SFY 2015-2016 Rural Health Centers Program Application

**ORGANIZATIONAL INFORMATION AND SIGNATURE SHEET**

Organization Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organization EIN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organization Fiscal Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organization Type (check one)

🞎 Rural Health Clinic (95-210)

🞎 State-Designated Rural Health Center

🞎 Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary County served (where the grant will be utilized): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Counties served (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grant Request: Total $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Summary of Request** – *Check all that apply:*  🞎 Medical Access Plan (MAP) Funding to expand access for uninsured or underinsured patients.  🞎 Innovation Projects Funding to expand access to care through one of the following:  🞎 Track A: Efforts supporting Patient Centered Medical Home recognition/certification  🞎 Track B: Efforts supporting Sustainable Technological Infrastructure (Meaningful Use)  🞎 Track C: Efforts supporting improve efficiencies, effectiveness, quality or access to care  🞎 Planning and Implementation Funding to expand access to care for rural and underserved patients  *Note: Grant application must address each funding option selected above* |

Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DUNS Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grant Application Submitted By:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**ORGANIZATIONAL PROFILE**

**IF THIS FORM IS NOT COMPLETED, YOUR REQUEST WILL NOT BE CONSIDERED FOR FUNDING**.

Number of Service Delivery Sites (locations): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total FTEs (full time equivalent) of Staff Employed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Refer to Appendix A for instructions on calculating number of FTEs)*

**Clinical Staff Profile**

|  |  |
| --- | --- |
|  | # of FTEs Employed |
| Physician |  |
| Nurse Practitioner |  |
| Physician Assistant |  |
| Certified Nurse Midwife |  |
| Registered Nurse (RN) |  |
| Licensed Practical Nurse (LPN) |  |
| Medical Assistant (CMA, COA, etc) |  |
| Licensed Clinical Social Worker or Psychologist |  |

**Patient Mix**

Report the number of patients seen during your most recently completed fiscal year.

|  |  |
| --- | --- |
|  | # of Unduplicated Patients |
| Uninsured |  |
| Medicaid & Health Choice |  |
| Medicare |  |
| Privately Insured |  |
| Other (define) |  |
| Total |  |

SFY 2015-2016 Rural Health Centers Program Application

**SUMMARY OF EVALUATION CRITERIA AND BASELINE DATA**

**IF THIS FORM IS NOT COMPLETED, YOUR REQUEST WILL NOT BE CONSIDERED FOR FUNDING**.

Complete Sections I and II.

**SECTION I: Unduplicated Patients Served**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Column A  Baseline  as of  07/01/2015 | Column B  Target to be reached by  06/30/2016 | Column C  Net Additional Patients  (Column B minus Column A) |
| 1. Uninsured Patients |  |  |  |
| 2. Self-Pay |  |  |  |
| 3. Medicaid & Health Choice Patients |  |  |  |
| 4. Medicare (not including Advantage) |  |  |  |
| 5. Blue Cross and Blue Shield |  |  |  |
| 6. Other Commercial |  |  |  |
| 7. Total Patients (sum of Lines 1-6) |  |  |  |

**SECTION II: Evaluation Criteria**

Please complete the performance measures below. If you have not previously captured this information, you must collect and report on these outcome measures as a requirement for funding. Performance measures must be quantifiable and can be tied directly to the quality of services provided. Contact the assigned Rural Health Operations Specialist with questions.

*For each measure in Section II: Evaluation Criteria, you will need to include the following information:*

* **Data Source:** where will you obtain the information you report for your performance measures?
* **Collection Process and Calculation:** what method will you use to collect the information?
* **Collection Frequency:** how often will you collect the information?
* **Data Limitations**: what may prevent you from obtaining data for your performance measures?

|  |  |  |
| --- | --- | --- |
| **Evaluation Criteria** | **Baseline Values/Measures as of 07/01/2015** | **Target to Be Reached**  **by 06/30/2016** |
| ***Example:***  ***REQUIRED:*** *To maintain the total number of FTEs supported by this grant*  ***Data Source****: Payroll records and time sheets*  ***Collection Process and Calculation:*** *We will compute and submit to the Division for review upon request and quarterly.*  ***Collection Frequency:*** *Quarterly*  ***Data Limitations****: None known* | *2.5 FTEs* | *2.5 FTEs* |
| **REQUIRED:** Number of FTEs supported by this grant  **Data Source**:  **Collection Process and Calculation:**  **Collection Frequency:**  **Data Limitations**: |  |  |
| **REQUIRED:** Number of non-elderly unduplicated patients served for whom no other source of payment is available  **Data Source**:  **Collection Process and Calculation:**  **Collection Frequency:**  **Data Limitations**: |  |  |
| **REQUIRED:** Number of face-to-face encounters for all patients  **Data Source**:  **Collection Process and Calculation**  **Collection Frequency:**  **Data Limitations**: |  |  |
| **REQUIRED ONLY FOR MAP:** Number of face-to-face MAP encounters  **Data Source**:  **Collection Process and Calculation:**  **Collection Frequency:**  **Data Limitations**: |  |  |
| **REQUIRED:** Number of unduplicated patients served  **Data Source:**  **Collection Process and Calculation:**  **Collection Frequency**:  **Data Limitations:** |  |  |
| **REQUIRED ONLY IF PROVIDING CLINICAL CARE THROUGH THIS GRANT**: Number of hypertension patients treated  **Data Source**:  **Collection Process and Calculation**:  **Collection Frequency**:  **Data Limitations**: |  |  |
| **REQUIRED ONLY IF PROVIDING CLINICAL CARE THROUGH THIS GRANT**: Number of hypertension patients treated with blood pressures (BP) greater than 140/90  **Data Source**:  **Collection Process and Calculation**:  **Collection Frequency**:  **Data Limitations**: |  |  |
| **REQUIRED ONLY IF PROVIDING CLINICAL CARE THROUGH THIS GRANT:** Number of patients with BMI screening  **Data Source**:  **Collection Process and Calculation**:  **Collection Frequency**:  **Data Limitations**: |  |  |
| **REQUIRED ONLY IF PROVIDING CLINICAL CARE THROUGH THIS GRANT**: Number of diabetic patients treated  **Data Source**:  **Collection Process and Calculation**:  **Collection Frequency**:  **Data Limitations**: |  |  |
| **REQUIRED ONLY IF PROVIDING CLINICAL CARE THROUGH THIS GRANT**: Number of diabetic patients treated with A1C levels greater than 9  **Data Source**:  **Collection Process and Calculation**:  **Collection Frequency**:  **Data Limitations**: |  |  |
| **REQUIRED**: At least two (2) rural health center representatives to attend 2016 Primary Care Conference  **Data Source**: NCCHCA Sign in Sheet  **Collection Process and Calculation**: Participants to sign-in on conference sign-in sheet at check-in  **Collection Frequency**: First and last days of conference attendance  **Data Limitations**: |  |  |
| **REQUIRED**: At least 2 rural health center representatives to attend 2016 ICD-10 Training  **Data Source**: Sign in Sheet  **Collection Process and Calculation**: Participants to sign-in on sign-in sheet at training session check-in  **Collection Frequency**: First and last days of training session attendance  **Data Limitations**: |  |  |
| **REQUIRED**: At least 2 rural health center representatives to attend 2016 Medicaid Conference  **Data Source**: Sign in Sheet  **Collection Process and Calculation**: Participants to sign-in on conference sign-in sheet at check-in  **Collection Frequency**: First and last days of conference attendance  **Data Limitations**: |  |  |
| **ADDITIONAL MEASURE (required for Innovation and Planning and Implementation Grant Funding):**  **Measure:**  **Data Source**:  **Collection Process and Calculation**:  **Collection Frequency**:  **Data Limitations**: |  |  |
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| **ADDITIONAL MEASURE (required for Innovation and Planning and Implementation Grant Funding):**  **Measure:**  **Data Source**:  **Collection Process and Calculation**:  **Collection Frequency**:  **Data Limitations**: |  |  |

**SECTION III: Narrative**

See *SFY 2015-2016 Rural Health Centers Program* *RFA Instructions* for guidance on how to complete each section. The grant narrative should not exceed five (5) pages excluding the budget template. Responses should be added within this application document or as a Word document using the same section headings.

Organization Information 5 points

**MAP, Innovation and Planning and Implementation Applications** should provide a brief description of your organization including:

1. What is your organization’s mission:
2. What have you achieved in the past year to advance your mission and improve your

organization’s capacity:

1. Do you provide comprehensive primary care services (e.g., preventive, primary, acute)?

* Yes
* No

If yes, approximately how many hours per week do you offer these services?

* + - * 1-10 hours/week
      * 11-20 hours/week
      * 21-30 hours/week
      * 31-40 hours/week
      * 41-50 hours/week
      * >50 hours/week

1. Do you provide prenatal care and/or delivery services?
   * Yes
   * No

If yes, approximately how many hours per week do you offer these services?

* + - * 1-10 hours/week
      * 11-20 hours/week
      * 21-30 hours/week
      * 31-40 hours/week
      * 41-50 hours/week
      * >50 hours/week

1. Do you provide dental services?
   * Yes
   * No

If yes, approximately how many hours per week do you offer these services?

* + - * 1-10 hours/week
      * 11-20 hours/week
      * 21-30 hours/week
      * 31-40 hours/week
      * 41-50 hours/week
      * >50 hours/week

1. Do you provide behavioral health services (e.g., mental health or substance abuse)?
   * No
   * Yes. Limited, such as screening, brief intervention and referral into treatment
   * Yes. Comprehensive services

If yes, approximately how many hours per week do you offer these services?

* + - * 1-10 hours/week
      * 11-20 hours/week
      * 21-30 hours/week
      * 31-40 hours/week
      * 41-50 hours/week
      * >50 hours/week

1. Do you provide specialty services (e.g., endocrinology, gastroenterology, neurology, and cardiology)?
   * Yes
   * No

If yes, please specify:

If yes, approximately how many hours per week do you offer these services?

* + - * 1-10 hours/week
      * 11-20 hours/week
      * 21-30 hours/week
      * 31-40 hours/week
      * 41-50 hours/week
      * >50 hours/week

1. Does your clinic have the capacity to accept new patients?
   * Yes
   * No

If no, is there a waiting list?

What is the average length of time for a new patient to be seen by a provider?

1. List the health insurers or provider networks for which the provider is considered in-network. For example, BCBS of NC, Inc.:
2. What is the current staff turnover rate?
3. Have you attested to Stage 1 Meaningful Use? If yes, Medicare or Medicaid? All providers?
4. Do you have broadband internet access? If yes, do you receive discounted cost through Healthcare Connect?
5. Where is your organization in the Patient Centered Medical Home process? Is an outside resource assisting with the process? If yes, who is the outside resource (organization and/or individual)?
6. What is your organization’s readiness for the October 1, 2015 transition date to ICD-10? Is an outside resource assisting with the transition? If yes, who is the outside resource (organization and/or individual)?
7. Please include any other information or additional explanation.

Community Need, Project Description, and Ability to Improve Access to Care 40 points

**Community Need: MAP, Innovation, Planning and Implementation Applications**

Note: if you are submitted a Planning and Implementation Grant and your organization is not currently seeing patients, describe the population you anticipate serving.

**Community Need: MAP Applications:**

Describe how MAP support will increase access to care for people in the service area by answering the following:

1. How many unduplicated uninsured persons will be served through the proposed funding for MAP?
2. Describe how funding will improve access to primary medical care.
3. What information or evidence will you use to verify success and/or identify improvements in your program?
4. How will you know when your impact has been achieved?

**Community Need: Innovation Project Applications:**

Describe your proposed project or initiative. Detail how it will address the organization’s needs and increase access to care for patients. Each track may require slightly different details on how the funds will support specific purposes and services to illustrate the different components of each track.

**Community Need: Planning and Implementation Applications:**

This seed funding opportunity is available to those organizations deemed by ORHCC as a state-designated rural health center on or after July 1, 2014. Grant dollars will support planning and implementation activities associated creating or implementing a community development plan that supports an operational move toward long-term sustainability.

Project Evaluation and Return on Investment (ROI) 40 points

**Program Evaluation (25 points – includes performance measures completed in Sections I and II): MAP, Innovation and Planning and Implementation Applications**

Describe how you will evaluate *your organization’s* influence on access to care.

**Return on Investment (ROI) 15 points: MAP, Innovation and Planning and Implementation Applications**

Describe how this project is a good use of State funds. Explain what criteria will be measured to arrive at the ROI ratio.

Complete the Program Budget Template using the file SFY 2015-2016 Master Budget Template

Project Budget (template) 15 points

**MAP Application:**

Complete the MAP Budget, Summary and Budget Narrative tabs. MAP encounters will be reimbursed at $100 per encounter. MAP copayment amounts will be at the discretion of the organization up to but not to exceed $25.

**Innovation Application:**

Complete the SFY 2015-2016 project budget template located at ORHCC’s website as well as the detailed budget narrative within the application and on the budget template Budget Narrative tab.

**Planning and Implementation Application:**

Complete the SFY 2015-2016 project budget template located at ORHCC’s website as well as the detailed budget narrative within the application and on the budget template Budget Narrative tab.