U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Federal Office of Rural Health Policy
Community-Based Division

Rural Health Care Coordination Program

Funding Opportunity Number: HRSA-20-030
Funding Opportunity Type: New
Assistance Listings (CFDA) Number: 93.912

NOTICE OF FUNDING OPPORTUNITY

Fiscal Year 2020

Application Due Date: March 12, 2020

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: December 13, 2019

Kanokphan Mew Pongsiri
Public Health Analyst, Federal Office of Rural Health Policy
Telephone: (301) 443-2752
Email: kpongsiri@hrsa.gov

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

EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA) is accepting applications for fiscal year (FY) 2020 Rural Health Care Coordination Program. The purpose of this program is to support rural health consortiums aiming to improve access and quality of care through application of care coordination strategies with the focus areas of collaboration, leadership and workforce, improved outcomes, and sustainability in rural communities.

The FY 2020 President's Budget does not request funding for this program. This notice is a contingency action taken to ensure that, should funds become available for this purpose, HRSA can process applications and award funds in a timely manner. You should note that this program may be cancelled prior to award.

Funding Opportunity Title:	Rural Health Care Coordination Program
Funding Opportunity Number:	HRSA-20-030
Due Date for Applications:	March 12, 2020
Anticipated Total Annual Available FY 2020 Funding:	$2,500,000
Estimated Number and Type of Awards:	Up to 10 grants
Estimated Award Amount:	Up to $250,000 per year
Cost Sharing/Match Required:	No
Period of Performance:	September 1, 2020 through August 31, 2023 (3 years)
Eligible Applicants:	• Located in a rural county or eligible rural census tract; **and** • Rural public and nonprofit private entities including faith-based and community organizations; **and** • In a consortium with at least two additional organizations. These two other organizations can be rural, urban, nonprofit or for-profit. The consortium must include at least three or more health care providers; **and** • Have not previously received an award for the same or similar project unless the applicant is proposing to expand the scope of the project or the area that will be served through the project. See Section III.1 of this notice of funding opportunity (NOFO) for complete eligibility information.

Application Guide

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

Technical Assistance

HRSA has scheduled the following technical assistance:

Webinar

Day and Date: Wednesday, January 29, 2020
Time: 2 - 3 p.m. ET
Call-In Number: 1-888-989-6418
Participant Code: 1367949
Weblink: https://hrsa.connectsolutions.com/rural_health_care_coordination_network/
Playback Number: 1-888-673-3568
Passcode: 2752

Table of Contents

I. PROGRAM FUNDING OPPORTUNITY DESCRIPTION 1

1. PURPOSE 1
2. BACKGROUND 2

II. AWARD INFORMATION 4

1. TYPE OF APPLICATION AND AWARD 4
2. SUMMARY OF FUNDING 4

III. ELIGIBILITY INFORMATION 4

1. ELIGIBLE APPLICANTS 4
2. COST SHARING/MATCHING 8
3. OTHER 8

IV. APPLICATION AND SUBMISSION INFORMATION 9

1. ADDRESS TO REQUEST APPLICATION PACKAGE 9
2. CONTENT AND FORM OF APPLICATION SUBMISSION 10
   i. Project Abstract 11
   ii. Project Narrative 12
   iii. Budget 25
   iv. Budget Narrative 25
   v. Attachments 25
3. DUN AND BRADSTREET DATA UNIVERSAL NUMBERING SYSTEM (DUNS) NUMBER AND SYSTEM FOR AWARD MANAGEMENT 28
4. SUBMISSION DATES AND TIMES 29
5. INTERGOVERNMENTAL REVIEW 29
6. FUNDING RESTRICTIONS 29

V. APPLICATION REVIEW INFORMATION 30

1. REVIEW CRITERIA 30
2. REVIEW AND SELECTION PROCESS 38
3. ASSESSMENT OF RISK 39

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: DRAFT PERFORMANCE MEASURES 44

APPENDIX B: COMMON DEFINITIONS 45

APPENDIX C: USEFUL RESOURCES 49

I. Program Funding Opportunity Description

1. Purpose

This notice announces the opportunity to apply for funding under the Rural Health Care Coordination Program (Care Coordination Program). The purpose of this program is to support rural health consortiums/networks aiming to achieving the overall goals of improving access, delivery, and quality of care through the application of care coordination[1] strategies in rural communities.

In order to achieve the goal of the Care Coordination Program, applicants are required to coordinate the health care delivery services in rural communities through the following four focus areas. Literature[2] and previous award recipients[3] have cited these key elements for a successful rural care coordination program.

1) **Collaboration**: Utilizing a collaborative approach to coordinate and deliver health care services through a consortium, in which member organizations actively engage in integrated, coordinated, patient-centered delivery of health care services.

2) **Leadership and Workforce**: Developing and strengthening a highly skilled care coordination workforce to respond to vulnerable populations' unmet needs within the rural communities.

3) **Improved Outcomes**: Expanding access and improving care quality and delivery, and health outcomes through evidence-based model and/or promising practices tailored to meet the local populations' needs.

4) **Sustainability**: Developing and strengthening care coordination program's financial sustainability by establishing effective revenue sources such as expanded service reimbursement, resource sharing, and/or contributions from partners at the community, county, regional, and state levels.

Successful award recipients of the Care Coordination Program will be able to demonstrate: 1) enhanced integrated systems to collaborate and share data among member organizations; 2) effective care coordination workforce to meet needs within the rural communities; 3) improved access, delivery, and quality of services and overall patients' health outcomes; and 4) increased program financial sustainability.

---

[1] Rural Health Information Hub. (2018). Defining Care Coordination. Rural Care Coordination Toolkit. Available at: https://www.ruralhealthinfo.org/toolkits/care-coordination.

[2] Alfero C, Coburn A, Lundblad J, MacKinney A, McBride T, Mueller K, Weigel, P. (2015). Care Coordination in Rural Communities Supporting the High Performance Rural Health System. Rural Policy Research Institute. Available at: http://www.rupri.org/wp-content/uploads/2014/09/Care-Coordination-in-Rural-Communities-Supporting-the-High-Performance-Rural-Health-System.-RUPRI-Health-Panel.-June-2015.pdf.

[3] Health Resources and Services Administration. (2018). Rural Health Care Coordination Network Partnership Grant Recipients Sourcebook, 2015-2018. Available at: https://www.ruralhealthinfo.org/resources/12555.

2. Background

This program is authorized by Section 330A(e) of the Public Health Service (PHS) Act (42 U.S.C. 254c(e)), as amended to improve access and quality of care through the application of care coordination strategies with the focus areas of collaboration, leadership and workforce, improved outcomes, and sustainability in rural communities.

The Agency for Healthcare Research and Quality (AHRQ) defines care coordination as "the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services".[1] Care coordination connects primary care physicians, specialists, hospitals, behavioral health providers, other health care organizations, and non-health social service organizations, including schools, housing agencies, correctional facilities, and transportation organizations. All of these entities work together to communicate information and organize patient's care to make it safer, more appropriate, and more effective.[2] Care coordination creates smooth transitions as a patient interacts with various providers and services and allows for holistic patient care and patient engagement in care management.[3]

Numerous developments in state health policy support the adoption of care coordination models, including patient centered medical homes (PCMH), accountable care organizations (ACO), and enhanced health information technology (HIT) such as electronic health records (EHR) and telehealth capabilities. These programs and other care coordination activities have shown improved outcomes for patients, providers, and payers. The benefits include improved overall patient experience and better health outcomes, as shown by fewer unnecessary hospitalizations and conflicting prescriptions and clearer communication between providers and patients about the best course of treatment.[4]

Care coordination is especially critical for rural communities to address the growing rural health disparities. Rural Americans have generally poorer health outcomes compared to their urban counterparts with higher prevalence of chronic diseases, mental illnesses,

[1]Agency for Healthcare Research and Quality. (2014). Chapter 2. What is Care Coordination? Available at: https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/chapter2.html.
[2] Rural Health Information Hub. (2018). Defining Care Coordination. Rural Care Coordination Toolkit. Available at: https://www.ruralhealthinfo.org/toolkits/care-coordination.
[3] Stanek M, Hanlon C, Shiras T. (2014). Realizing Rural Care Coordination: Considerations and Action Steps for State Policy-Makers. Robert Wood Johnson Foundation. Available at: https://www.shvs.org/wp-content/uploads/2014/04/RWJF_SHVS_Realizing-Rural-Care-Coordination.pdf.
[4] Agency for Healthcare Research and Quality. (2016). National Healthcare Quality and Disparities Report Chart book on Care Coordination. Available at: https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhgrdr/chartbooks/carecoordination/qdr2015-chartbook-carecoordination.pdf.

and obesity.[1,2] Rural areas also have higher rates of avoidable or excess mortality from some of the leading causes of death (cancer, heart disease, injury and respiratory disease).[3,4] Local health care providers are often not available or not easily accessible in rural communities that span large geographic areas due to long distances. Rural populations also tend to have lower socioeconomic status[5] and are more likely not to have health insurance.[6] Because of these challenges, patients from rural communities may greatly benefit from care coordination. Care coordination programs and strategies can be tailored to address a rural community's specific challenges within the community's available resources. Strategies may include special emphasis on: (1) recruiting or training personnel to assume care coordination responsibilities, including either clinical staff or supporting nonclinical staff, such as community health workers; (2) developing new or utilizing existing resources, such as co-locating available behavioral and primary health care services; (3) addressing quality improvement through innovations like telehealth; and (4) establishing a consortium or network to leverage strengths and resources of different member organizations, including hospitals, federally qualified health centers, primary care physicians, local health departments, and/or non-profit organizations.[7]

Care coordination in rural communities is increasingly important, as these communities often experience widening disparities in access to care, health status, and available infrastructure relative to their urban counterparts. For many rural communities throughout the United States, care coordination is one of key strategies to achieve better patient care, improved overall health outcomes, and lower health care costs[1].

To find resources on how to develop a rural health care coordination program, see **Appendix C** for Rural Care Coordination Toolkit. To learn about rural health program sustainability through strategic partnerships, please visit the Rural Health Public-Private Partnership (RHPPP) and Rural Health Aligned Funding Initiative – Care Coordination Opportunity Page at https://www.ruralhealthinfo.org/philanthropy/aligned-funding-opportunity

[1].Alfero C, Coburn A, Lundblad J, MacKinney A, McBride T, Mueller K, Weigel, P. (2015). Care Coordination in Rural Communities Supporting the High Performance Rural Health System. Rural Policy Research Institute. Available at: http://www.rupri.org/wp-content/uploads/2014/09/Care-Coordination-in-Rural-Communities-Supporting-the-High-Performance-Rural-Health-System.-RUPRI-Health-Panel.-June-2015.pdf.

[2] Rural Health Information Hub. (2019). Rural Health Disparities. Available at: https://www.ruralhealthinfo.org/topics/rural-health-disparities.

[3] CDC Center for Surveillance, Epidemiology, and Laboratory Services (CSELS). (2017). Leading Causes of Death in Rural America. Available at: https://www.cdc.gov/ruralhealth/cause-of-death.html.

[4] Moy E, Garcia MC, Bastian B, et al. Leading Causes of Death in Nonmetropolitan and Metropolitan Areas — United States, 1999–2014. MMWR Surveill Summ 2017. Available at: https://www.cdc.gov/mmwr/volumes/66/ss/ss6601a1.htm.

[5] Rural Health Information Hub. (2018). Defining Care Coordination. Rural Care Coordination Toolkit. Available at: https://www.ruralhealthinfo.org/toolkits/care-coordination.

[6] Stanek M, Hanlon C, Shiras T. (2014). Realizing Rural Care Coordination: Considerations and Action Steps for State Policy-Makers. Robert Wood Johnson Foundation. Available at: https://www.shvs.org/wp-content/uploads/2014/04/RWJF_SHVS_Realizing-Rural-Care-Coordination.pdf.

[7] Rural Health Information Hub. (2018). Partnerships Model Implementation Considerations. Available at: https://www.ruralhealthinfo.org/toolkits/care-coordination/2/partnerships-model/implementation-considerations.

II. Award Information

1. Type of Application and Award

Type of applications sought: New

HRSA will provide funding in the form of a grant.

2. Summary of Funding

HRSA estimates approximately $2,500,000 to be available annually to fund 10 recipients. The actual amount available will not be determined until enactment of the final FY 2020 federal appropriation. You may apply for a ceiling amount of up to $250,000 total cost (includes both direct and indirect, facilities and administrative costs) per year. The FY 2020 President's Budget does not request funding for this program. This program notice is subject to the appropriation of funds, and is a contingency action taken to ensure that, should funds become available for this purpose, HRSA can process applications and award funds in a timely manner. The period of performance is September 1, 2020 through August 31, 2023 (3 years). Funding beyond the first year is subject to the availability of appropriated funds for the Rural Health Care Coordination 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 Rural Health Care Coordination Program must meet all of the eligibility requirements stated below.

A. Ownership and Geographic Requirements

Applicants for the Rural Health Care Coordination Program must meet the ownership and geographic requirements provided below. Applicants that do not meet the below criteria will not be considered under this notice of funding opportunity (NOFO).

1. The applicant organization must be a rural public or rural nonprofit private entity that represents a consortium of three or more health care providers. For the purposes of the Care Coordination Program, a consortium can also be a health care network (see **Appendix B** for definitions). The applicant organization must be located in a non-metropolitan county or in a rural census tract of a metropolitan county. All services must be provided in a non-metropolitan county or rural census tract. The applicant's EIN number should verify it is a rural entity. To determine rural eligibility of the applicant organization and the population served through this funding, please refer to: https://data.hrsa.gov/tools/rural-health to search by county or street address. The applicant organization's county name must be filled out 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. A consortium or network serving rural communities, but whose applicant organization is not in a designated rural area, will not be considered for funding under this notice.

2. In addition to the 50 U.S. states, only organizations in Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, American Samoa, the U.S. Virgin Islands, the Federated State of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau may apply. If you are located outside the 50 states, you must still meet the rural eligibility requirements.

3. Faith-based and community-based organizations are eligible to apply for these funds. Tribes and tribal organizations are eligible to apply for these funds. Eligible organizations include state, local, and tribal governments, institutions of higher education, other non-profit organizations (including faith-based, community-based, and tribal organizations), and hospitals.

4. If the applicant organization is a nonprofit entity (including a tribal organization), one of the following documents must be included in **Attachment 2** to prove nonprofit status (not applicable to state, local, and tribal government entities):
    - 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 your 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 organization, a statement signed by the parent organization that your organization is a local nonprofit affiliate.

5. If the applicant organization is a public entity, proof of nonprofit status is not necessary. The applicant organization must, however, identify themselves as a public entity and submit an official signed letter on city, county, state, or tribal government letterhead in **Attachment 2** (applicants may include supplemental information such as documentation of the law that created the organization or documentation showing that the state or a political subdivision of the state, controls the organization.) Tribal government entities should verify their federally-recognized status via the Bureau of Indian Affairs website: http://www.bia.gov.

6. Funding provided through this program must be used for programs that serve populations residing in HRSA designated rural areas. Please confirm that your service area and recipients of this award reside in a HRSA designated rural area by visiting: https://data.hrsa.gov/tools/rural-health?tab=StateCounty.

7. 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 1.**

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

urbanized area population into consideration will not be eligible. For further information, please visit: https://www.census.gov/programs-surveys/geography.html. Prisoners held in local jails cannot be removed from the core urbanized area population. This exception is only for the purpose of eligibility for FORHP award programs. To find out if you are eligible for a reclassification, please contact Steve Hirsch at 301-443-7322 or SHirsch@hrsa.gov. If eligible, you will be required to request the exception and present the data in **Attachment 14.** Eligibility will be verified by HRSA/FORHP. Please contact HRSA with any questions or further clarification.

8. Foreign entities are not eligible for this HRSA award.

B. Consortium Requirements

Applicants must meet the following consortium requirements:

1. As stated in Section 330A(e) of the Public Health Service Act (42 U.S.C. 254c(e)), a consortium composed of at least three or more health care providers (**Appendix B** for definition) will be required to be eligible for this notice of funding opportunity (NOFO).

2. Only one consortium member will serve as the applicant of record and you, as the applicant organization, are required to meet the ownership or geographic requirements stated in Section III(1)(A). Other consortium members do not have to meet the ownership and geographic eligibility requirements.

3. Entities that do not meet the eligibility requirements (i.e., urban, for-profit etc.) are not eligible to be the applicant organization but are eligible to be consortium members. Examples of eligible consortium member entities include: hospitals, public health agencies, home health providers, mental health centers, primary care service providers, oral health service providers, substance abuse service providers, rural health clinics, social service agencies, health professions schools, local school districts, emergency services providers, community and migrant health centers, black lung clinics, churches and other faith-based organizations, civic organizations, foundations, and philanthropies.

4. Each consortium member must demonstrate substantial involvement in the project and contribute significantly to the goals of the project. The roles and responsibilities of each consortium member must be clearly defined in a Memorandum of Understanding/Agreement (MOU/A). The MOU/A must be signed by all consortium members and submitted as **Attachment 3**.

5. For the purposes of this program, a consortium is defined as an organizational arrangement among at least three separately owned local or regional health care providers in which each member has their own EIN number and has a substantial role in the project. The consortium must maintain at least three separate and different health care provider organizational members throughout the entire period of performance. The applicant must provide a list of all consortium members and submitted as **Attachment 11**.

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 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 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.

If the applicant organization has a history of receiving funds from HRSA/FORHP, they must propose a project that is different from the previously funded project (i.e., expanding the service area of the project, serving a new population, providing a new service or expanding the scope of the previous award activities) and have at least two (2) new consortium members. Abstracts from previous HRSA/FORHP awards must be submitted in **Attachment 5**.

Notifying your State Office of Rural Health
You are required to notify the State Office of Rural Health (SORH) of your intent to apply to this program. A list of the SORHs can be accessed at https://nosorh.org/nosorhmembers/nosorh-members-browse-by-state/. You must include in **Attachment 4** a copy of the letter or email sent to the SORH, and any response received to the letter (including an exempt response), that was submitted to the SORH describing your project.

Each state has a SORH, and HRSA recommends making every effort to contact the SORH entity early in the application process to advise them of your intent to apply. The SORH may be able to provide some consultation to you regarding model programs, data resources, and technical assistance for consortiums, evaluation, partner organizations, or support of information dissemination activities. If you do not receive a response, please include the original letter of intent requesting the support.

If you are located in Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, American Samoa, the U.S. Virgin Islands, the Federated States of Micronesia, the Republic of the Marshall Islands, or the Republic of Palau, you do not have a designated SORH. If you are from one of these above listed areas, you can request an email or letter from the National Organization of State Offices of Rural Health confirming the contact. The email address is donnap@nosorh.org.

Rural Health Public-Private Partnerships (RHPPP)
Applicants have an opportunity to build public-private partnerships into their applications. RHPPP includes a number of philanthropies and trusts from across the country that focus on rural health. Many RHPPP-participating organizations have expressed interest in using care coordination as a strategy toward improving health outcomes in rural communities. Applicants may wish to see if they are located in a service area served by an RHPPP-participating organization. To learn more information on this partnership, please visit: https://www.ruralhealthinfo.org/philanthropy/aligned-funding-opportunity

IV. Application and Submission Information

1. Address to Request Application Package

HRSA ***requires*** you to apply electronically. HRSA encourages you to apply through Grants.gov using the SF-424 workspace application package associated with this notice of funding opportunity (NOFO) following the directions provided at http://www.grants.gov/applicants/apply-for-grants.html.

The NOFO is also known as “Instructions” on Grants.gov. You must provide your email address when reviewing or preparing the workspace application package in order to receive notifications including modifications and/or republications of 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 the *Application Guide* for the Application Completeness Checklist.

Application Page Limit

The total size of all uploaded files may not exceed the equivalent of **80 pages** when printed by HRSA. The page limit includes the abstract, project and budget narratives, attachments, and letters of commitment and support required in the *Application Guide* and this NOFO. Standard OMB-approved forms that are included in the workspace application package do not count in the page limit. 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 this notice.

Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification

1) You, on behalf of the applicant organization certify, by submission of your proposal, that neither you nor your principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
2) Failure to make required disclosures can result in any of the remedies described in 45 CFR § 75.371, including suspension or debarment. (See also 2 CFR parts 180 and 376, and 31 U.S.C. 3321).
3) Where you are unable to attest to the statements in this certification, an explanation shall be included in **Attachment 15**: Other Relevant Documents.

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

Program-Specific Instructions

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

i. Project Abstract

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

Please provide a brief abstract with the following information:

ABSTRACT HEADING CONTENT
Applicant Organization Information Organization Name, Address, Facility/Entity Type and Website Address *(if applicable)*
Designated Project Director Information Project Director Name & Title, Contact Phone Numbers and E-Mail Address
Rural Health Care Coordination 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.
Consortium/Network Members ○ Brief description of the name and purpose of the consortium ○ Total number and facility/entity type of consortium members involved in the project and those who have signed a Memorandum of Understanding/Agreement.
Consortium/Network Project Activities/Services Brief description of the proposed project activities and/or services through four focus areas: Collaboration, Leadership and Workforce, Improved Outcomes, and Sustainability.
Expected Outcomes Brief description of the proposed project's expected outcomes.
Evidence-based or Promising Practice Models The title/name of the evidence-based or promising practice model(s) that you will be adopting and/or adapting. If the model was tailored for the proposed project, please briefly describe how it was modified.
Funding Preference If requesting a funding preference, ***please place request for funding preference at the bottom of the abstract.*** Applicants must explicitly request a qualifying funding preference and cite the qualification that is being met (see 42 U.S.C. 254c (h) (3)). HRSA highly recommends you include this language: "***Applicant's organization name*** is requesting a funding preference based on ***qualification X***. *County Y is in a designated HPSA; or in a MUC/MUP; or is focusing on primary care, and wellness and prevention strategies*" at the bottom of the abstract if requesting funding preference. If applicable, you need to provide supporting documentation in **Attachment 6: Funding Preference**. Please refer to Section V.2 for further information.

ii. Project Narrative

Your project narrative provides a comprehensive framework and description of all aspects of the proposed project. It should be succinct, self-explanatory, consistent with forms and attachments, and well organized so that reviewers can understand the proposed project.

Applicants are to develop an innovative project to improve access, delivery, and quality of health care services and improve overall health outcomes in their communities using care coordination strategies[1]. Through a consortium, applicants are to coordinate the delivery services in rural communities with the focus areas of collaboration, leadership and workforce, improved outcomes, and sustainability.

Successful applications will contain the information below. Please use the following section headers for the narrative:

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

  Briefly describe the purpose of the proposed project. Summarize the project's goals and expected outcomes as well as explicitly state the evidence-based or promising practice model the proposed project will adopt and/or adapt to meet your community's need. Briefly describe the modification or deviation from the actual model (if any) in making it suitable and appropriate for the proposed project. Further details about the evidence-based or promising practice model must be explained in the "Methodology" section. Please see "Methodology" section for further instructions.

  Programs are encouraged to utilize evidence-based practices or models to promote successful program implementation. Models can be found at https://www.ruralhealthinfo.org/project-examples/evidence-levels/evidence-based.

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

  This section outlines the community's need for your proposed project, and how the local community or region to be served will be involved in the ongoing operations of your project. Describe how your target population was involved in determining the need and relevant barriers the project intends to overcome, and provide a geographical snapshot of the targeted service area(s).

  Please use the following sub-headings for this section: Target Population, Disease Burden, Geographic Details of Service Area, Barriers/Challenges, and Health Care Availability in Service Area.

[1] Rural Health Information Hub. (2018). Defining Care Coordination. Rural Care Coordination Toolkit. Available at: https://www.ruralhealthinfo.org/toolkits/care-coordination.

1. **Target Population**
    a. Describe the target population. Consider disparities based on race, ethnicity, gender identity, sexual orientation, geography, socioeconomic status, disability status, primary language, health literacy, and other relevant elements. You should also consider people with disabilities; non-English speaking populations; people with limited health literacy; or populations that may otherwise be overlooked when identifying target populations.

    b. Describe the target population of the proposed project and the associated unmet health needs (if funded, this is the population that will be monitored and tracked). The population description may include information about the incidence and prevalence of specific conditions, such as chronic diseases, or regarding age and socioeconomic status of the target population. If the focus is specifically on the needs of the consortium members (such as enhancing HIT and obtaining PCMH recognition), describe how addressing the consortium member needs will directly correlate to the unmet health needs of the community.

    c. Compare local data to state and federal data where possible in order to highlight the population's unique needs. For example, the uninsured rate in Community A is 75 percent whereas the state uninsured rate is 60 percent and the national rate is 20 percent. When possible, incorporate any national and/or local rankings data to aid in illustrating the community's need. Cite data for factors that are relevant to the project, such as specific health status indicators, age, etc. Insurance information, poverty, transportation, and statistics regarding crime, drug abuse and other social problems may be relevant and should be included. This section should demonstrate/describe the target population that will be served by the proposed project.

2. **Disease Burden**
    a. Identify specific diseases and/or conditions for the proposed project.

    b. Describe the burden of diseases and/or conditions among the target population to be served. The applicant should describe the quality of life for those affected by these diseases and/or conditions. Data should be used and cited wherever possible to support the information provided.

3. **Geographic Details of Service Area**
    a. Identify the target service area(s) for the proposed project.

    b. Describe any relevant geographical features of the service area that impact access to health care services.

4. **Barriers/Challenges**
    a. Identify any relevant key challenges and barriers to the service area, such as geographic, socioeconomic, linguistic, cultural, ethnic or other barriers, and discuss how the project plans to overcome identified barriers.

    b. All projects that will primarily serve multiple ethnic or racial groups must describe specific plans for ensuring the services provided address the cultural, linguistic, religious, and social differences of the target populations.

5. **Health Care Availability in Service Area**
    a. Describe the health care services available in or near your target service area, such as the number and types of relevant health and social service providers that are located in and near the service area of the project and their relation to the project. How does the proposed project complement the current services in the community? Alternatively, does the proposed project duplicate services that are already available to the community?

    b. Describe how the local community or region to be served will benefit from the consortium because of the Care Coordination Program.

    c. Demonstrate the need for federal funding to support the care coordination activities by describing the environment in which the consortium has developed and why federal funds are appropriate now.

- *METHODOLOGY -- Corresponds to Section V's Review Criterion 2: Response, Review Criterion 3: Evaluative Measures, and Review Criterion 4: Impact*

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

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

2. Strategic Plan

Explain the consortium's strategy for accomplishing the stated goals and objectives. The narrative should include a description of how the proposed award-funded activities will further the consortium's strategic plan and/or business plan.

Demonstrate the consortium's strategies to expand access and improve quality of care focusing on collaboration, leadership and workforce, improved outcomes, and sustainability in rural communities.

a. **Collaboration:** *Utilizing a collaborative approach to coordinate and deliver health care services through a consortium, in which member organizations actively engage in integrated, coordinated, patient-centered delivery of health care services.*

Briefly illustrate the level of collaboration of members in the consortium. Describe each consortium members' contribution to accomplish set program goals. Describe the communication plan that will be used within the consortium and how frequently consortium meetings will be held.

Describe how the consortium previously collaborated or plans to collaborate with any community, county, regional, and/or state-level organizations (i.e., an organization who may share common goals as the consortium and could provide support to the care coordination program through time, financial resources, and/or technical assistance). Consider participating in the RHPPP to strengthen your current or future collaboration. Please refer to **Appendix C** for information on the RHPPP.

b. Leadership and Workforce: *Developing and strengthening a highly skilled care coordination workforce to respond to vulnerable populations' unmet needs within the rural communities.*

Describe how the applicant will develop and strengthen the care coordination workforce. Describe how the care coordination team will be equipped with relevant targeted training and resources to perform their duties, such as addressing barriers based on a patient's social determinants of health. Describe how the consortium will leverage the care coordination team to achieve set program goals. Discuss how the applicant plans to build and/or maintain buy-in from each consortium member organization's executive-level staff (i.e., CEO, CFO, etc.)

c. Improved Outcomes: *Expanding access and improving care quality and delivery, and health outcomes through evidence-based model and/or promising practices tailored to meet the local populations' needs.*

Describe how the consortium plans to demonstrate improved outcomes through specific measures that align with the goals of the proposed project. Establish baseline data for the project specific measures that you have developed. Please refer to HRSA/FORHP Program Specific and Project Specific Measures for two different sets of performance measures you will need to use and/or develop to monitor the project. Successful award recipients of the Care Coordination Program will be able to demonstrate: 1) enhanced integrated systems to collaborate and share data among member organizations; 2) effective care coordination workforce to meet needs within the rural communities; 3) improved access, delivery, and quality of services and overall patients' health outcomes; and 4) increased program financial sustainability.

Outline the specifics of the care coordination evidence-based model and/or promising practices and activities and address the following:

a. Describe the care coordination model and types of activities that will be funded through the Rural Health Care Coordination Program.
b. Describe any anticipated challenges to the care coordination activities described previously. Suggest solutions to the challenges described.
c. If applicable, explain how the applicant plans on overcoming geographic barriers and addressing transportation barriers (i.e., leveraging health information technology and/or telehealth).

d. Sustainability: *Developing and strengthening care coordination program's financial sustainability by establishing effective revenue sources such as expanded service reimbursement, resource sharing, and/or contributions with partners at the community, county, regional, and state levels.*

Demonstrate a cohesive preliminary sustainability plan, which positions the consortium to continue the care coordination activities after the three-year period of performance. The plan should identify:

a. The anticipated plan to sustain the consortium and maintain activities, services, and impact created as a result of the Care Coordination Program. Discuss how the consortium plans to develop and strengthen care coordination program's financial sustainability by establishing effective revenue sources such as expanded service reimbursement, resource sharing, and/or contributions with partners at the community, county, regional, and state levels.

b. How the consortium plans to disseminate information about the care coordination activities and results to consortium members, its communities, and/or any community, county, regional, and/or state-level partners.

c. How the consortium will document and disseminate the value of its programs and services, whether through return on investment (ROI, improvement in quality measures, or other benefits to stakeholders. The applicant shall describe how they will disseminate information gained at the community, county, regional, and/or state-level, including efforts by grassroots, faith-based or community-based organizations.

Please include your preliminary sustainability plan in **Attachment 13**.

- *WORK PLAN -- Corresponds to Section V's Review Criterion 2: Response and Review Criterion 4: Impact*

  Describe the process to achieve each of the activities proposed in the Methodology section. Use a time line that includes completion dates for each activity and identifies responsible staff. This section should clearly demonstrate that the completion of work plan activities utilizes a collaborative approach with all network members. This section should also provide clear evidence that the network has the capacity to begin the rollout and implementation of the proposed activities immediately.

  Please use the following sub-headings in responding to this section: Work Plan, Impact, Replicability, and Dissemination Plan.

  1. Work Plan

  Your work plan narrative description that discusses, at minimum:

  a. Proposed plans for project implementation (including actions steps for implementation);
  b. b. Timeframes assigned for execution of the work plan for each year of the three-year period of performance;
  c. If an activity is a direct service activity, please explicitly write "direct service activity" next to the activity. Note: The direct service activities can account for no more than 30 percent of the award budget. The direct service activities should not be the primary focus of the award but should enhance collaboration and/or serve as a component for business planning and sustainability to the network.
  d. Key personnel and/or partners responsible for implementing project activities;
  e. Performance benchmarks for measuring progress and success of project implementation; and
  f. A clear description of how to measure the work plan output.

  All work plans are required to **include a timeline for all three 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. Identify responsible staff and/or consortium members on the work plan for each project activity and/or activities. Include 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. 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.

2. **Impact**
   - Include a description of the short term and long term impact that will result from the implementation of the proposed program and supporting work plan, including:
     a. Expected impact on the identified target population;
     b. Expected impact on service area health care delivery and services; and
     c. 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.

3. **Replicability**
   - Describe how the proposed program and its intended impact on population health management may serve as a model for use in similar communities with comparable needs. Include any project results that may be nationally relevant and/or have relevant local or state implications regarding replicability.

4. **Dissemination Plan**
   - Describe the methods for disseminating project results and strategies to varying audiences and stakeholders, including information on the types of platforms, mediums, or conferences that will be utilized to share program information so that other rural and non-rural communities may benefit from the program.

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

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

- *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*

  Describe current experience, skills, and knowledge base, including individuals on staff, materials published, and previous work of a similar nature. As appropriate, describe the data collection strategy to collect, analyze, and track data to measure process, impact, and outcomes, with different cultural groups (i.e., race, ethnicity, language) and explain how the data will be used to inform program development and service delivery.

  Please use the following sub-headings in responding to this section: Logic Model, Project Monitoring, Project Assessment, and Resources/Capabilities.

  1. **Logic Model**
     You are required to provide an "outcomes approach" logic model for designing and managing the project. This one-page diagram presents the conceptual framework for the proposed project and clearly illustrates the inputs, activities, outputs, short-term and long-term outcomes, and the impact of the proposed Rural Health Care Coordination activities. The logic model should clearly provide a basis for the work plan and support the measures proposed in the evaluation plan. Illustrate how the logic flow relates to customers (people served), consortium members, and the community. Include the following information:
     a. Goals and objectives of the project.
     b. Inputs and resources utilized to implement the proposed activities to address the selected topic area(s).
     c. Activities or key interventions that will achieve the goals and objectives of the program and topic area.
     d. Outputs, outcome measures, and the population health impact resulting from achievement of the goals and objectives of the program activity(s).
     e. Provide a narrative explaining the logic model (i.e., presumed effects of the Rural Health Care Coordination Program).

     Include the project's logic model and narrative description in **Attachment 7**.

     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.

2. Project Monitoring

There will be two different sets of performance measures you will need to use and/or develop to monitor the project: PIMS measures and project-specific measures.

a. Rural Health Care Coordination Program Specific Measures (PIMS measures)

- You are required to utilize Federal Office of Rural Health Policy Rural Health Network Development Program measures (Performance Improvement Measurement System (PIMS) measures) to help monitor your project (as appropriate and relevant to the proposed project). Award recipients are required to report on the Performance Improvement Measurement System (PIMS) through HRSA's Electronic Handbook (EHB) after each budget period. Award recipients will be required to provide data on these measures annually for continued funding. See Appendix A for PIMS measures. These PIMS measures are subject to change and final PIMS measures will be shared upon notice of award.
- All baseline PIMS data will be collected 60 days after the start of the period of performance.

b. Project Specific Measures (non-PIMS measures)

- Because every project is unique, you must describe and develop measures to be tracked for assuring effective performance of your proposed award-funded project activities. These project specific measures must align with the goals and objectives of the proposed project and measure the potential health impact. Award recipients will be required to articulate the outcomes of the project justified by these measures at the end of the three years of the period of performance.
- In order to demonstrate the effectiveness of the intervention(s) and to determine the replicability of the project to other rural communities, you must propose measures that can be monitored and tracked throughout the three years of the period of performance.
- You will need to establish baseline data for the project specific measures that you have developed.
- You must list all proposed measures and corresponding baseline data for your non-PIMS measures in **Attachment 12**. Organize the proposed measures and corresponding baseline data in a tabular format) when listing them in **Attachment 12**.

3. Project Assessment

You are required to periodically assess the project throughout the period of performance. This is a self-assessment of your program to assess progress towards meeting program goals and objectives. You are required to assess your project by:

a. Identifying the strategies and measures that will be used to assess the project based on the logic model. You should describe how progress toward meeting project goals would be tracked, measured, and assessed.

b. Including outcome and process measures (including baseline measures) that will be tracked throughout the period of performance. These measures must align with the goals and objectives of the proposed project and the potential health impact. Although HRSA/FORHP recognizes that it may be challenging to demonstrate impact in three years, your assessment should describe how the proposed project would contribute to overall health improvement.
c. Reporting on the Performance Improvement Measurement System (PIMS) through HRSA's Electronic Handbook (EHB) after each budget period. Therefore, relevant and applicable measures on HRSA/FORHP's PIMS must also be included in the project's assessment in addition to other measures applicants decide to include.
d. Describing the method by which data and relevant information for identified measures will be collected and analyzed. Identification of the approach selected for use in assessing project progress in relation to proposed outputs and outcomes is required.
e. Providing thorough, meaningful periodic project assessments that clearly demonstrate outcomes and impacts. This may be conducted internally. Explain any assumptions made in developing the project work plan as it relates to the anticipated outputs and outcomes of award-funded activities.

4. Resources/Capabilities

a. You should identify a Project Director who will have administrative and programmatic direction over funded activities, and devote at least halftime (0.50 FTE) to the project.
b. You should describe a clear, coherent plan detailing the staffing requirements necessary to run the project. The information should align with the *Leadership and Workforce Plan*, as described in the Methodology in Section IV.2.ii: Project Narrative.
c. A staffing plan is required and should be included in **Attachment 9**. Specifically, the following should be addressed:
    - The job descriptions for key personnel listed in the application.
    - The number and types of staff, qualification levels, and FTE equivalents.
    - The 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. Resumes/biographical sketches of key personnel should be included in **Attachment 8**.
    - Staffing needs should have a direct link to the activities proposed in the project narrative and budget portion of the application.

- *ORGANIZATIONAL INFORMATION -- Corresponds to Section V's Review Criterion 5: Resources/Capabilities*

  This section describes the abilities and contributions of your organization and the consortium member organizations. Please use the following sub-headings when responding to this section: Applicant Organization, Consortium Composition, and Consortium Involvement.

  1. Applicant Organization

  a. Provide a brief overview of your organization (the applicant organization) and include information regarding mission, structure, and current primary activities. Your organization should describe its ability to manage the project and personnel. Include information regarding support and any oversight to be provided by executive-level staff (e.g., CEO, CFO, etc.) at your organization. It should also identify and describe financial practices and systems that assure your organization has the capacity to manage federal funds. Provide documentation that your organization is a rural nonprofit or public entity (See **Attachment 2**).
  b. Provide an organizational chart of your organization in **Attachment 10**.
  c. State whether your organization has a Project Director in place, or an interim Project Director. If your organization has an interim Project Director, discuss the process and timeline for hiring a permanent project director for this award. The applicant should also describe the system and processes in place to address staff turnover.
  d. Provide information on the individual who will serve as the Project Director (or interim) and be responsible for monitoring the project and ensuring the execution of activities. It is preferred, not required, that your organization will identify a permanent Project Director prior to receiving award funds. Provide evidence that the Project Director will allot adequate time to the project and has management experience involving multiple organizational arrangements. Your organization should have at least one paid half-time staff employed at the time of application.
  e. A description of the roles of key personnel and how their roles relate to the consortium and the proposed project (See **Attachment 9**).

  2. Consortium Composition

  a. The applicant organization is encouraged to carefully consider the selection of participants for the consortium to ensure that the consortium positively contributes to the success of common project goals. The purpose of the consortium is to: 1) encourage creative and lasting collaborative relationships among health providers in rural areas; 2) ensure that your organization receives regular input from relevant and concerned entities within the health sector; and 3) to ensure that the award-funded project addresses the health needs of the identified community.

b. Discuss the strategies employed for creating and defining the consortium. Explain why each of the consortium partners are appropriate collaborators and, what expertise they bring to the project. You should identify when each of the consortium members became involved in the project and detail the nature and extent of each consortium member's responsibilities and contributions to the project.
c. If applicable, describe the history of the consortium.
d. Provide a list of the consortium members. A table may be used to present the following information on each consortium member: the organization, name, address, primary contact person, current role in the community/region, and **the Employer Identification Number (EIN) must be provided for each consortium member.** This should be included in **Attachment 11.**
e. The consortium organizational chart should depict the structure of the consortium for the project and should describe how authority will flow from your organization receiving the federal award funds to the consortium members. This should be included in **Attachment 11.**

3. Consortium Involvement

a. All consortium members must provide significant contribution to the project and be actively engaged in the project; each member must have an identifiable role, specific responsibilities, and a realistic reason for being a consortium member. The roles and responsibilities for each of the organizations in the consortium must be clearly defined in the application.
b. Provide evidence of the ability for each organization participating in the consortium to deliver the services, contribute to the consortium, and otherwise meet the needs of the project. Please note that each participating consortium member must have a substantive and vital role to the achievement of project goals. You must submit a Memorandum of Understanding /Agreement (MOU/A) that is signed and dated by all consortium members as **Attachment 3**. A MOU/A is a written document that must be signed by all consortium members to signify their formal commitment as a consortium. An acceptable MOU/A should at least describe the consortium's purpose and activities; clearly specify each organization's role in the consortium, responsibilities, and any resources (cash or in-kind) to be contributed by the member to the consortium. For the purposes of this program, a letter of commitment is not the same as a MOU/A; a letter of commitment may represent one organization's commitment to the project but does not necessarily outline the roles and responsibilities that are mutually agreed upon among the consortium.

c. Provide details regarding how and when the consortium will regularly meet. Explain the proposed process for soliciting and incorporating input from the consortium for decision-making, problem solving, and urgent or emergency situations. Provide a plan for communication and discuss how coordination will work with the consortium members. Indicators should be included to assess the effectiveness of the communication and coordination of the consortium and its timely implementation. Discuss potential challenges with the consortium (i.e., consortium disagreements, personnel actions, expenditure activities, etc.) and identify approaches that can be used to resolve the challenges.
d. Address how communication and coordination will occur between the Project Director and consortium members and how often communication is expected. Discuss how frequently project updates will be provided to the consortium members and the extent to which the project director will be accountable to the consortium. You should identify a process for periodic feedback and program modification as necessary
e. Describe the relationship of the consortium with the community/region it proposes to serve. Describe the extent to which the consortium and/or its members engage the community in its planning and functioning.

NARRATIVE GUIDANCE

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

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

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. 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 HRSA selects the application for funding, you will have a well-organized plan and by carefully following the approved plan can avoid audit issues during the implementation phase.

Reminder: The Total Project or Program Costs are the total allowable costs (inclusive of direct **and** indirect costs) 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." See Section 4.1.iv Budget – Salary Limitation of HRSA's *SF-424 Application Guide* for additional information. Note that these or other salary limitations may apply in the following fiscal years, as required by law.

iv. Budget Narrative

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

v. Attachments

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

Attachment 1: Letter from Urban Parent Organization (if applicable)

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

Attachment 2: Proof of Nonprofit Status

The applicant must include a letter from the IRS or eligible state entity that provides documentation of nonprofit status. In place of the letter documenting nonprofit status, public entities may indicate their type of public entity (state or local government) and include it here**.** Refer to Section III 1 for more information. This attachment **will not count** towards the 80-page limit.

Attachment 3: Memorandum of Understanding/Agreement (MOU/A)
You must include a MOU/A (signed and dated by all consortium members). The MOU/A should at least clearly specify each organization's role in the consortium, each member's responsibilities, and any resources (cash or in-kind) to be contributed by the member to the consortium related to care coordination activities.

Attachment 4: State Office of Rural Health Letter
You are required to notify your State Office of Rural Health (SORH) early in the application process to advise them of your intent to apply. The SORH can often provide technical assistance. You should request an email or letter confirming that you have contacted your SORH. State Offices of Rural Health also may or may not, at their own discretion; offer to write a letter of support for the project. Please include a copy of the letter or confirmation of contact in **Attachment 4**. In the case that you do not receive a response from the SORH, submit a copy of your request for consultation to the SORH.

Attachment 5: HRSA Federal Office of Rural Health Policy Funding History Information
Current and former HRSA/FORHP award recipients must include the following information for awards received within the **last 5 years**:

- Dates of prior award(s) received;
- Grant number assigned to the previous project(s);
- A copy of the abstract that was submitted with the previously awarded grant application(s); and
- A description of the roles of your organization and consortium members in the previous award.

Attachment 6: Proof of Funding Preference Designation/Eligibility
If requesting a Funding Preference, include proof of funding preference designation/eligibility in this section (i.e., designated HPSA; or in a MUC/MUP; or is focusing on primary care, and wellness and prevention strategies). Include a printout or screenshot that displays the HPSA and/or MUC/P designation and respective score: https://data.hrsa.gov/topics/health-workforce/shortage-areas.

The printout or screenshot of the HPSA designation can also be found at http://hpsafind.hrsa.gov/ and the MUC/P designation can be found at http://muafind.hrsa.gov/. For further information on Funding Preferences, please refer to Section V.2.

Attachment 7: Logic Model and Narrative Description
You are required to submit a logic model and narrative that illustrates the inputs, activities, outputs, outcomes, and impact of the project.

Attachment 8: Biographical Sketches for Key Personnel
Include biographical sketches for persons occupying the key positions described in the Staffing Plan, not to exceed two pages in length per person. In the event that a biographical sketch is included for an identified individual not yet hired, include a letter of commitment from that person with the biographical sketch.

Attachment 9: Staffing Plan and Job Descriptions for Key Personnel (see Section 4.1. of HRSA's SF-424 Application Guide)
See Organizational Information section for staffing plan requirements. Keep each job description to one page in length as much as is possible. Include the role, responsibilities, full time equivalents (FTE), and qualifications of proposed project staff. Also, please include a description of your organization's timekeeping process to ensure that you will comply with the federal standards related to documenting personnel costs. Key Personnel is defined as persons funded by this award or persons conducting activities central to this program. If the Project Director (PD) serves as a PD for other federal awards, please list the federal awards as well as the percent FTE for that respective federal award.

Attachment 10: Project Organizational Chart
Provide a one-page figure that depicts the organizational structure of the project. The governing body's relationship to the consortium should also be depicted in this chart.

Attachment 11: Consortium Member List and Organizational Chart
For each member of the existing network, include the following (**Must be provided in a table format; list the applicant organization first**):

i. Member name
ii. Member street address (include city, county, state, zip code)
iii. Primary point of contact at organization (name, title, contact information)
iv. Member Employer Identification Number (EIN)
v. Facility type (e.g., hospital, Rural Health Clinic, Federally Qualified Health Center, etc.)
vi. Sector (e.g., healthcare, public health, education, transportation, etc.)
vii. List each of the consortium member organizations' roles, responsibilities and contributions to the project
viii. Specify (yes/no) whether member located in a HRSA-designated rural county or rural census tract of an urban county, as defined by: https://data.hrsa.gov/tools/rural-health?tab=Address

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

Attachment 12: Additional Proposed Measures not included in PIMS
These are additional proposed measures not included in the proposed PIMS measures in **Appendix A**.

Attachments 13: Preliminary Sustainability Plan
Applicants are required to submit a preliminary sustainability plan that demonstrates a cohesive plan for sustaining the impact of the consortium programs and services created with this funding. Refer to Section IV.ii. Project Narrative for more information.

Attachment 14: Exception Request (If Applicable)
If a metropolitan area would otherwise be considered non-metropolitan (in the event that the core, urbanized area population count did not include federal and/or state prison populations) you must present and submit documented evidence of the total population for the core urbanized area. In addition, you must demonstrate validity through data from the Census Bureau, state, or Federal Bureaus of Prisons or Corrections Departments. This exception is only for the purpose of eligibility for FORHP/HRSA award programs. To find out if you are eligible for a reclassification, please contact Steve Hirsch at SHirsch@hrsa.gov or 301-443-7322.

Attachment 15: Other Relevant Documents (Optional)
Applicants with additional information not provided in previous attachments may provide this information here.

3. Dun and Bradstreet Data Universal Numbering System (DUNS) 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*.

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.

In accordance with the Federal Government's efforts to reduce reporting burden for recipients of federal financial assistance, the general certification and representation requirements contained in the Standard Form 424B (SF-424B) – Assurances – Non-Construction Programs, and the Standard Form 424D (SF-424D) – Assurances – Construction Programs, have been standardized federal-wide. Effective January 1, 2020, the updated common certification and representation requirements will be stored and maintained within SAM. Organizations or individuals applying for federal financial assistance as of January 1, 2020, must validate the federally required common certifications and representations annually through SAM located at SAM.gov.

If you fail to allow ample time to complete registration with SAM or Grants.gov, you will not be eligible for a deadline extension or waiver of the electronic submission requirement.

4. Submission Dates and Times

Application Due Date
The due date for applications under this NOFO is *March 12, 2020 at 11:59 p.m. ET*. HRSA suggests submitting applications to Grants.gov at least **3 calendar days before the deadline** to allow for any unforeseen circumstances. See Section 8.2.5 – Summary of emails from Grants.gov of HRSA's *SF-424 Application Guide* for additional information.

5. Intergovernmental Review

The Rural Health Care Coordination 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 3 years, at no more than $250,000 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) are in effect at the time this NOFO is posted. Please see Section 4.1 of HRSA's *SF-424 Application Guide* for additional information. Note that these or other restrictions will apply, as required by law in subsequent appropriations acts for FY 2020. HRSA will issue an NOA that references the final FY 2020 appropriations act.

Award funds may not be used to build or acquire real property, or for construction, 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 organization complies with all legal requirements and restrictions applicable to the receipt of federal funding including statutory restrictions on use of funds for lobbying, executive salaries, gun control, abortion, etc. Like those for all other applicable grants requirements, the effectiveness of these policies, procedures, and controls is subject to audit.

All program income generated from awarded funds must be used for approved project-related activities. The program income alternative applied to the award(s) under the program will be the 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 technical merit of applications to provide for an objective review and to assist you in understanding the standards against which your application will be reviewed. HRSA has critical indicators for each review criterion to assist you in presenting pertinent information related to that criterion and to provide the reviewer with a standard for evaluation.

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

Review criteria are used to review and rank applications. The Rural Health Care Coordination Program has six review criteria. See the review criteria outlined below with specific detail and scoring points.

CRITERION	NUMBER OF POINTS
1. Need	25
2. Response	25
3. Evaluative Measures	5
4. Impact	10
5. Resources/Capabilities	25
6. Support Requested	10
TOTAL POINTS	100

Criterion 1: NEED (25 points) – Corresponds to Section IV's Introduction and Needs Assessment

Sub-criterion One: 15 points
Analysis of the Community Data and Existing Services and Programs

The extent to which the application:

- Describes the purpose of the proposed activity, how it supports rural health consortiums, and how the project will meet the health care needs of the rural underserved population. Clearly and succinctly submits information on the activities/types of services provided, collaborating consortium members, and expected program outcomes and community impact.

- Describes the relationship between the challenges impacting the consortium's rural communities and the need for the Care Coordination Program in a clear and logical manner.

- Indicates the need for the identified care coordination activities using submitted information on the target population, disease burden, geographic details of service area, barriers/challenges, and health care availability in service area.

- Identifies diseases and/or conditions for the proposed project, the burden of diseases and/or conditions among the target population.

- Uses appropriate data sources (i.e., local, state, federal) in their analysis of the health care and consortium needs and the environment in which the consortium is functioning and the degree to which this evidence substantiates the need for the consortium and proposed care coordination activities.

- Provides quantifiable information on the lack of existing services/programs available in the applicant's community/region. Extent to which the applicant clearly demonstrates the nature of geographical services area, including consortium membership. Manner in which the applicant will meaningfully contribute to fill gaps in existing services.

- Identifies the key challenges and barriers to consortium functions and implementation of the care coordination activities/services in the service area and discusses a plan to overcome the identified challenges and barriers.

Sub-criterion Two: 10 points
Addressing Community Needs and Demonstrating Need for Grant Funds

The extent to which the application:

- Discusses relevant services currently available in or near the consortium service area and the potential impact of the consortium's activities on providers, programs, organizations, and other consortium entities in the community.

- Describes how the local community or region to be served will benefit from the consortium as a result of the care coordination program.

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

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

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

Sub-criterion One: 10 points
Developing Strategies to Accomplish Goal

The extent to which the application:

- Describes the goals and objectives of the proposed grant-funded activities in a clear, concise and appropriate manner. These goals and objectives directly relate to the information presented in the *Needs Assessment* Section. These activities flow logically from the goals and objectives. The applicant's approach and strategy is innovative and clearly relates to the process and outcome measures chosen by the applicant.

- Discusses an evidence-based or promising practice model that will be used to meet the health care needs of their target population.

- Describes the consortium's strategy for accomplishing the state goals and objectives using the project's four focus areas: 1) Collaboration, 2) Leadership and Workforce, 3) Improved Outcomes, and 4) Sustainability.

- Addresses potential challenges in providing coordinated quality health care and a strategy to address challenges.

- Presents a clear and cohesive plan for communicating consortium activities and how the plan is integrated into each consortium members' organizational activities. Appropriateness of the approach and frequency for consortium meetings.

Sub-criterion Two: 5 points
Demonstrating Collaboration Activities and Using Evidence-Based and/Promising Practices Model to Improve Outcomes

The extent to which the application:

- Describes the consortium level of collaboration and whether the collaboration level is appropriate to achieve the stated activities.

- Describes each consortium members' contribution to accomplish set program goals.

- Describes how the consortium previously collaborated or plans to collaborate with any community, county, regional, and/or state-level organizations or any organizations within the RHPPP (i.e., foundations, and philanthropies).

- Describes an evidence-based or promising practice care coordination model and activities and how they will be used to meet the health care needs of their target population.

- Demonstrates a comprehensive understanding of potential challenges likely to be encountered in designing and implementing the activities described in the Work Plan. Appropriateness of proposed approaches to resolve the identified potential challenges.

- Describes the approach to overcoming any geographical barriers and addressing barriers related to target population's social determinants of health.

Sub-criterion Three: 10 points
Demonstrating an Appropriate Work Plan as well as Leadership and Workforce and Sustainability Plans

The extent to which the application:

- Includes a clear and coherent work plan aligned with the consortium's annual goals, objectives, and strategies. Appropriateness of the work plan in identifying responsible individual(s) and organization(s) and a timeline for each activity for all three years. Appropriateness of associated process, outcome, and patient and provider satisfaction measures and their benchmarks for each activity and respective goal.

- Aligns the Work Plan with the implementation timeline and deliverables.

- Describes how to build and strengthen the care coordination workforce.

- Includes plans to provide the care coordination team with relevant targeted training and resources to perform their duties, such as addressing barriers based on a patient's social determinants of health.

- Includes plans to build and/or maintain buy-in from each consortium member organization's executive-level staff.

- Demonstrates a cohesive sustainability plan, which positions the consortium to sustain the care coordination activities and impact. The extent to which the applicant presents:

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

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

c. A plan on how to document and disseminate the value of its programs and services, whether though return on investment (ROI), improvement in quality measures, or other benefits to stakeholders.

Criterion 3: EVALUATIVE MEASURES (5 points) – Corresponds to Section IV's Evaluation and Technical Support Capacity

The extent to which the application:

- Demonstrates that the logic model strengthens the work plan as evidenced by the inputs, activities, outputs, short-term and long-term outcomes, and the impact of the project in **Attachment 7**.

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

- Demonstrates the effectiveness of the process for collecting and analyzing data/information for program assessment measures and the approach for assessing the consortium's progress in relation to proposed outputs and outcomes.

- Demonstrates the effectiveness of the proposed method to create a strong program assessment. The strength of the assessment plan in regards to the needs assessment, program goals, work plan, and sustainability.

- Identifies and incorporates measures that are aligned with the goals and objectives of the program and the supporting work plan activities.

- Explains the feasibility of collecting data and how the data will be used to inform program development and service delivery.

- Demonstrates how the consortium will monitor the project. Presence and appropriateness of specific measures to use for assuring effective performance of the proposed grant-funded activities and on-going quality assurance/quality improvement strategies that will assist in the early identification and modification of ineffective efforts.

Criterion 4: IMPACT (10 points) – Corresponds to Section IV's Methodology, Work Plan, and Evaluation and Technical Support Capacity

The extent to which the application:

- Demonstrate the proposed care coordination activities (discussed in the applicant's Work Plan and logic model) will positively impact the patients, providers, consortium members, and community and the extent to which the project may be replicable in other communities with similar needs.

- Describe the anticipated impacts of the selected evidence-based or promising practice model/s that was used in the design and development of the proposed project.

- Describe how to demonstrate the anticipated outcomes through specific measures that align with the goals of the project. Appropriateness of baseline data for the project specific measures. Provides baseline and targeted outcome data with a clear alignment to program activities and would indicate success or progress of the program in meeting program goals and objectives. Includes any additional proposed measures not included in PIMS measures in **Attachment 12**.

- Presents clear benchmarks of success for each year. Extent to which the benchmarks to be applied to the project are industry standard from recognized sources, such as NQF, NCQA, CMS; or, the extent to which the applicant proposes appropriate benchmarks if industry standards are not available.

- Describe clearly how the consortium will strengthen its relationship with the community/region/county/state it serves. Degree to which, where appropriate, applicant clearly demonstrates the role of lay consumers of care in the consortium and care coordination planning and functioning.

- Presents a realistic and effective approach for widely disseminating information regarding results of the project.

Criterion 5: RESOURCES/CAPABILITIES (25 points) – Corresponds to Section IV's Evaluation and Technical Support Capacity and Organizational Information.

1. The quality and appropriateness of the resources and the abilities of your organization and the consortium members in fulfilling program requirements and meeting program expectations.

2. The capability to implement and fulfill the requirements of the proposed project based on the resources available and the qualifications of the project staff.

3. The strength of the consortium as evidenced by:
    a. The nature and extent of each consortium member's responsibilities and contributions to the project.
    b. The extent to which the consortium partners are appropriate collaborators and the expertise they bring to the project.
    c. Clearly defined roles and responsibilities for each of the organizations in the consortium and how authority will flow from your organization receiving the federal funds to the consortium members.
    d. The ability of each organization participating in the consortium to deliver the services, contribute to the consortium, and otherwise meet the needs of the project.
    e. The relationship of the consortium with the community/region it proposes to serve.
    f. The extent to which the consortium and/or its members engage the community in its planning and functioning.

4. The strength of the proposed strategies for communication and coordination of the consortium members as evidenced by:
    a. How and when the consortium will meet and the proposed process for soliciting and incorporating input from the consortium for decision- making, problem solving, and urgent or emergency situations.
    b. The plan for communication and coordination between the project director and consortium members, including how often communication is expected.
    c. The proposed frequency of project updates that will be given to the consortium members and the extent to which the project director will be accountable to the consortium.
    d. The strength and feasibility of the proposed process for periodic feedback and program modification as necessary.

5. The strength of the proposed indicators to assess the effectiveness of the communication and coordination of the consortium and its timely implementation.

6. The degree to which you discuss potential challenges with the consortium (consortium disagreements, personnel actions, expenditure activities, etc.) and identify approaches that can be used to resolve the challenges.

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

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

The SF-424A budget forms, along with the budget justification components of the itemized budget and budget narrative, are to be used in the review of this section. Together, they provide information regarding the reasonableness of the support requested.

1. The budget justification logically documents how and why each line item request (such as personnel, travel, equipment, supplies, information technology, and contractual services) supports the goals and activities of the proposed award-funded activities over the length of the three-year period of performance.

2. The degree to which the estimated cost to the government for proposed award-funded activities is reasonable.

2. Review and Selection Process

The objective 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 3 below. In addition to the ranking based on merit criteria, HRSA approving officials will apply other factors (i.e., geographical distribution) described below in selecting applications for award. 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(e) of the Public Health Service (PHS) Act (42 U.S.C. 254c(e)). Applicants receiving the preference will be placed in a more competitive position among applications that can be funded. Applications that do not receive a funding preference will receive full and equitable consideration during the review process. HRSA staff will determine the funding factor and will grant it to any qualified applicant that demonstrates they meet the criteria for the preference(s) as follows:

Qualification 1: Health Professional Shortage Area (HPSA)
You can request this funding preference if the service area of the applicant is located in an officially designated health professional shortage area (HPSA). Applicants must include a screenshot or printout from the HRSA Shortage Designation website, which indicates if a particular address is located in a HPSA:
https://data.hrsa.gov/tools/shortage-area/by-address.

Qualification 2: Medically Underserved Community/Populations (MUC/MUPs)
You can request this funding preference if the applicant is located in a medically underserved community (MUC) or serves medically underserved populations (MUPs). Applicants must include a screenshot or printout from the HRSA Shortage Designation website that indicates if a particular address is located in a MUC or serves an MUP: https://data.hrsa.gov/tools/shortage-area/by-address.

Qualification 3: Focus on Primary Care, and Wellness and Prevention Strategies
You can request this funding preference if your project focuses on primary care and wellness and prevention strategies. You must include a brief justification (no more than 3 sentences) describing how your project focuses on primary care and wellness and prevention strategies in **Attachment 6**.

If requesting a funding preference, please indicate which qualification is being met in the **Project Abstract** and **Attachment 6**. HRSA highly recommends that the applicant include this language:

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

Please provide documentation of funding preference and label documentation as "Proof of Funding Preference Designation/Eligibility." See page 41 of the HRSA SF-424 Application Guide.

You only have to meet one of the qualifications stated above to receive the preference. Meeting more than one qualification does not increase an applicant's competitive position.

3. Assessment of Risk

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

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

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

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).

VI. Award Administration Information

1. Award Notices

HRSA will issue the Notice of Award (NOA) prior to the start date of September 1, 2020. See Section 5.4 of HRSA's *SF-424 Application Guide* for additional information.

2. Administrative and National Policy Requirements

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

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

Human Subjects Protection
Federal regulations (45 CFR part 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:

Annual Reports

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 EHBs. Further information will be provided upon receipt of the award.

2) **Progress Reports**. 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 of subsequent year funds. This report demonstrates award recipient's progress on program-specific goals. Further information will be provided in the NOA.

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

Other Required Reports and/or Plans

4) **Strategic Plan.** Award recipients will be required to submit a three-year strategic plan during the first year of their period of performance. This strategic plan will provide guidance for program development throughout the period of performance and beyond. Further information will be provided upon receipt of the award.

5) **Sustainability Formative Assessment.** Award recipients are required to submit a sustainability formative assessment during the second year of their period of performance. Further information will be provided upon receipt of the award.

6) **Final Sustainability Plan.** 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.

7) **Final Evaluation Report.** Award recipients are required to submit a final program evaluation report at the end of their period of performance that would show, explain and discuss their results and outcomes. Further information will be provided upon receipt of the award.

8) **Final Report.** A final report is due within 90 days after the period of performance ends. The final report will collect information such as program-specific goals and progress on strategies; core performance measurement data; impact of the overall project; the degree to which the recipient achieved the mission, goal and strategies outlined in the program; recipient objectives and accomplishments; barriers encountered; and responses to summary questions regarding the recipient's overall experiences over the entire period of performance. Further information will be provided upon receipt of the award.

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

VII. Agency Contacts

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

Ann Maples
Grants, Management Specialist
Division of Grants Management Operations, OFAM
Health Resources and Services Administration
5600 Fishers Lane, Mailstop 10SWH03
Rockville, MD 20857
Telephone: (301) 443-2963
Fax: (301) 443-9810
Email: amaples@hrsa.gov

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

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

You may need assistance when working online to submit your application forms electronically. Always obtain a case number when calling for support. For assistance with submitting the application in Grants.gov, contact Grants.gov 24 hours a day, 7 days a week, excluding federal holidays at:

Grants.gov Contact Center
Telephone: 1-800-518-4726 (International Callers, please dial 606-545-5035)
Email: 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 a.m. to 8 p.m. ET, excluding federal holidays at:

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

VIII. Other Information

Technical Assistance

HRSA has scheduled following technical assistance:

Webinar

Day and Date: Wednesday, January 29, 2020
Time: 2:00 - 3:00 PM ET
Call-In Number: 1-888-989-6418
Participant Code: 1367949
Weblink: https://hrsa.connectsolutions.com/rural_health_care_coordination_network/
Playback Number: 1-888-673-3568
Passcode: 2752

Tips for Writing a Strong Application

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

Appendix A: Draft Performance Measures

Rural Health Care Coordination Program

Proposed Performance Improvement and Measurement System (PIMS)

Please Note: *The following measures are proposed, non- 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.
NETWORK/CONSORTIUM (applicable to all award recipients): Identify types and number of nonprofit and for-profit organizations in the consortium; Assess consortium's strength across 7 out of 8 characteristics of a sustained network (See RHI's Aim for Sustainability Portal); Calculate the Return on Community Investment (ROCI) a methodology for evaluating or assessing the financial and economic impact of a government or nonprofit investment in a community.
SUSTAINABILITY (applicable to all award recipients): Sources of sustainability; List the ratio for economic impact vs. HRSA program funding (use the HRSA's Economic Impact Analysis tool to calculate ratio).
CARE COORDINATION (applicable to all award recipients): Care coordination mechanisms/ activities you implemented.
SOCIAL DETERMINANTS OF HEALTH (applicable to all award recipients): Determine your community's Determinant Status across 4 out of 12 dimensions of Social Environment (See CDC Data Set Directory); Change over time data; Determine community's level of isolation- (see Windshield surveys- Community Tool Box).
WORKFORCE/ RECRUITMENT & RETENTION (applicable to all award recipients): Number providers trained to work on the project**;** Total number recruited; Total number that completed the training/rotation**;** Total number that plan to practice in a rural area; Identify the type(s) of trainee primary care focus area(s)**;** Identify the type(s) of trainee's discipline**;** Number of new trainings/rotations**;** Identify the types and number of training sites.
UTILIZATION (applicable to all award recipients): Emergency department (ED) rate and 30-day hospital readmission rate.
TELEHEALTH (applicable to all award recipients): Number of Patient Care Sessions and Total number of miles saved.
ELECTRONIC HEALTH RECORD (optional for award recipients): Summary of Care Record: Use of certified EHR technology (CEHRT) to create a summary of care record and electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals.
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 0024 Weight Assessment and Physical Activity for Children/Adolescents,, 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, NQF 2508 Dental Sealants 6-9 Year-Old, CMS74v7 Primary Carries Prevention, CMS50v6: Closing the Loop, NQF 0097 Medication Reconciliation.

Appendix B: Common Definitions

For the purpose of this Notice of Funding Opportunity, the following terms are defined:

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

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

Consortium – An association or agreement of at least three separately owned and governed entities (i.e., health care providers, nonprofit organizations, and educational institutions) formed to undertake an enterprise beyond the resources of any one member. A formal organizational arrangement among at least three separately owned health care providers or other entities that provide or support the delivery of health care services. The purpose of a consortium is to foster collaboration and integration of functions among consortium entities to strengthen the rural health care system.

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

Evidence-Based Programs – Evidence-based public health is defined as the development, implementation, and evaluation of effective programs and policies in public health through application of principles of scientific reasoning, including systematic uses of data and information systems, and appropriate use of behavioral science theory and program planning models[1].

Programs are encouraged to utilize evidence-based practices or models to promote successful program implementation. Models can be found at https://www.ruralhealthinfo.org/project-examples/evidence-levels/evidence-based.

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

[1] Brownson, Ross C., Elizabeth A. Baker, Terry L. Leet, and Kathleen N. Gillespie, Editors. Evidence- Based Public Health. New York: Oxford University Press, 2003. https://phpartners.org/tutorial/04-ebph/2- keyConcepts/4.2.2.html. Accessed April, 2017.

Health Information Technology – The electronic storage of records, electronic billing, electronic ordering of tests and procedures, and even a shared, interoperable network to allow providers to communicate with one another.

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

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

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

Notice of Award – The legally binding document that serves as a notification to the recipient and others that funds have been awarded, contains or references all terms of the award and documents the obligation of federal funds in the HHS accounting system.

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

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

Promising Practice Model – A model with at least preliminary evidence of effectiveness in small-scale interventions or for which there is potential for generating data that will be useful for making decisions about taking the intervention to scale and generalizing the results to diverse populations and settings." [1] An example of a promising practice is a small-scale pilot program that generates positive outcome results and justifies program expansion to new access points and/or service populations.

Recipient – An entity, usually but not limited to non-federal entities, that receives a federal award directly from a federal awarding agency to carry out an activity under a federal program. The term recipient does not include sub recipients.

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

Rural – All counties that are not designated as parts of Metropolitan Areas (MAs) by the Office of Management and Budget (OMB) are considered rural. In addition, HRSA uses the Rural Urban Commuting Area Codes (RUCAs), developed by the WWAMI Rural Research Center at the University of Washington and the Department of Agriculture's Economic Research Service, to designate "rural" areas within MAs. https://datawarehouse.hrsa.gov/tools/analyzers/geo/Rural.aspx

Rural Health Public-Private Partnership (RHPPP) – This Public-Private Collaboration in Rural Health has presented an opportunity for public and private organizations to connect with one another and discuss how combined efforts might produce better health outcomes for rural communities. Currently there are nearly 70 foundations and trusts active in the RHPPP each year. More information can be found at https://www.ruralhealthinfo.org/philanthropy/partnership.

Applicants have an opportunity to build public-private partnerships into their applications as part of the Rural Health Aligned Funding Initiative – Care Coordination Opportunity. Many RHPPP participating organizations have expressed interest in using care coordination as a strategy toward improving health outcomes in rural communities. More information on the Initiative can be found at https://www.ruralhealthinfo.org/philanthropy/aligned-funding-opportunity.

Rural Hospital – Any short-term, general, acute, non-federal hospital that is not located in a metropolitan county, is located in a RUCA type 4 or higher, or is a Critical Access Hospital.

State – Includes, in addition to the 50 states, Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, American Samoa, the U.S. Virgin Islands, and the Republic of Palau.

Telehealth – The use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration.

Tribal Government – Includes all federally recognized tribes and state-recognized tribes.

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

Vulnerable Populations – Vulnerable populations are communities that face significant barriers to better health and whose circumstances have made them susceptible to poor health. Vulnerable populations encounter significant disparities in life expectancy, limited access to and use of health care services, and increased morbidity and mortality rates linked to developmental problems, personal incapacities, disadvantaged social status, inadequacy of interpersonal networks and supports, degraded neighborhoods and environments, and the complex interactions of these factors over the life course.[1]

Some characteristics of vulnerable and underserved populations include individuals who share one or more of the following characteristics. They may:

- Have a high risk for multiple health problems and/or pre-existing conditions
- Have limited life options (i.e., financial, educational, housing)
- Display fear and distrust in accessing government programs or disclosing sensitive information about family members

[1] Agency for Healthcare Research and Quality. (1998). Chapter Eight: Focusing on Vulnerable Populations. Available at: http://archive.ahrq.gov/hcqual/meetings/mar12/chap08.html.

Appendix C: Useful Resources

Several sources offer data and information that will help you in preparing the application. You are especially encouraged to review the reference materials available at the following websites:

Rural Specific Resources and Relevant Websites

A. Federal Office of Rural Health Policy: https://www.hrsa.gov/rural-health/index.html

- Resource Guide for New Applicants and Grantees (PDF - 316 KB):
  - https://www.hrsa.gov/sites/default/files/ruralhealth/resources/newapplicantresourceguide.pdf

The FORHP Resources Guide is a non-comprehensive compendium that provides new applicants and award recipients with an array of relevant resources, tools, and services organized by topic area that will assist in the implementation and sustainability of rural health projects, organizations, and networks.

B. National Organization of State Offices of Rural Health: https://nosorh.org/
National Organization of State Offices of Rural Health (NOSORH) was established to assist State Offices of Rural Health (SORH) in their efforts to improve access to, and the quality of, health care for America's rural citizens. The general purpose of each SORH is to help their individual rural communities build health care delivery systems, and they are expected to: collect and disseminate information; coordinate rural health care activities in states in order to avoid duplication; and provide technical assistance to public and non-profit private entities.

C. National Rural Health Resource Center : https://www.ruralcenter.org/
The National Rural Health Resource Center provides technical assistance, information, tools, and resources for the improvement of rural health care. The Center focuses on five core areas: Performance Improvement; Health Information Technology; Recruitment and Retention; Community Health Assessments; and Networking.

D. RHI Hub: https://www.ruralhealthinfo.org/

- Rural Care Coordination Toolkit: https://www.ruralhealthinfo.org/toolkits/care-coordination
- Rural Community Health Gateway: https://www.ruralhealthinfo.org/community-health/toolkits
- Sustainability Planning Tools: https://www.ruralhealthinfo.org/sustainability

The Rural Health Information Hub (RHIhub) is supported by funding from FORHP and helps rural communities and other rural stakeholders access the full range of available programs, funding, and research that can enable them to provide quality health and human services to rural residents. RHIhub also provides free customized assistance that can provide support in gathering data, statistics, and general rural health information.

E. **Rural Health Link**: http://ruralhealthlink.org/Resources/ResourceLibrary.aspx
Rural Health Link, The Community Health Systems Development team of the Georgia Health Policy Center, hosts this site as a resource for clients, including recipients of HRSA awards.

F. **Rural Health Value**: https://cph.uiowa.edu/ruralhealthvalue/TnR/
The Rural Health Value (RHV) goal is to assist rural communities and providers achieve a high performance health system by providing tools and resources appropriate for varying levels of change-readiness. The RHV website provides tools and resources designed to facilitate transitions to a high performance rural health system.

G. **Rural Health Research Gateway**: https://www.ruralhealthresearch.org/
The Rural Health Research Gateway website provides easy and timely access to all of the research and findings of the HRSA-funded Rural Health Research Centers. You can use the site to find abstracts of both current and completed research projects, publications resulting from those projects, and information about the research centers themselves as well as individual researchers.

Logic Model Resources

A. **Kellogg Foundation**: https://www.wkkf.org/resource-directory/resource/2006/02/wk-kellogg-foundation-logic-model-development-guide
The W.K. Kellogg Foundation (WKKF) works with communities to create conditions for vulnerable children so they can realize their full potential in school, work and life. WKKF's Logic Model Development guide was developed to provide practical assistance to nonprofits engaged in this process. In the pages of this guide, we hope to give staff of nonprofits and community members alike sufficient orientation to the underlying principles of "logic modeling" to use this tool to enhance their program planning, implementation, and dissemination activities.

B. **University of Wisconsin Cooperative Extension**
- Logic Model Course: http://lmcourse.ces.uwex.edu/
- Logic Model Training Guide and other Resources: https://fyi.uwex.edu/programdevelopment/logic-models/

C. **CDC Program Evaluation Resources**:
http://www.cdc.gov/healthyyouth/evaluation/pdf/brief2.pdf
The CDC offers links to other evaluation resources, including manuals, toolkits, websites, and professional associations.

D. **Innovation Network Logic Model Workbook**:
http://www.pointk.org/client_docs/File/logic_model_workbook.pdf

E. **Community Toolbox: Developing a Logic Model or Theory of Change**: http://ctb.ku.edu/en/table-of-contents/overview/models-for-community-health-and-development/logic-model-development/main

Needs Assessments and Other Community Development Tools

A. CDC's Social Determinant of Health (SDoH) Resources

- Tools for Putting Social Determinants of Health into Action: https://www.cdc.gov/socialdeterminants/tools/index.htm
- Sources For Data On SDoH: https://www.cdc.gov/socialdeterminants/data/
- The Data Set Directory: https://www.cdc.gov/dhdsp/docs/data_set_directory.pdf
- The Promoting Health Equity Workbook: https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/sdoh-workbook.pdf
- Vulnerable Population Footprint: https://www.maps.communitycommons.org/ Tool allows you to locate areas of concern for vulnerable populations and health disparities in your community based on spatial visualization of two key indicators: poverty rate and educational attainment.

B. **Community Health Maps**: https://communityhealthmaps.nlm.nih.gov/resources/
Collaborative effort between the National Library of Medicine, the Center for Public Service Communications, and Bird's Eye View to provide information about low cost mapping tools for community organizations.

C. **Agency for Healthcare Research and Quality (AHRQ) Practice Facilitation Handbook**: https://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/index.html
AHRQ designed this handbook to assist in the training of new practice facilitators as they begin to develop the knowledge and skills needed to support meaningful improvement in primary care practices.

Rural Health Care Coordination Program Resources

A. **The Rural Health Care Coordination Network Partnership Directory**: https://www.ruralhealthinfo.org/pdf/2015-2018-rural-health-care-coordination-grantee-directory.pdf
This directory was developed at the *beginning* of a period of performance and provides a brief description of each award recipient's project.

B. **The Rural Health Care Coordination Network Partnership Grant Recipients Sourcebook**: https://www.ruralhealthinfo.org/resources/12555
This sourcebook was at the *end* of a period of performance and provides a description and outcomes of each award recipient's project from 2015-2018.

C. **The Rural Health Public-Private Partnership (RHPPP)**:
- RHPPP: https://www.ruralhealthinfo.org/philanthropy/partnership
- Rural Health Aligned Funding Initiative: https://www.ruralhealthinfo.org/philanthropy/aligned-funding-opportunity

The Public-Private Collaborations in Rural Health has presented an opportunity for public and private organizations to connect with one another and discuss how combined efforts might produce better health outcomes for rural communities. Currently there are nearly 70 foundations and trusts active in the RHPPP each year.