant organization is a rural nonprofit or public entity in [Attachment 1: Proof of Nonprofit Status](#).

Organizational Chart

Applicants are required to provide an organizational chart of for the applicant organization and any relevant project partners, if applicable, under [Attachment 6: Organizational Chart](#).

B. Consortium/Network

Although it is not a requirement, HRSA strongly encourages organizations to form consortia and/or networks for this program. The purpose of a consortium or network is to encourage creative and lasting collaborative relationships among health and social service providers in rural areas. Working collaboratively with other organizations is often necessary to provide coordinated care, for achievement of improvements to population health across rural community service areas and to effectively address quality improvement.

If the applicant organization is forming a consortium or network and/or is currently a part of a consortium and/or network that will be involved directly with the proposed project, applicants are asked to identify and briefly describe the contributions of the proposed consortium or network to the project in response to this section. Applicants should also include details regarding history of previous collaborations with named consortium or network, if applicable. How communication and coordination will occur between consortium or network members for the proposed project should also be clearly detailed. If applicable, a list of all consortium or network partners proposed for direct involvement of proposed project implementation is requested, along with any formal established signed Memorandum of Understanding/Agreement (MOU/A) documentation and/or letter of commitment among named consortium or network partners.

If applicable, this information should be included under [Attachment 6 Organizational Chart](#) and [Attachment 12: Other Relevant Documents](#) respectively.

NARRATIVE GUIDANCE	
In order to ensure that the Review Criteria are fully addressed, this table provides a crosswalk between the narrative language and where each section falls within the review criteria.	
<u>Narrative Section</u>	<u>Review Criteria</u>
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 Justification Narrative	(6) Support Requested – the budget section should include sufficient justification to allow reviewers to determine the reasonableness of the support requested.

iii. Budget

See Section 4.1.iv of HRSA’s [SF-424 Application Guide](#). Please note: the directions offered in the SF-424 Application Guide may differ from those offered by Grants.gov. Please follow the instructions included in the Application Guide and the additional budget instructions provided below. A budget that follows the Application Guide will ensure that, if the application is selected for funding, you will have a well-organized plan and, by carefully following the approved plan, can avoid audit issues during the implementation phase.

Additionally, HRSA recently published a one-page guide to help HRSA award recipients develop effective financial management practices. The technical assistance document, titled “[Tip Sheet for HRSA Grantees: A Guide for Developing Effective Financial Management Practices](#)” provides some simple tips to help recipients avoid misspending award funds on unallowable expenditures or activities.

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

The Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019 (P.L. 115-245), Division B, § 202, states, “None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II.” Please see Section 4.1.iv Budget – Salary Limitation of HRSA’s [SF-424 Application Guide](#) for additional information. Note that these or other salary limitations may apply in FY 2019, as required by law.

iv. Budget Narrative

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

The Rural Quality Program requires the following:

- Budget for Multi-Year Award

This notice is inviting applications for a period of performance of up to three years. Awards, on a competitive basis, will be for a one-year budget period, although the period of performance may be for three years. Submission and HRSA approval of the Progress Report(s) and any other required submission or reports is the basis for the budget period renewal and release of subsequent year funds. Funding beyond the one-year budget period but within the multi-year period of performance is subject to availability of funds, satisfactory progress of the awardee, and a determination that continued funding would be in the best interest of the Federal Government. However, three separate and complete budget years must be submitted with this application.

In addition, HRSA would like to note the following:

1. **Travel:** Please allocate travel funds for up to two program staff to attend an annual 2.5-day program technical assistance meeting in Washington, DC and include the cost in this budget line item.
2. **Funding restrictions:** [See Section IV.6.](#)

v. Attachments

Please provide the following items, in the order specified below, to complete the content of the application. **Unless otherwise noted, attachments count toward the application page limit.** Indirect cost rate agreements and proof of non-profit status (if applicable) will not count toward the page limit. **Each attachment must be clearly labeled.**

Attachment 1: Proof of Nonprofit or Public Status (will not count toward the page limit)

If you are a nonprofit or public entity, include one of the following documents to document nonprofit status:

- 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 net earnings accrue to any private shareholders or individuals;
- A certified copy of the organization's certificate of incorporation or similar document if it clearly establishes the 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. You may include supplemental

information such as documentation of the law that created the organization or documentation showing that the state or a political subdivision of the state controls the organization. Tribal government entities should verify their federally-recognized status via the Bureau of Indian Affairs: <http://www.indianaffairs.gov/>. This attachment **will NOT count** towards the 80-page limit.

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

If the applicant organization is owned by an urban parent, the urban parent must assure HRSA in writing that they will exert no control over the rural organization for this project. If applicable, a letter stating this should be submitted in *Attachment 2*. This attachment **will count** towards the 80-page limit.

Attachment 3: State Office of Rural Health (SORH) Letter

You 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 in *Attachment 3*.

Attachment 4: Work Plan

Submit the Work Plan for the project that includes all information detailed in the [Work Plan](#) section narrative as *Attachment 4*. This attachment **will count** towards the 80-page limit.

Attachment 5: Logic Model and Narrative Description

Submit a logic model and narrative that illustrates the inputs, activities, outputs, outcomes, and impact of the project. This attachment **will count** towards the 80-page limit. This attachment should align with the content provided in the [Evaluation and Technical Support Capacity](#) section narrative.

Attachment 6: Organizational Chart

Applicants are required to submit an organizational chart in *Attachment 6*. This attachment **will count** towards the 80-page limit. This attachment should align with the content provided in the [Organizational Information](#) narrative section.

Attachment 7: Staffing Plan and Position Descriptions for Key Personnel

Applicants are required to submit a staffing plan and position descriptions of key personnel listed in the application for the proposed project. This plan should describe a clear and coherent plan for managing and staffing the proposed project 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. Provide a table of contents for this attachment. This attachment **will count** towards the 80-page limit. Responses should align with the content provided in response to item [B. Resources and Capabilities](#) under the [Evaluation and Technical Support Capacity](#) narrative section.

Attachment 8: Biosketches of Key Personnel

Include biographical sketches for persons occupying key positions, not to exceed two pages in length for each person. In the event that a biographical sketch is included for an identified individual who is not yet hired, please include a letter of commitment (*Attachment 12*) from that person with the biographical sketch. This attachment **will count** towards the 80-page limit. This attachment should align with the content provided in the [Evaluation and Technical Support Capacity](#) narrative section.

Attachment 9: Funding Preference

If requesting a funding preference, include proof of funding preference designation or eligibility. This attachment **will count** towards the 80-page limit.

Include a printout or screenshot that displays the HPSA and/or MUC/P designation and respective score:

<http://datawarehouse.hrsa.gov/GeoAdvisor/ShortageDesignationAdvisor.aspx>.

The printout or screenshot of HPSA designation can also be found at:

<http://hpsafind.hrsa.gov> and; MUAS/P designation can also be found at:

<http://muafind.hrsa.gov>.

Attachment 10: Exception Request (if applicable)

Applicants from Metropolitan counties in which the combined population of the core-urbanized area is more than 50,000 that request an exception by demonstrating that through the removal of federal and/or state prisoners from that count, they would have a population total of less than 50,000. Provide the required documentation for this attachment. This exception is only for the purpose of eligibility for HRSA award programs. To find out if you are eligible for a reclassification, please contact Steve Hirsch at 301-443-7322. This attachment **will count** towards the 80-page limit.

Attachment 11: HRSA Funding History Information (if applicable)

Current and former award recipients of any HRSA community-based programs from the last ten 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). This attachment **will count** towards the 80-page limit.

Attachment 12-15: 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 Universal Numbering System Number and System for Award Management

You must obtain a valid DUNS number, also known as the Unique Entity Identifier, for your organization/agency and provide that number in the application. You must also register with the System for Award Management (SAM) and continue to maintain active SAM registration with current information at all times during which you have an active federal award or an application or plan under consideration by an agency (unless the applicant is an individual or federal agency that is exempted from those requirements under 2 CFR § 25.110(b) or (c), or has an exception approved by the agency under 2 CFR § 25.110(d)).

HRSA may not make an award to an applicant until the applicant has complied with all applicable DUNS and SAM requirements and, if an applicant has not fully complied with the requirements by the time HRSA is ready to make an award, HRSA may determine that the applicant is not qualified to receive an award and use that determination as the basis for making an award to another applicant.

If 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.

The Grants.gov registration process requires information in three separate systems:

- Dun and Bradstreet (<http://www.dnb.com/duns-number.html>)
- System for Award Management (SAM) (<https://www.sam.gov>)
- Grants.gov (<http://www.grants.gov/>)

For further details, see Section 3.1 of HRSA's [SF-424 Application Guide](#).

UPDATED SAM.GOV ALERT: For your SAM.gov registration, you must submit a [notarized letter](#) appointing the authorized Entity Administrator. The review process changed for the Federal Assistance community on June 11, 2018. Read the [updated FAQs](#) to learn more.

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 *April 22, 2019 at 11:59 p.m. Eastern Time*. HRSA suggests submitting applications to Grants.gov at least **3 days before the deadline** to allow for any unforeseen circumstances.

See Section 8.2.5 – Summary of e-mails from Grants.gov of HRSA's [SF-424 Application Guide](#) for additional information.

5. Intergovernmental Review

The Small Health Care Provider Quality Improvement Program is a program subject to the provisions of Executive Order 12372, as implemented by 45 CFR 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 three years, at no more than \$200,000 per year (inclusive of direct **and** indirect costs). 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 B of the Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019 (P.L. 115-245) apply to this program. Please see Section 4.1 of HRSA's [SF-424 Application Guide](#) for additional information. Note that these or other restrictions will apply in the following FY, 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)).

Minor renovations and alterations are allowable.

You are required to have the necessary policies, procedures, and financial controls in place to ensure that your organizations comply 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. 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. The program income alternative applied to the award(s) under the program will be addition/additive alternative. You can find post-award requirements for program income at [45 CFR § 75.307](#).

V. Application Review Information

1. Review Criteria

HRSA has procedures for assessing the merit of applications have been instituted to provide for an objective review of applications and to assist the applicant in understanding the standards against which each application will be reviewed. HRSA has critical indicators for each review criterion to assist the applicant in presenting pertinent information related to that criterion and to provide the reviewer with a standard for evaluation. See the review criteria are outlined below with specific detail and scoring weights.

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

The Small Health Care Provider Quality Improvement Program has six (6) review criteria:

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

Criterion 1: NEED (15 points) – Corresponds to Section IV’s [Introduction](#) and [Needs Assessment](#).

- a) The extent to which the applicant is able to provide an effective explanation justifying the reasons why federal assistance 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 patient population (including the target patient population and full patient panel, as applicable) for this project, including:
 - i. Clear identification, definition, and inclusion criteria;
 - ii. Details for how selection was determined;
 - iii. Defined full patient panel available to receive project services upon award, if funded;
 - iv. Ability of the project to serve and meet the needs of the patient population(s);
 - v. Description and feasibility of the expected results for the patient population(s); and
 - vi. Description and appropriateness of how the local community and patient population(s) will be engaged in the proposed project.
- d) The extent to which applicant includes relevant health disparities and socio-cultural determinants of health;
- e) 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 patient population proposed to be served;
- f) The extent to which the applicant describes relevant barriers or challenges to health care in the service area that the project hopes to overcome;

- g) The extent to which the applicant describes the geographic details of the service area;
- h) The extent to which the applicant identifies and describes other health care services available in the target service area, including:
 - i. The potential impact of the project on other providers;
 - ii. Why existing health care services do not meet the needs of the service area; and
 - iii. How the proposed project would not provide duplicative services.
- i) 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 (20 points) – Corresponds to Section IV’s [Methodology](#), [Work Plan](#), and [Resolution of Challenges](#)

- a) The extent to which the proposed project responds to the Rural Quality Program *Purpose* identified in the program description. This includes the extent to which the proposed applicant is able 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. As appropriate, incorporate QI initiatives such as PCMH and VBC;
 - v. If applicable, address rural chronic disease management;
 - vi. If applicable, influence the integration of mental/behavioral health care services into the primary care setting; and
 - vii. Show demonstrated improvements to rural patient health, quality and delivery of care as a result of the project at the end of the three-year period of performance.
- b) The extent to which the applicant is able to describe and clearly define specific, measurable, achievable, realistic, and time-bound goals for the project;
- c) The extent to which the applicant discusses anticipated challenges to project implementation and the approaches for resolution;
- d) 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;
- e) 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);

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

- g) 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 the integration of mental health into the primary care setting, if applicable; and
 - v. Description of any consortium or network partner roles for implementation of QI model(s), if applicable.

- 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 project staff will be trained to utilize the identified approach;
 - iii. Description of any relevant collaborations or partnership engagement; and
 - iv. How well approach supports ability to track patient population(s) and demonstrate meaningful outcomes to improvements to patient health, quality and delivery of care.

Criterion 3: EVALUATIVE MEASURES (15 points) – Corresponds to Section IV's [Methodology](#), [Work Plan](#), and [Evaluation and Technical Support Capacity](#)

- 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 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 patient population(s) identified can effectively be used for measuring success of the project;
- 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 consortium or network partners, if applicable; and
- g) 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.

Criterion 4: IMPACT (20 points) – Corresponds to Section IV’s [Work Plan](#) and [Evaluation and Technical Support Capacity](#)

- a) The extent to which the applicant’s work plan describes the project goals, objectives, activities, outputs, outcomes, and timeframe for effective project implementation, including assignment of responsible staff and/or consortium 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.
- c) 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.
- d) The extent to which the applicant describes how the execution of project implementation is capable of achieving project goals.
- e) The extent to which the applicant describes how delivery of health care will be improved as a result of the project. This includes the integration of mental health into the primary care setting, if applicable.
- f) 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.

Criterion 5: RESOURCES/CAPABILITIES (15 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 Biographical Sketches (**Attachments 7 and 8**) that document the education, experience, and skills necessary for successfully carrying out the proposed project.
- c) Adequate time and effort is 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 three-year period of performance.

Criterion 6: SUPPORT REQUESTED (15 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 key personnel have adequate time devoted to the project to achieve project objectives, and the application’s budget provides sufficient detail about the role and responsibilities of each award-supported staff position; and
 - iii. 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 three-year period of performance.

2. Review and Selection Process

The independent review process provides an objective evaluation 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 V.3 below. HRSA will use other factors other than merit criteria in selecting applications for federal award. Please 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 organization that specifically requests and demonstrates that they meet the criteria for the preference 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:

<http://datawarehouse.hrsa.gov/GeoAdvisor/ShortageDesignationAdvisor.aspx>.

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:

<http://datawarehouse.hrsa.gov/GeoAdvisor/ShortageDesignationAdvisor.aspx>.

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.

If requesting a funding preference, please indicate which qualifier is being met in the [Project Abstract](#). HRSA highly recommends that the applicant include this language: ***“Applicant’s organization name is requesting a funding preference based on qualification X. County Y is in a designated HPSA.”***

If a funding preference is requested, documentation of funding preference must be included in [Attachment 9: Funding Preference](#). Please 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.

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

3. Assessment of Risk and Other Pre-Award Activities

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.

Effective January 1, 2016, 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 any of 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 posed 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](#)).

4. Anticipated Announcement and Award Dates

HRSA anticipates issuing/announcing awards prior to the start date of August 1, 2019.

VI. Award Administration Information

1. Award Notices

HRSA will issue the Notice of Award prior to the start date of August 1, 2019. See Section 5.4 of HRSA’s [SF-424 Application Guide](#) for additional information.

2. Administrative and National Policy Requirements

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

Requirements of Subawards

The terms and conditions in the Notice of Award (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. See [45 CFR § 75.101 Applicability](#) for more details.

Human Subjects Protection: Federal regulations (45 CFR 46) require that applications and proposals involving human subjects must be evaluated with reference to the risks to the subjects, the adequacy of protection against these risks, the potential benefits of the

research to the subjects and others, and the importance of the knowledge gained or to be gained. If you anticipate research involving human subjects, you must meet the requirements of the HHS regulations to protect human subjects from research risks.

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 of the period of performance. Data dashboards identify key project data to support the ongoing data collection, documentation and tracking across the three-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 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 third 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 three 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.

VII. Agency Contacts

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

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

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

Katherine Lloyd
Public Health Analyst
Federal Office of Rural Health Policy
Health Resources and Services
Administration 5600 Fishers Lane, Room
17W53-A Rockville, MD 20857
Telephone: (301) 443-2933
Fax: (301) 443-2803
E-mail: klloyd@hrsa.gov

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

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

Successful applicants/recipients may need assistance when working online to submit information and reports electronically through HRSA's Electronic Handbooks (EHBs). For assistance with submitting information in HRSA's EHBs, contact the HRSA Contact Center, Monday-Friday, 8:00 a.m. to 8:00 p.m. ET:

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

VIII. Other Information

Logic Models

You can find additional information on developing logic models at the following website: <http://www.acf.hhs.gov/sites/default/files/fysb/prep-logic-model-ts.pdf>.

Although there are similarities, a logic model is not a work plan. A work plan is an “action” guide with a time line used during program implementation; the work plan provides the “how to” steps. You can find information on how to distinguish between a logic model and work plan at the following website: <http://www.cdc.gov/healthyyouth/evaluation/pdf/brief5.pdf>.

Technical Assistance

HRSA has scheduled the following technical assistance:

Webinar

Day and Date: Tuesday, March 5, 2019

Time: 2:30-3:30 p.m. ET

Call-In Number: 1-800-593-7188

Participant Code: 4206450

Weblink: https://hrsa.connectsolutions.com/fy19_small_health_care_provider/

Webinar Recording: <https://www.mymeetings.com/mm/ims/d.php?o=8555765>

Playback Number: 800-310-4931

Passcode: 8468

Please see [Appendix B](#) for a comprehensive resource list provided for Rural Quality Program applicants.

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)

PROPOSED MEASURES

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

ACCESS TO CARE (applicable to all award recipients): Number of unique individuals from target patient population who received direct services, type of direct service encounters provided.
POPULATION DEMOGRAPHICS (applicable to all award recipients): Number of people served by ethnicity, race, age group (Children (0-12), Adolescents (13-17), Adults (18-64), Elderly (65 and over)) and insurance status/coverage.
SUSTAINABILITY (applicable to all award recipients): 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).
NETWORK/CONSORTIUM (optional for award recipients): Identify types and number of nonprofit organizations in the consortium
QUALITY IMPROVEMENT IMPLEMENTATION STRATEGIES (applicable to all award recipients): Health Technology, Patient Care / Service Delivery, Provider Performance, Quality Improvement Methodology, Organizational Positioning and Accreditation
UTILIZATION (optional for award recipients): Emergency department (ED) rate and 30-day hospital readmission rate
TELEHEALTH (optional for award recipients): Number of Patient Care Sessions and Total number of miles saved
CLINICAL MEASURES (applicable to all award recipients): (CMS347v2 is the 2019 version) Statin Therapy for the Prevention and Treatment of Cardiovascular Disease, NQF 0059 (CMS 122v7 is the 2019 version) Comprehensive Diabetes Care, NQF 0421 (CMS69v9 is the 2019 version) Body Mass Index (BMI) Screening and Follow-Up, NQF 0018 (CMS165v7 is the 2019 version) Controlling High Blood Pressure, NQF 0028 (CMS138v7 is the 2019 version) Tobacco Use: Screening & Cessation Intervention, NQF 0418 (CMS2v8 is the 2019 version) Screening for Clinical Depression and Follow-Up Plan
OPTIONAL MEASURES (optional for award recipients): NQF 0024 (CMS155v7 is the 2019 version) Weight Assessment and Counseling for Children/Adolescents, NQF 0004 (CMS137v7 is the 2019 version) Alcohol and Other Drug (AOD) Dependence Treatment, NQF1789 Hospital-Wide All-Cause Unplanned Readmission, NQF 0097 Medication Reconciliation Post Discharge, NQF 0102 Chronic Obstructive Pulmonary Disease (COPD) Inhaled Bronchodilator Therapy

Appendix B

Resources for Applicants

Resources for Health Care Quality Improvement

U.S. Department of Health and Human Services Secretary Value Based Care Priority https://www.hhs.gov/about/leadership/secretary/priorities/index.html#value-based-healthcare
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
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.html
U.S. Preventive Services Task Force Clinical Guideline Recommendations https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations
Centers for Medicare and 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 Uniform Data System (UDS) Mapper https://www.udsmapper.org/index.cfm
HRSA Data Warehouse https://datawarehouse.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
CDC Heart Age Risk Calculator https://www.cdc.gov/vitalsigns/cardiovascular-disease/heartage.html
Health Resources and Services Administration (HRSA) Quality Toolkit http://www.hrsa.gov/quality/toolbox/

Agency for Healthcare Research and Quality (AHRQ) Quality and Patient Safety

<http://www.ahrq.gov/qual/qualix.htm>

Institute for Healthcare Improvement

<http://www.ihl.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

<http://www.thecommunityguide.org/>

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.html>

Resources for Mental/Behavioral Health Care Services

U.S. Department of Health and Human Services Secretary Opioids Crisis Priority

<https://www.hhs.gov/about/leadership/secretary/priorities/index.html#opioids>

HRSA Opioids Website

<https://www.hrsa.gov/opioids>

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

<http://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

<http://www.wkkf.org/knowledge-center/resources/2006/02/WK-Kellogg-Foundation-Logic-Model-Development-Guide.aspx>

Centers for Disease Control and Prevention (CDC) Program Evaluation Resources

<http://www.cdc.gov/healthyyouth/evaluation/pdf/brief2.pdf>

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/sites/helpfullcontacts/drocontactlist.pdf>

Primary Care Offices (PCOs)

<https://nhsc.hrsa.gov/sites/helpfullcontacts/drocontactlist.pdf>

FORHP Resources

Small Health Care Provider Quality Improvement Program Grantee Directory

<https://www.ruralhealthinfo.org/assets/744-2233/2016-2019-small-provider-quality-improvement-grantee-directory.pdf>

Rural Health Information Hub (RHlhub) <https://www.ruralhealthinfo.org/>

Note: The RHlhub also provides free customized assistance to support gathering data, statistics, and general rural health information. To utilize RHlhub's free customized assistance, please call 1-800-270-1898 or email them at info@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/>

Note: For information on how SORHs can be helpful in supporting rural community organizations, please visit the NOSORH website and check out the following resources:

- Community-Based Division 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>