**Rural Health Centers Program**

**Medical Access Plan and Project Grants**

**SFY 2020- 2021**

**General Information**

**RFA Title:** Rural Health Centers Support Grants

**Funding Agency Name:** North Carolina Office of Rural Health (NC ORH)

**Funding Agency Address:** 311 Ashe Avenue, Raleigh, NC 27603

**Funding Agency Contacts/Inquiry Information:**

Dorothea Brock, 919 527-6477, [Dorothea.Brock@dhhs.nc.gov](mailto:Dorothea.Brock@dhhs.nc.gov)

Monifa Charles, 919 527-6474, [Monifa.Charles@dhhs.nc.gov](mailto:Monifa.Charles@dhhs.nc.gov)

**Medical Access Plan (MAP), Behavioral Health (BH), and Project Grant Funding Opportunities** (formerly known as Non-MAP Funding).

Awards will be granted until all funding has been obligated. **Award date 7/1/2020**

**Application Closing Date and Submission Instructions:**

Grant applications must be received via electronic survey by **Monday April 6, 2020**.

All questions regarding the application should be sent to [**RuralHealthOperations\_Grantees@dhhs.nc.gov**](mailto:RuralHealthOperations_Grantees@dhhs.nc.gov)

Incomplete applications and applications not completed in accordance with the instructions provided below will not be reviewed.

**RFA Description**

The purpose of grants awarded under this program is to support State-Designated Rural Health Centers. NC ORH assists underserved communities and populations with developing innovative strategies for improving access, quality, and cost-effectiveness of health care. Distribution of primary care providers in North Carolina has historically been skewed toward cities and larger towns. Rural residents, who often face transportation issues, find accessing primary care services difficult. Through the establishment of rural health centers, NC ORH partners with local communities to provide access to their underserved populations who would otherwise be unable to receive needed primary care services due to geographic, economic, or other barriers. Thus, rural health centers have become an integral part of the health care safety net for North Carolina’s rural and underserved residents.

**The SFY 2020-2021 RFA seeks to supports developing sustainable models of care as well as partnering with community-based organizations to ensure access to transportation, food, housing and personal violence resources.**

North Carolina received approval of its [Medicaid 1115 Waiver and Transformation](https://www.ncdhhs.gov/assistance/medicaid-transformation/proposed-program-design). NC Department of Health and Human Services (NC DHHS) has developed tools to support the development and implementation of the Waiver and assist communities in improving health, not just paying for health care. [Healthy Opportunities](https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities) is the foundation for Medicaid Transformation).

For that reason, the application encourages the implementation of a variety of strategies that align with Medicaid Transformation including:

1. **Healthy Opportunities Screening**
2. **Telehealth (including Telepsychiatry) and Integrated Care**
3. **Opioid Disorder Treatment**
4. **Incorporating** [**Community Health Workers into the care setting**](https://www.ncdhhs.gov/divisions/office-rural-health/community-health-workers)

**A new requirement for this application cycle: Project Fund grantees is strongly encouraged to address specific items identified from the Area Health Education Center (AHEC) practice assessment or another assessment report. If you are using another assessment, please reference the report in your workplan**

**Grant Funding Descriptions:**

**Medical Access Plan (MAP)-** Funds available to help North Carolina residents that cannot afford primary health care coverage. Visits are reimbursable through medically necessary on-site face-to-face provider encounters, as follows: onsite x-rays, in-house labs, surgical procedures, services performed by practice providers, prophylaxis, and telemedicine.

**Behavioral Health Funds –** Funds available to help North Carolina residents that cannot afford behavioral health and mental health counseling services. Visits are reimbursable through on-site face-to-face behavioral health provider encounters: licensed social worker, advanced practice registered nurses, psychiatrics, and psychiatrists.

**Projects Funds** – All projects must show ability to create systems and processes that promote sustainability of the organization being funded. Funding shall assist the applicant with accomplishing one of the following goals:

1. Advanced Medical Home - Supports efforts to becomerecognized as a National Committee for Quality Assurance (NCQA)Patient Centered Medical Home (PCMH).

Grant funds must support either:

1. an outside subject matter expert to assist with PCMH/AMH recognition or
2. costs associated with educating site personnel with becoming a PCMH Certified Content Expert and/or Advanced Medical Home
3. Supports the creation and implementation of sustainable technological infrastructure that enhances access to health care and improves quality. These efforts may include:
   1. Technological infrastructure (hardware, software, telehealth applications etc.)
   * Administrative and clinical innovations that sustain primary medical care delivery models through the adoption of Electronic Health Records (EHR) technology, and using the North Carolina HealthConnex, formerly known as the Health Information Exchange. In 2015 North Carolina passed a law (NCGS 90-414.7) establishing the North Carolina Health Information Exchange Authority (NC HIEA) to oversee and administer the NC Health Information Exchange Network called NC HealthConnex.
   1. Methods for expanding the ability to collect, exchange, store, and disseminate health information while augmenting the practice’s capacity to provide access to and delivery of primary health care
4. Supports rural health center’s activities that increase and/or improve efficiencies, effectiveness, transformation, sustainability, quality, or access to care. Provides rural health centers with funding to hire or retain professional services including but not limited to: legal aid, actuarial services, and other professional services deemed prudent and necessary for business operations. Grantees must use the practice assessment/workplans completed to inform request for funds in this category.
5. Funding to **support Innovative Strategies including but not limited to:**
   * Healthy Opportunities Screening
   * Telehealth (including Telepsychiatry), Community Paramedicine, Integrated Care, etc.
   * Opioid Disorder Treatment
   * Incorporating [Community Health Workers into the care setting](https://www.ncdhhs.gov/divisions/office-rural-health/community-health-workers)
   * Innovative collaboration with Community-Based Organizations to support Healthy Opportunities
   * Staffing and contract services
   * The use of NC HealthConnex to promote access, exchange and analysis of health information to improve patient care and coordination of care.

**Eligibility**

To be eligible to apply for these funds, your organization must be a State-Designated Rural Health Center by NC ORH and comply as a 501c (3). The maximum total grant award is dependent upon demonstrated need at the rural health center or by the organization and is contingent upon funding availability.

Eligible organizations *may use these funds to support any of the following:*

* Telehealth patient care
* Community health workers
* Health promotion, health maintenance, health counseling
* Disease prevention
* Patient education
* Diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (care coordination/care management by a primary care entity, behavioral health, oral health, women’s health, maternal and child health that supports health care services in a primary care setting)
* Collaborative community-based whole person-centered health care delivery models
* Medication Assisted Therapy (MAT)
* Substance Abuse Disorder Treatment
* AHEC Practice Assessments action plan recommendations: (Access, Care Coordination, Optimal Use of HIT, Team Based Relationships, Patient & Family Engagement, QI Culture, Financial Health)

The Department of Health and Human Services (DHHS) and NC ORH work to advance the health, safety and well-being of all North Carolinians in collaboration with a wide array of partners and stakeholders. In its [Strategic Plan, 2019-2021](https://files.nc.gov/ncdhhs/NCDHHS-Strategic-Plan-2019-2021-WEB.pdf), DHHS focuses on and encourages collaboration among community partners in integrating physical health and behavioral health services, increasing community awareness and prevention of drug overdose and death, and the importance of healthy children and families.

All applicants are encouraged to consider such collaborations. When describing collaborative relationships, outline specific partnerships within the community and their role in the partnership. If applicants in communities with multiple safety net organizations cannot show collaborative relationships, please address the barriers that exist to developing these relationships.

Access to health care can be a problem for patients in a remote area. It may be difficult to get to a hospital quickly in an emergency or patients may be required to travel long distances to get routine checkups and screenings. Additional points may be added to applications from communities with a low ratio of providers per population.

As a condition of receiving a grant award, successful applicants must:

* Submit a monthly expense report in a specified format for reimbursement by the 10th of each month.
* Submit performance reports quarterly or biannually throughout the grant term
* Use an electronic financial software application (EXCEL spreadsheets are not acceptable formats)
* Document collaboration among safety net and social support organizations specifying distinct roles of each organization and designated fiscal responsibilities
* Connect to NC HealthConnex
* Agree to participate in other activities conducted by ORH to support successful completion of grant activities.

***Note****: To meet the state’s mandate, a provider is “****connected****” when its clinical and demographic information are being sent to NC HealthConnex at least twice daily.” For further information, please see the HIEA website*:  <https://hiea.nc.gov>

**Application Components**

Grant applications must be received by the Office of Rural Health by April 6, 2020.

Only electronic applications will be accepted. Access to the electronic application is a two-step process:

1.You must submit your organization name and contact information through the following link:

<https://ncruralhealth.az1.qualtrics.com/jfe/form/SV_5ngAqyHY7Y7Sd2B>

2.Once you submit your contact information in the link above, you will receive an email with a personalized link specific to your organization. The link in the e-mail will give you access to the electronic application. **The Application closes April 6, 2020.**

1. Organizational Information and Signature Sheet
2. Organizational Profile
3. Grant Narrative
4. Summary of Evaluation Criteria and Baseline Data
5. Budget

* **Technical Assistance**: Zoom Connection: March 13, 2020 12:00noon. – 1:00 p.m.
* **You must request a link to your application through the online survey tool by clicking on the following link:**

<https://ncruralhealth.az1.qualtrics.com/jfe/form/SV_5ngAqyHY7Y7Sd2B>

* Applicants may apply for MAP and Project funding
* Grant awards are based on the availability of funding. The maximum total grant award is dependent upon demonstrated need at the rural health center. **Grant funds must be used at physical locations where primary medical care is provided and may not be used for vehicles or to pay down loans.**

**Funding Cycle**

The funding cycle is July 1, 2020 through June 30, 2021. All grantees must fully expend grant funds prior to June 30, 2021. All invoices for completed and projected work must be submitted to ORH for reimbursement no later than June 7, 2021.

**Scoring Criteria**

**Applications will be reviewed and scored according to the following criteria:**

|  |  |
| --- | --- |
| Grant Narrative: Overview of the Organization | 10 Points |
| Grant Narrative: Community Need, Project Description, and Improved Access to Care | 30 Points |
| Grant Narrative: Community Collaboration (eg, health departments, departments of social services, housing authority, etc.) | 20 Points |
| Grant Narrative: Work Plan | 30 Points |
| Budget | 10 Points |
| **Total Points Awarded** | **100 Points** |

**Application**

SFY 2020-2021 Rural Health Centers Program

**ORGANIZATIONAL INFORMATION & SIGNATURE SHEET**

|  |  |
| --- | --- |
| Organization Name: |  |
| Organization EIN: |  |
| Organization NPI (if applicable): |  |
| Mailing Address: |  |
| Organization Fiscal Year: |  |
| Organization Type: (check all that apply) | 🞎 FQHC 🞎 FQHC Look-Alike 🞎 Rural Health Clinic  🞎 Small/Rural Hospital 🞎 State- Designated Rural Health Center (required) |
| Primary County served (where the grant will be utilized)  Other Counties serviced (if applicable) |  |

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

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

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

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

Grant Application Submitted By:

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

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

Board Chair Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

**Contact List of Board Members**

|  |  |  |  |
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| Member Names | Email Address | Title/Position | Office Term |
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SFY 2020 Rural Health Centers Program Grant Application

**Grant Narrative**

***I. Overview of Organization \_\_\_\_\_ 10 Poi*nts**

1. **Provide a brief description of your organization:** **Include total hours that the center provides primary care services and unique services provided.** (500-character limit; character limit is inclusive of space and punctuation)
2. **Using the past year application, provide an overview of the progress on the goals and objectives.** 500-character limit; character limit is inclusive of space and punctuation).
3. **Have you attested to Meaningful Use?**

**a. If yes, what stage?**

**b. If yes, Medicare or Medicaid?**

**c. All providers?**

1. **Where is your organization in the Patient Centered Medical Home (PCMH) continuum?**
2. **Does your organization have an Electronic Health Record?**
   1. **If so, please provide the name and version.**
3. **Is your organization currently connected to the NC HealthConnex** (formerly the NC Health information Exchange)?
   1. If so, is data being submitted to NC HealthConnex?
   2. Does your organization have a need for additional technical assistance regarding NC HealthConnex (ex, report generation options, other potential opportunities for use of HIE data)?
   3. If your organization is not currently connected, is the organization actively working with the HIEA to execute a participation agreement?
4. **Is your organization currently connected to NCCARE360? (Your organization can check county status by going to** https://nccare360.org/)

 Yes

 No

1. **Please list *all* provider NPI numbers associated with your organization including each provider. Please list provider’s NPI by name and type (MD, DO, PA, NP, CNM, etc.).**
2. **Describe how you will incorporate the NC DHHS Healthy Opportunities Screening Tool in your practice.** [**NCDHHS Healthy Opportunities Screening Tool**](https://files.nc.gov/ncdhhs/Updated-Standardized-Screening-Questions-7-9-18.pdf)

**(See attached Screening Tool questions at the end of this application)**

1. **Please include any other pertinent information or additional explanation:** (500-character limit; character limit is inclusive of space and punctuation)
2. **Please list any additional funding received from Office of Rural Health (if applicable).**

Community Health Grant: Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_

 Medication Assistance Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Access Plan (MAP) Funding: Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 North Carolina Farmworker: Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 None

***II. Community Need, Project Description and Improved Access to Care 30 Points***

Briefly describe the population served by your organization and their healthcare needs - include information on the incidence of poverty in the targeted community and other pertinent demographic data. Please reference your county/region community health needs assessment to provide information in this section.

Available resources include<https://www.healthenc.org/> for the Eastern part of the state and <https://www.wnchn.org/> for the Western part of the state. Check your local health department’s website to find your county’s community health needs assessment. If you still need assistance locating your region or county's community health needs assessment, please reach out to the Office of Rural Health.  
  
(8,000-character limit, inclusive of spaces and punctuation)

**III. Collaboration \_\_\_\_\_\_\_\_ \_\_ *20 points***

The Office of Rural Health sees collaboration as an important tool to address community health needs. Collaboration may include partnerships with organizations that improve the coordination of patient care across multiple providers. Together these partnerships improve the overall health of the community and may be focused on healthy opportunities (such as social determinates of health that include transportation, food security, personal safety, and housing).

A. What are your plans for collaborating with partners in your community to improve health?

Partners can include safety net providers, primary care providers, allied health organizations, or agencies that address social determinants (transportation, food security, personal safety and housing).

**Include:**

* How will these funds help in your collaborations? How will you document your collaboration in the coming year?
* Describe, *using a specific example*, how your organization has built collaborative partnerships with other safety net organizations in your community. The example should include:

1) the names of each partner organization; 2) the purpose of the collaboration; 3) the outcome of the collaboration

Make sure to document the collaborative roles among the safety net organizations in your example, specifying the distinct function of each organization and the designated fiscal contribution. Describe any unique or innovative community partnerships. Detail any barriers to collaboration.

(8,000-character limit, inclusive of spaces and punctuation).

***IV. Work Plan 30 Points***

A work plan is required for Project specific grants. In the following questions you will be asked to create a goal and provide objectives on reaching that goal. Each goal should be associated with items from your organization's practice assessment. You can have up to four goals, but four goals are not required.

Example of a goal is shown below:



Goal 1:

Goal is related to following Item in the Practice Assessment:

|  |  |  |
| --- | --- | --- |
| Objectives | Title | Timeframe |
| 1. |  |  |
|  |  |  |
|  |  |  |
| 2. |  |  |
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|  |  |  |

Note: You can add as many major objectives as necessary for your program.

Goal 2:

Goal is related to following Item in the Practice Assessment:

|  |  |  |
| --- | --- | --- |
| Objectives | Title | Timeframe |
| 1. |  |  |
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| 2. |  |  |
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Note: You can add as many major objectives as necessary for your program.

Goal 3:

Goal is related to following Item in the Practice Assessment:

|  |  |  |
| --- | --- | --- |
| Objectives | Title | Timeframe |
| 1. |  |  |
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| 2. |  |  |
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Note: You can add as many major objectives as necessary for your program.

Goal 4:

Goal is related to following Item in the Practice Assessment:

|  |  |  |
| --- | --- | --- |
| Objectives | Title | Timeframe |
| 1. |  |  |
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| 2. |  |  |
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Note: You can add as many major objectives as necessary for your program.

**V. Budget 10 Points**

**Grant Request:**

1. **Note: Please include the annual amount that you are expected to utilize. As a guide, you can use the prior amount as an estimation for SFY 2021. For example, if your awarded MAP was $100,000 you can use that amount as an estimation.**

MAP Total $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For MAP Funding (Only):**

Complete only the following statement on the Budget Narrative tab in the separate Excel Document.

**“Approximately\_\_\_\_ (enter number) MAP encounters x $100 per encounter = $\_\_\_\_ [TOTAL AMOUNT OF AWARD]”**

This is the only Budget requirement for the MAP program.

1. **Note: Please include the annual amount that you are expected to utilize. As a guide, you can use the prior amount as an estimation for SFY 2021. For example, if your awarded Behavioral Health Funds was $30,000 you can use that amount as an estimation.**

Behavioral Health Total $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Behavioral Health Funding (Only):**

Complete only the following statement on the Budget Narrative tab in the separate Excel Document.

**“Approximately\_\_\_\_ (enter number) BH encounters x $75 per encounter = $\_\_\_\_ [TOTAL AMOUNT OF AWARD]”**

This is the only Budget requirement for the Behavioral Health program

1. **Note: Project Grant funds are strongly encouraged to align with your Practice Assessment and Clinical Measures. For example, applicant will participate in state-wide initiative or community program(s) to improve outcomes for patients with diabetes. Integrate collaborative activities, hire a care coordinator, community health worker, or Certified Diabetes Specialist, or implement a certification program, etc.**

**(Please see Appendix D for additional information)**

Project Grant Total $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**You will be required a detailed breakdown of the project grant budget using the** [**Excel template**](https://ncruralhealth.az1.qualtrics.com/CP/File.php?F=F_eXw8gJ4G3drf81L) **provided by the Office of Rural Health.**

The budget should be for the project start date through the designated end date. **This should be project specific budget, NOT for your entire organization.**

Provide a detailed cost breakdown for the project and identify all sources of funding for the project. Clearly identify which project costs will be covered with grant funds and enter these in Column A; all other project costs should be entered in Column B. Use the budget narrative tab to explain in greater detail how funds will be used.

Project grantfunds may not be used to purchase and/or lease vehicles or pay down existing mortgages and/or other loans or debt.

Reimbursement for eligible expenses. Complete Budget Template attached.

Line Item Budget and Budget Narrative

**General Instructions for Budget and Budget Narrative:**

Budget narratives must show calculations for all budget line items and must clearly justify/explain the need for these items. Calculations should be easy to follow/recreate. Each budgeted line item should explain:

What is it?

How many?

How much?

For what purpose?

Do not add new line items to the budget. All budget expenses must fit into one of the line items listed in the budget template.

Please use the guidelines below to place your project expense in the proper budget category.

|  |  |
| --- | --- |
| Project Expenses | Description |
| Staffing | |
| Employee Salary | Include separate descriptions of each position, including position title, name of staff person, position duties relative to project activities, & part/full-time status. Include the total annual salary for each staff person in the project. List only staff members that will work on project activities. Only include hours worked (regular and overtime). Do not include bonuses of any kind. |
| Employee Fringe Benefits | Include the employer part of health, dental & vision insurance, FICA (Social Security & Medicare tax) and 401k employer match. Indicate cost per category per staff person. Fringe shall not exceed 30% of total line item for salary allocated to the grant. |
| Contracted Staff | Temporary workers or subcontractor staff. Include hours to be worked and hourly rate. |
| Facility Expenses | |
| Rent | Office space, program meeting space |
| Rented Equipment | Rented or leased equipment, such as copier machine or phone system |
| Utilities (If not included in the rent) | Gas/Electric/Water monthly expenses |
| Telephone/Internet | Monthly phone and/or internet |
| Security | Security services in the form of personnel such as security guard, retained by the Contractor. (Purchase of a security system belongs under Equipment – Other). |
| Repair and Maintenance | Custodial services or basic repair/maintenance not billed in the Professional Service Area line item |
| General Supplies (Not Capital Equipment): | |
| Office Supplies | Business cards, printer ink, paper, etc. |
| Medical Supplies | List out individual supplies |
| Patient Education Materials | Training manuals, handouts, one-pagers, information cards. List out specific materials. |
| Postage and Delivery |  |
| Other Operating Expenses (Not Capital Equipment) | |
| Travel | Include purpose of travel (e.g. travel to visit patients, travel to conferences). Note that reimbursement should not exceed current State rates as defined by the NC Office of State Budget and Management. |
| Staff Development | Conferences and conference registration, trainings |
| Marketing/Community Awareness | Advertising, publications, PSAs, websites, and web materials. |
| Professional Services | Legal services, IT related technical services, accounting, bookkeeping, payroll |
|  |  |
| Capital Equipment | Any item purchased outright exceeding $500.00 is considered capital equipment |

SFY 2021 Rural Health Centers Program

**Organizational Profile**

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

Total FTEs (full time equivalent) of Staff Employed in the organization (at the site(s) where the grant will be utilized: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (please 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 Insurance Status in your Organization:Enter the number of unduplicated patients, by category, who are *projected* to be served during the project period at the site where the grant will be utilized. Enter a projected baseline value as of July 1, 2020, in Column A; an *estimated* target value for the total number of patients who will be served by June 30, 2021 in Column B; and the projected net additional patients served in Column C for each insurance type.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Column A  Projected Baseline Served  as of  07/01/2020 | Column B  Projected Target Served  as of  06/30/2021 | Column C  Projected Net Additional Patients  Served  Col B minus  Col A |
| None/Uninsured Patients |  |  |  |
| Medicaid |  |  |  |
| Children’s Health Insurance Program (CHIP) |  |  |  |
| Medicare (including duals) |  |  |  |
| Other Public Insurance (e.g. Tricare) |  |  |  |
| Private Insurance (e.g. BCBS) |  |  |  |
| Total Unduplicated Patients Served (sum of above) |  |  |  |

Patients by Race and Ethnicity: Enter the number of unduplicated patients by Race & Latino Ethnicity that you currently serve (a baseline value as of July 1, 2020). Only include patients at the site(s) where the grant will be utilized. Please use line ‘g’ if race is not reported. Use column C if race is reported but ethnicity is not. The total number of patients should align with the number in the patient insurance status.

|  |  |  |  |
| --- | --- | --- | --- |
| Race | Column A  Hispanic/ Latino | Column B  Non-Hispanic/ Latino | Column C  Unreported/ Refused to Report Ethnicity |
| * 1. American Indian / Alaska Native |  |  |  |
| * 1. Asian |  |  |  |
| * 1. Black/African American |  |  |  |
| * 1. Native Hawaiian / Other Pacific Islander |  |  |  |
| * 1. White |  |  |  |
| * 1. More than one race |  |  |  |
| * 1. Unreported / Refused to report race |  |  |  |

Does your practice collect data on individual patient’s social risk factors or social determinants of health?

🞎 Yes

🞎 No, but in planning stages to collect this information

🞎 No, not planning to collect this information

If yes, what type of tool does your practice use?

* 1. Accountable Health Communities Screening Tools <https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf>
  2. Upstream Risks Screening Tool and Guide <https://www.aamc.org/system/files/c/2/442878-chahandout1.pdf>
  3. IHELLP (Income, Housing, Education, Legal Status, Literacy, and Personal Safety) <https://www.aap.org/en-us/Documents/IHELLPPocketCard.pdf>
  4. Recommend Social and Behavioral Domains for EHRs
  5. Health Leads USA recommended screening tool    <https://healthleadsusa.org/wp-content/uploads/2016/07/Health-Leads-Screening-Toolkit-July-2016.pdf>
  6. PRAPARE (Protocol for Responding to and Assessing Patient’s Assets, Risks and Experiences)  <http://www.nachc.org/research-and-data/prapare/>
  7. WE-CARE Survey (Well-child care visit, Evaluation, Community resources, Advocacy, Referral, Education) <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Pages/Screening-Tools.aspx>
  8. WellRx
  9. Health Leads Screening Toolkit
  10. NC DHHS Screening Questions
  11. THRIVE (Tool for Health and Resilience In Vulnerable Environments)  <https://www.preventioninstitute.org/tools/thrive-tool-health-resilience-vulnerable-environments>
  12. Hunger VitalSign <http://academicdepartments.musc.edu/ohp/SFSP/FINAL-Hunger-Vital-Sign-2-pager1.pdf>
  13. iScreen Social Screening Questionnaire  <http://pediatrics.aappublications.org/content/pediatrics/suppl/2014/10/29/peds.2014-1439.DCSupplemental/peds.2014-1439SupplementaryData.pdf>  <http://pediatrics.aappublications.org/content/134/6/e1611>
  14. The EveryONE Project (by the American Academy of Family Physicians AAFP)

<https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/sdoh-guide.pdf>

* 1. Other, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  2. We do not use a standardized assessment

**Evaluation Criteria**

Complete the mandatory performance measures required for all applicants. These measures will be reported quarterly. Add additional measures to the table as needed working with the assigned Rural Health field support staff.

*For each measure, 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**

|  |  |  |
| --- | --- | --- |
| **Evaluation Criteria Primary and Preventive Care** | **Baseline Values/Measures as of 07/01/2020** | **Target to Be Reached**  **by 06/30/2021** |
| *Example:*  *Increase uninsured patient visits from 300 to 348 encounters per month by adding one evening clinic per week.* | *300 encounters per month*  *(Projected value)* | *348 encounters per month*  *(Projected target)* |
| **REQUIRED:** Output Measure  Number of face-to-face MAP patient encounters |  |  |
| Measure Type: Outcome |  | |
| Data Source: |  | |
| Collection Process and calculation |  | |
| Collection Frequency: Quarterly |  | |
| Data Limitations |  | |
|  |  | |
| **REQUIRED**: Input Measure  Number of Full-time Equivalent (FTEs) support by this grant |  | |
| Measure Type: |  | |
| Data Source: |  | |
| Collection Process and calculation |  | |
| Collection Frequency: Annually |  | |
| Data Limitations |  | |
|  |  | |
| **REQUIRED:** Output Measure  Number of unduplicated patients served (MAP and non-MAP patients) |  | |
| Measure Type |  | |
| Data Source: |  | |
| Collection Process and calculation |  | |
| Collection Frequency: Quarterly |  | |
| Data Limitations |  | |
|  |  | |
| **REQUIRED:** Quality Measure  Level of Patient Centered Medical Home certification attained |  | |
| Measure Type: |  | |
| Data Source: |  | |
| Collection Process and calculation |  | |
| Collection Frequency: Annually |  | |
| Data Limitations |  | |

**Controlling High Blood Pressure:** Percentage of patients 18-85 years old who had a diagnosis of Hypertension (overlapping the reporting period) and whose most recent Blood Pressure was adequately controlled (less than 140/90 mm Hg) during the reporting period.

Note that this is a “positive” measure. For this measure, the higher the number of patients with controlled hypertension the better the performance on the measure.

Source: HRSA Uniform Data System (UDS) 2020 p. TBD; CMS eMeasure ID: CMS165v8; National Quality Forum#: eCQI indicates “N/A” (formerly 0018)

This measure is calculated using the numerator and denominator defined below.

|  |  |  |
| --- | --- | --- |
| Measure | Baseline Value as of **07/01/2020** | Target to be reached by **06/30/2021** |
| Patients 18-85 years of age who had a visit and diagnosis of essential hypertension overlapping the measurement period.  **(Denominator)** |  |  |
| Patient Population Exclusions | Exclusions: Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period. Exclude patients whose hospice care overlaps the measurement period. Exclude patients 66 and older who are living long term in an institution for more than 90 days during the measurement period. Exclude patients 66 and older with advanced illness and frailty because it is unlikely that patients will benefit from the services being measured. | |
| Guidance | * Note that this is a “positive” measure. For this measure, the higher the number of patients with controlled hypertension the better the performance on the measure. * Include patients who have an active diagnosis of hypertension even if their medical visits during the year were unrelated to the diagnosis. * Include blood pressure readings taken at any visit type at the health center as long as the result is from the most recent visit. * Only blood pressure readings performed by a clinician in the provider office are acceptable for numerator compliance with this measure. Blood pressure readings from the patient's home (including readings directly from monitoring devices) are not acceptable. * If no blood pressure is recorded during the reporting period, the patient's blood pressure is assumed "not controlled” and isn’t counted in the numerator * If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading. | |
| Measure Type | Outcome | |
| Data Source |  | |
| Collection Process and Calculation |  | |
| Collection Frequency | Quarterly (at Q2 and Q4 only) | |
| Data Limitations |  | |

|  |  |  |
| --- | --- | --- |
| Measure | Baseline Value as of **07/01/2020** | Target to be reached by **06/30/2021** |
| Patients 18-85 years old who had a diagnosis of hypertension *(who meet the population above)* **AND** whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure less than 140 mmHg and diastolic blood pressure less than 90 mmHg) during the reporting period (**Numerator**)  (Note that Adequate Control is defined as systolic blood pressure lower than 140 mm Hg **and** diastolic blood pressure lower than 90 mm Hg.) |  |  |
| Guidance | * Include blood pressure readings taken at any visit type at the health center as long as the result is from the most recent visit. * Only blood pressure readings performed by a clinician in the provider office are acceptable for numerator compliance with this measure. Blood pressure readings from the patient's home (including readings directly from monitoring devices) are not acceptable. * If no blood pressure is recorded during the reporting period, the patient's blood pressure is assumed "not controlled” and isn’t counted in the numerator * If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading. | |
| Measure Type | Outcome | |
| Data Source |  | |
| Collection Process and Calculation |  | |
| Collection Frequency | Quarterly (at Q2 and Q4 only) | |
| Data Limitations |  | |

**Diabetes: Hemoglobin A1c Poor Control:** Percentage of patients 18-75 years of age with diabetes who had hemoglobin HbA1c greater than 9.0 percent during the reporting period (or who had no test conducted during the reporting period).

Note that this is a “negative” measure. For this measure, the lower the number of adult diabetics with poorly controlled diabetes, the better the performance on the measure. Also note that unlike the Hypertension measure, this measure calls for reporting on patients with diabetes regardless of when they were first diagnosed.

Source: HRSA Uniform Data System (UDS) 2019 p.100; CMS eMeasure ID: CMS122v8; National Quality Forum#: eCQI indicates “N/A” (formerly 0059)

This measure is calculated using the numerator and denominator defined below.

|  |  |  |
| --- | --- | --- |
| Measure | Baseline Value as of **07/01/2020** | Target to be reached by **06/30/2021** |
| Patients 18-75 years old with diabetes with a medical visit during the reporting period  (**Denominator**) |  |  |
| Patient Population Exclusions | * Patients with diagnosis of secondary diabetes due to another condition (e.g., Patients with Gestational diabetes, steriod-induced diabetes) * Patiens who were in hospice care during the reporting period | |
| Guidance | * Only include patients with an active diagnosis of Type 1 or Type 2 diabetes | |
| Measure Type | Outcome | |
| Data Source |  | |
| Collection Process and Calculation |  | |
| Collection Frequency | Quarterly (at Q2 and Q4 only) | |
| Data Limitations |  | |

|  |  |  |
| --- | --- | --- |
| Measure | Baseline Value as of **07/01/2020** | Target to be reached by **06/30/2021** |
| Patients 18-75 with a diagnosis of Type 1 and Type 2 diabetes *(who meet the population above)* who met one of the following criterial   * thier most recent hemoglobin A1c level is greater than 9.0 percent   **OR**   * they had no test conducted during the contract period   **OR**   * their test result is missing (**Numerator**) |  |  |
| Guidance | * Include patients in the numerator whose most recent HbA1c level is greater than 9 percent, the most recent HbA1c result is missing, or when no HbA1c tests were performed or documented during the reporting period. | |
| Measure Type | Outcome | |
| Data Source |  | |
| Collection Process and Calculation |  | |
| Collection Frequency | Quarterly (at Q2 and Q4 only) | |
| Data Limitations |  | |

**Body Mass Index Screening and Follow -Up:** Percentage of patients aged 18 years and older with a visit during the reporting period with a documented BMI during the most recent visit or within the previous twelve months **AND** with a *BMI outside of normal parameters\*,* a follow-up plan is documented during the visit or during the previous twelve months of the current visit.

\* Normal parameters: Age 18 years and older BMI greater than or equal to 18.5 and less than 25 kg/m2

Note that this is a “positive” measure. For this measure, the higher the number of patients with a screening the better the performance on the measure.

Source: HRSA Uniform Data System (UDS) 2019 p. 82; CMS eMeasure ID: CMS69v7; National Quality Forum#: 0421e

This measure is calculated using the numerator and denominator defined below.

|  |  |  |
| --- | --- | --- |
| Measure | Baseline Value  as of **07/01/2020** | Target to be reached by **06/30/2021** |
| Patients who are 18 years of age or older on the date of the visit with at least one medical visit during the reporting period  (**Denominator**) |  |  |
| Exclusions | * Patients who are pregnant, * Patients receiving palliative care * Patients who refuse measurement of height and/or weight or refuse follow-up visit * Patients with a documented medical reason during the visit or within 12 months of the visit, including:   + Elderly patients (65 years or older) for whom weight reduction/weight gain would complicate other underlying health conditions such as the following examples:     - Illness or physical disability     - Mental illness, dementia, confusion     - Nutritional deficiency, such as vitamin/mineral deficiency     - Patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient’s health status,   + There is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate. | |
| Guidance | * Report this measure for all patients seen during the reporting period. | |
| Measure Type | Quality / Process | |
| Data Source |  | |
| Collection Process and Calculation |  | |
| Collection Frequency | Quarterly (at Q2 and Q4 only) | |
| Data Limitations |  | |

|  |  |  |
| --- | --- | --- |
| Measure | Baseline Value as of **07/01/2020** | Target to be reached by **06/30/2021** |
| Patients *(who meet the population above*) with a documented BMI (not just height and weight) during their most recent visit or during the previous 12 months of the most recent visit, **AND** meet one of the following criteria:   * when the BMI is outside of normal parameters, a follow-up plan is documented during the visit or during the previous 12 months of the current visit   **OR**   * the documented BMI is within normal parameters   (**Numerator**) |  |  |
| Normal Parameters | Age 18-64 years and BMI was greater than or equal to 18.5 and less than 25  Age 65 years and older and BMI was greater than or equal to 23 and less than 30 | |
| Guidance | * An eligible professional or their staff is required to measure both height and weight. Both height and weight must be measured within 12 months of the current encounter and may be obtained from separate visits. Do not use self-reported values. * BMI may be documented in the medical record at the health center or in outside medical records obtained by the health center. * If more than one BMI is reported during the measurement period, use the most recent BMI to determine if the performance has been met. * Document the follow-up plan based on the most recent documented BMI outside of normal parameters. * Documentation in the medical record must show the actual BMI or the template normally viewed by a clinician must display BMI. * Do not count as meeting the measurement standard charts or templates that display only height and weight. The fact that an HIT/EHR can calculate BMI does not replace the presence of the BMI itself. | |
| Measure Type | Quality / Process | |
| Data Source |  | |
| Collection Process and Calculation |  | |
| Collection Frequency | Quarterly | |
| Data Limitations |  | |

**Tobacco Use and Screening:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months **AND** *if identified as a tobacco user*, received cessation counseling intervention

Note that this is a “positive” measure. For this measure, the higher the number of patients with a screening the better the performance on the measure. This measure is meant to capture patients who are screened for tobacco use and offered cessation intervention if they are a tobacco user. A tobacco user who is screened and *not* offered cessation intervention would be included in the denominator but *not* included in the numerator.

Source: HRSA Uniform Data System (UDS) 2019 p. 83; CMS eMeasure ID: CMS138v8; National Quality Forum#: 0028e

This measure is calculated using the numerator and denominator defined below.

|  |  |  |
| --- | --- | --- |
| Measure | Baseline Value as of **07/01/2020** | Target to be reached by **06/30/2021** |
| All patients aged 18 years and older seen for at least two visits **or** at least one preventive visit during the reporting period  (**Denominator**) |  |  |
| Exclusions | * Documentation of medical reason(s) for not screening for tobacco use or for not providing tobacco cessation intervention (e.g., limited life expectancy, other medical reason). | |
| Measure Type | Quality / Process | |
| Data Source |  | |
| Collection Process and Calculation |  | |
| Collection Frequency | Quarterly (at Q2 and Q4 only) | |
| Data Limitations |  | |

|  |  |  |
| --- | --- | --- |
| Measure | Baseline Value as of **0701/2020** | Target to be reached by **06/30/2021** |
| Patients *(who meet the population above)* who were screened for tobacco at least once in the last 24 months **AND** meet one of the following criteria:   * patient was screened for tobacco use, was identified as a tobacco user and received documented tobacco cessation intervention   **OR**   * patient was screened for tobacco and was not a tobacco user   (**Numerator**) |  |  |
| Guidance | * Include in the numerator patients with a negative screening ***and*** those with a positive screening who had cessation intervention if a tobacco user. * If patients use any type of tobacco (i.e., smokes or uses smokeless tobacco), the expectation is that they should receive tobacco cessation intervention (counseling and/or pharmacotherapy). * If a patient has multiple tobacco use screenings during the 24-month period, use the most recent screening which has a documented status of tobacco user or non-user. * If tobacco use status of a patient is unknown, the patient does not meet the screening component required to be counted in the numerator and has not met the measurement standard. "Unknown" includes patients who were not screened or patients with indefinite answers. * The medical reason exception applies to the screening data element of the measure or to any of the tobacco cessation intervention data elements. * If a patient has a diagnosis of limited life expectancy, that patient has a valid denominator exception for not being screened for tobacco use or for not receiving tobacco use cessation intervention (counseling and/or pharmacotherapy) if identified as a tobacco user. * Electronic nicotine delivery systems (ENDS), including electronic cigarettes for tobacco cessation, are not currently classified as tobacco. They are not to be evaluated for this measure. * Include in the numerator records that demonstrate that the patient had been asked about their use of all forms of tobacco within 24 months before the end of the measurement period. * Include patients who receive tobacco cessation intervention, including:   + Received tobacco use cessation counseling services, ***or***   + Received an order for (a prescription or a recommendation to purchase an over-the-counter [OTC] product) a tobacco use cessation medication, ***or***   + Are on (using) a tobacco use cessation agent. | |
| Measure Type | Quality / Process | |
| Data Source |  | |
| Collection Process and Calculation |  | |
| Collection Frequency | Quarterly (at Q2 and Q4 only) | |
| Data Limitations |  | |

**Appendix A: Table for proper conversion of hours to Full Time Equivalent (FTE)**

|  |  |  |
| --- | --- | --- |
| **# of FTEs** | **Conversion** | **Logic when staff sustained from grant >1.00 FTE**  **Add 1.00 to fraction of part time.**  **Example: if there is a part time staff working 10 hours a week in addition to one full time, that converts to**  **1.00+.25=1.25 FTE**  **Hint: for staff working odd number of hours (e.g., 3 hours per week) round up to next level or, in this case, to**  **4 hours=.10FTE.** |
| 2 hours/week | .05 FTE |
| 4 hours/week | .10 FTE |
| 6 hours/week | .15 FTE |
| 8 hours/week | .20 FTE |
| 10 hours/week | .25 FTE |
| 12 hours/week | .30 FTE |
| 14 hours/week | .35 FTE |
| 16 hours/week | .40 FTE |
| 18 hours/week | .45 FTE |
| 20 hours/week | .50 FTE |
| 22 hours/week | .55 FTE |
| 24 hours/week | .60 FTE |
| 26 hours/week | .65 FTE |
| 28 hours/week | .70 FTE |
| 30 hours/week | .75 FTE |
| 32 hours/week | .80 FTE |
| 34 hours/week | .85 FTE |
| 36 hours/week | .90 FTE |
| 38 hours/week | .95 FTE |
| 40 hours/week | 1.00 FTE |

**Appendix B** – [**NCDHHS Healthy Opportunities Screening Tool**](https://files.nc.gov/ncdhhs/Updated-Standardized-Screening-Questions-7-9-18.pdf)

<https://files.nc.gov/ncdhhs/documents/SDOH-Screening-Tool_Paper_FINAL_20180405.pdf>

**Updated Standardized Screening Questions for Health-Related Resource Needs 7-9-2018**

Revisions to the standardized set of screening questions for health-related resource needs (social determinants of health) were made based on public comment and further input from the NC DHHS Technical Advisory Group on screening. The current questions are below. This set of questions will undergo field testing and validation over the next several months. Further revisions may be made based on the results of the field testing.



**Appendix C- AHEC Practice Assessment**

Instructions:

**Note:** Sites that completed AHEC Assessment will provide a goal and task based on the categories or priorities for their site locations.

Sites that **did not complete AHEC assessment** please indicate how your site can implement or incorporate from any of the categories noted below.

|  |  |  |
| --- | --- | --- |
| **Category**  (Access, Care Coordination, Optimal Use of HIT, Team Based Relationships, Patient & Family Engagement, QI Culture, Financial Health) | **Goal/Task** | **Proposed**  **Completion Date** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Practice Assessment Category Descriptions**



Access *(practice visits, assigning patients to a provider panel, enhanced access to care, and 24/7 patient communication)*

 Care Coordination *(care management of high-risk patients, referrals to appropriate community resources, transitions of care follow-up)*

 Optimal Use of Health Information Technology *(HIT utilization for population health, utilization of practice management system, using HIT for quality improvement efforts)*

 Team Based Relationships *(team member roles, team training, measuring continuity)*

 Patient and Family Engagement *(shared decision making, 4 habits model, physical and behavioral health outcomes, patient feedback)*

 Quality Improvement Culture and Evidence-Based Care *(comprehensive guidelines information, quality improvement concepts, behavioral health)*

 Financial Health Leadership *(business leadership engagement, strategic planning and budgeting)*

 Financial Health Management *(financial and operating reports, administrative process improvement and efficiency, revenue cycle management, financial status)*