NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
MARGARET L. SAUER, MS, MHA • Director, Office of Rural Health

North Carolina Office of Rural Health
State Designated Rural Health Center Request for Applications
SFY 2024

RFA TITLE: State Designated 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

RFA OPENS: February 27, 2023
RFA DEADLINE: March 24, 2023, 5:00 p.m. until funds as obligated.
RFA TECHNICAL ASSISTANCE WEBINAR: March 9, 2023, 10:30 a.m. – 11:30 a.m.

HOW TO OBTAIN FURTHER INFORMATION: Questions regarding the application can be sent to Justin Kearley at justin.kearley@dhhs.nc.gov or you may reach out to your regional operations specialist based on the appropriate NC Medicaid Region.

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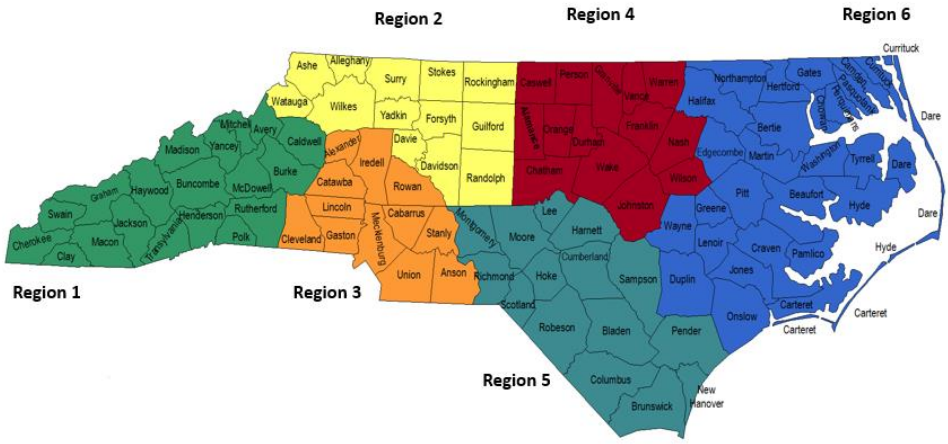

BACKGROUND

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, may find accessing primary care services difficult. Through the establishment of State Designated Rural Health Centers (SDRHC), NC ORH partners with local communities to provide funding to improve ability to serve underserved, Medicaid and Medicare populations who would otherwise be unable to access needed primary care services due to geographic, economic, or other barriers. Thus, SDRHCs have become an integral part of the health care safety net for North Carolina's rural and underserved residents.

The primary purpose of the state designation is to support new access points and stabilize current access in care sites that do not already receive support through the Federally Qualified Health Center (FQHC) or FQHC Look a Like designation. Funding is available to support and sustain access to care in rural areas that may face sufficient challenges without the SDRHC funding. Recognizing the need for access to healthcare as the demographics of NC, as well as access points, change (due to FQHC growth and multi-site practice locations) is necessary for incubating and supporting the growth of new access points for health care in rural NC.

ORH defines an SDRHC as a health care safety net organization that a is a 501(c)3 non-profit organization not owned, controlled, or operated by another entity with an active board that has as its primary mission to provide primary health care services to those residing in its community. SDRHCs must be located within communities that are both rural and underserved and must currently be delivering primary health care services.

The SDRHC Guide is available as a resource for more detailed information about NC ORH's work to increase access to quality care in rural and underserved communities. The Guide outlines the process for receiving State Designation as Rural Health Center and the activities the funds support.
SFY2023_2024 SDRHC Manual

RFA DESCRIPTION

NC ORH is accepting applications for continuing and new SDRHCs. The purpose of grants awarded under this program is to support SDRHCs.

These grant funds, supported through the North Carolina General Assembly, are for assuring access to primary and preventive care to meet the health needs of rural, underserved and medically indigent patients in North Carolina. An important component of this work is to stabilize and strengthen the safety net through increased levels of collaboration and integration of services to meet and sustain the needs of those served more effectively.

The SFY 2024 RFA supports the state mission of improving the health, safety and well-being of all North Carolinians while being good stewards of limited resources. The RFA seeks to develop sustainable models of care as well as address the conditions in which people live that directly affect health, known as "social drivers of health." The initial focus encourages partnering with community-based organizations to ensure access to transportation, food, housing, and personal safety resources.

TYPE (S) OF APPLICATIONS

New Rural Health Center Applicants: An organization that is not currently funded through the NC ORH SDRHC grant and seeks to serve an underserved service area and uninsured target population with one or more permanent service delivery site(s). The organization may have received funds from other NC ORH programs but not as an SDRHC.

Rural Health Center Continuing Applicants: A current SDRHC that has received funds from the NC ORH and seeks to continue serving its current service area and target population. Continuing applicants are required to attach an attestation sheet along with the application indicating that the site is currently offering primary care services, has an established board of directors, is actively using an identified EHR system, and follows the State of North Carolina requirements. Continuing applicants seeking to serve a different service access point or service area must include justification in the application narrative. This request is subject to approval. The organization must also meet eligibility criteria to apply for SDRHC funding.

Grant Funding Descriptions

A. **Health service delivery site: Medical Access Plan (MAP) and/or Behavioral Health (BH) –** Proposal to provide a comprehensive package of healthcare services to rural uninsured/underinsured residents. These visits are reimbursable at a rate of $100.00 per **MAP** encounter to the health center based on medically necessary face-to-face provider encounters, as follows: onsite x-rays, in-house labs, minor surgical procedures, services performed by practice providers, prophylaxis, and telemedicine. **BH** funds are available for behavioral health and mental health counseling services. The visits are reimbursable at a rate of $75.00 per encounter to the health center based on face-to-face behavioral health provider encounters. Eligible providers include licensed clinical social workers, advanced practice registered nurses, psychologists, and psychiatrists.

Funding preferences: Preference will be given to applicants based on the criteria listed below.

- Demonstrates a need for increased health care services for rural and underserved residents in their community.
- Demonstrates capacity to effectively address barriers to care for rural residents and provide quality services.
- Demonstrates capacity to provide a healthcare home and link to primary, dental, and behavioral health services and to respond to additional needs.
- Proposes a plan to incorporate rural community and patient feedback into their service delivery approach or quality improvement efforts.
- Proposes a plan to integrate SDOH screening questions and assist patients with unmet needs utilizing NCCARE360.
- Describes the capacity to meet the NC ORH requirements and expectations outlined in the application.

B. **Operating/Infrastructure Funds** – An organization applying for funds in this category must describe how operating funds will support access to primary care for the population in the service area. The organization must demonstrate the ability to create systems and processes that promote sustainability of the organization being funded or how the funds will supplement the primary care services provided through MAP and/or BH.

Funding preferences: Preference will be given to applicants based on responses to the criteria below:

- Propose the creation and implementation of sustainable staff and technological infrastructure that enhances access to health care and improves quality.
- Propose innovative strategies to promote healthcare equity and inclusion.
- Demonstrate capacity to effectively carry out COVID-19, flu and other prevention and response efforts.
- Propose an efficient strategy that uses local resources and collaborates with partners to respond to health care gaps in their community specifically leveraging the use of MAP and BH funds.
- Propose a plan to blend behavioral health services fully or partially within the primary care practice.

REQUIREMENTS AND ELIGIBILITY

Applicants must demonstrate a readiness to fulfill the requirements of an SDRHC. Applicants must document the need for primary health care services in their service area and propose a comprehensive plan that demonstrates alignment to the NC ORH mission and vision. The plan must ensure the availability and accessibility of primary health care services to all individuals in the service area and target population with collaborative and coordinated delivery systems. Applicants must be providing care within a site physically located in North Carolina.

To determine eligibility to become an SDRHC, the applicant organization must first assess if the proposed location can meet certain criteria. The purpose of the SDRHC program is to increase access to primary care for rural, uninsured, and underinsured residents. The following are specific requirements that must be met to be eligible for funding:

- Rural determination
- Health Professional Shortage Area determination

- Unmet need
- County Distress Ranking – Tier 1 or 2
- Proof that the organization is not owned, controlled, or operated by another entity and holds an active 501 c3 Status.
- Provide access to primary health care services to all individuals in the defined service area regardless of ability to pay.
- Ability or plans to enroll eligible providers in Medicare and Medicaid reimbursement program.

As a condition of receiving state funds, the SDRHC agrees to comply with the standards of the NC Office of the Controller, NC Office of Budget and Management standards, and NC ORH Operations Program. Link for detailed requirements includes (1) Compliance Standards (Completion of all NC DHHS Contract Approval Forms), (2) Contractual Agreement, and (3) Program Operations.

Applicants are required to include the following attachments:

- Copy of Bylaws and documentation of 501c3 status
- Weblink to the most recent county or regional community health needs assessment (CHNA)
- Organizational Chart and description of Quality Improvement Team
- Proof of sliding fee scale and payor mix, e.g., Medicare, Medicaid *(Documentation of a completed Medicaid application and Provider enrollment before RFA submission is acceptable.)*
- Project Narrative - Project Narrative
- **Budget Template and Narrative (Note: this will be a separate Excel attachment with multiple tabs)** Budget Link
- Attestation agreement
  Attestation Link

AWARD INFORMATION

Applicants may apply for multiple funding options within the same application. For example, an applicant may apply for behavioral health funds and operating/infrastructure funds. The maximum total grant award is dependent upon response to the application, documented need, operating structure, and past performance (for continuing applicants) at each of the sites and is contingent upon funding availability. Grant funds must be used at physical location(s) where primary medical care is provided and may not be used for vehicles or to pay down loans. Applicant awardees will be awarded for a 1-year period, with the option to renew for year 2 and must comply with participating in a site visit or desk review within 3 months of the awarded start date. Award notifications are anticipated to be sent by April 15, 2023.

FUNDING CYCLE: The funding cycle is July 1, 2023, through June 30, 2025, contingent upon successful completion of year one and project compliances are met. All grantees must fully expend grant funds

prior to June 30, 2025. **Any remaining balances from Year 1 funds will not carry forward into Year 2.** All invoices for completed and projected work must be submitted to NC ORH for reimbursement no later than June 7, 2025.

SCORING CRITERIA: Grant awards will be based on the criteria listed below. Failure to fully complete all sections will impact the funding amount, up to disqualification. Applications will be reviewed and scored according to all the following criteria regardless of the funding categories requested.

Overview of the Organization	5 Points
Community Need	20 Points
Improved Access to Care	25 Points
Community Collaboration (e.g., health departments, departments of social services, housing authority, etc.)	15 Points
Performance Measures	20 Points
Budget	15 Points
Total Points Awarded	**100 Points**

SFY 2024 STATE DESIGNATED RURAL HEALTH CENTER RFA

How to Apply

Applicants must submit their application electronically through an online REDCap survey. There is a two-step process to receive a personalized link to the application. The link below will request information about your organization and a contact person. The contact person will then be sent a personalized link to apply to the Rural Health Centers Support Grants RFA. Use this document as guidance for the electronic version of the application. All necessary attachments are noted within the requirements section of the document.

Note: this document is not an attachment to be included in the REDCap survey.

Click link to access electronic version of application:
https://ncorh.ncdhhs.gov/redcap/surveys/?s=TPYL3PK3CRYHNRHR

Organizational Information

Contract Administrator		
Email Address		
Phone Number/Fax Number		
Address		
Authorized Signatory (Board Chair or other designated board member who will review and sign the contract)		
Email Address		
Phone Number/Fax Number		
Chief Medical Officer or Lead Provider (Designated person to support the clinical quality measures the organization is required to report)		
Email Address		
Phone Number/Fax Number		
Quality Improvement Coordinator		
Email Address		
Phone Number/Fax Number		

Organization Name:	
Organization EIN (Employer Identification Number):	
Organization NPI (National Provider Identifier (if applicable):	
Mailing Address:	
Website	
Organization Type: (check all that applies)	☐FQHC ☐FQHC Look-Alike ☐Free and Charitable Clinic ☐Rural Health Clinic ☐Health Dept ☐Faith-based Organization ☐Small/Rural Hospital ☐State-Designated Rural Health Center (current) ☐Community Coalition ☐Other _____
Primary County served (where the grant will be utilized)	
Other Counties serviced (if applicable)	
Please check all that apply, if your organization has received funds from NC ORH in the past year	☐Community Health Grant Amount: ☐Medication Assistance Program Amount: ☐Medical Access Plan (MAP) Amount: ☐North Carolina Farmworker Amount: ☐None
Does your organization have an Electronic Health Record?	☐Yes: Please list name and version: ☐No
Is your organization currently connected to the NC HealthConnex?	☐Yes ☐No
Clinically Integrated Network/Clinically Integrated Organization	☐Yes ☐No

Is your organization currently connected to NCCARE360?	☐Yes, if yes, ☐actively sending and/or ☐actively receiving ☐No:

Please list all provider names, title (MD, DO, PA, NP, CNM, etc.), NPI number, and FTE associated with your organization/and other staff members at the site(s) where the grant will be utilized.

Provider Name / Staff Name	Title	NPI number	FTEs (full-time equivalent)

I. **Overview of the Organization (5 Points)**

1. Indicate the number of service delivery site(s) and location(s) where the grant will be used.

2. List your organization's hours of operation.

3. Provide a brief description of the following:
   a. Your organization's history and mission.
   b. Your organization's primary care services or experience in primary care.
   c. Unique services provided by your organization.

4. Patient Insurance Status: Using the excel spreadsheet Tab 1 – Organizational Overview. Enter the number of unduplicated patients, by category, who are projected to be served during Year 1 of the project period (July 1, 2023 - June 30, 2024) at the site(s) where the grant will be used. Enter a projected baseline value of patients, by category, who are to be served by your organization as of July 1, 2023, in Column D. Enter an estimated target value for the total number of patients who will be served during Year 2 of the project period (July 1, 2024 - June 30, 2025) in Column E. Column F will calculate the projected net additional patients. The total unduplicated patients served row will automatically calculate.

	Projected Baseline Served	Projected Target Served (Year 1)	Projected Target Served (Year 2)	Projected Net Additional Patients Served (Year 1 + Year 2)
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				

5. Patients by Race and Ethnicity: Enter the number of unduplicated patients by Race & Ethnicity that you currently serve (as of July 1, 2023). The total number of patients will be calculated and does not have to align with the number of patients reported in the patient insurance status chart.

Race	Hispanic/ Latino	Non-Hispanic/ Latino
American Indian / Alaska Native		
Asian		
Black/African American		
Native Hawaiian / Other Pacific Islander		
White		
More than one race		
Unreported / Refused to report race		
Total		

6. In the Patients by Race and Ethnicity Table, is the number of unduplicated patients served reflective of the community? If the current patient population is not reflective of the community, describe plans to increase services to underserved populations.

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

   ☐Yes

   If yes, List the screening tool: _____

   ☐No, but in planning stages to collect this information

   ☐No, not planning to collect this information

II. **Community Need (20 Points)**

1. Please provide a description of the proposed service area, including population demographics, other safety net services in the area, barriers, poverty levels, percent uninsured, and other pertinent data. Please reference your county/region community health needs assessment to provide information in this section. Resource data used should be no older than three years.

Available resources include https://www.healthenc.org/ (Eastern NC) and https://www.wnchn.org/ (Western NC). 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. Health Atlas Map

2. Provide a description of how the organization's services will be communicated in the community or to stakeholders. *(Ex: website, newsletter, community forums, social media, press release, etc.)*

III. **Improve Access to Care (25 Points)**

1. Describe in detail how your organization is positioned to effectively use the Medical Access Plan, Behavioral Health and/or the Operational/Infrastructure funds to increase access to care for **underserved** residents in your defined service area.

2. Please indicate how much funding is requested for Medical Access Plan (MAP) and Behavioral Health (BH). (What percentage of the uninsured/underinsured in your service area?) Please indicate "N/A" if only Project Funds are requested. *(These visits are reimbursable at a rate of $100.00 per MAP encounter to the health center based on medically necessary face-to-face provider encounters, as follows: onsite x-rays, in-house labs, surgical procedures, services performed by practice providers, prophylaxis, and telemedicine. BH funds available for behavioral health and mental health counseling services. The visits are reimbursable at a rate of $75.00 per encounter to the health center based on face-to-face behavioral health provider encounters.)*

3. Please list your agency's plan to achieve 100% expenditures of MAP, BH, **and/or** Project Funds. Include information about activities planned throughout the year, community engagement/outreach activities, and how referrals are made into your program.

4. To support rural healthcare access, describe how your organization will educate the target population based on health care services/needs and access to additional resources in the community.

5. NC DHHS is committed to racial equity as part of an overall emphasis on diversity and inclusion. In 2020, NC DHHS added the value of "Belonging" to "intentionally promote an inclusive, equitable workplace that reflects the communities we serve, where everyone feels a sense of belonging, and our diverse backgrounds and experiences are valued and recognized as strengths." This value should be subsequently reflected in both state Divisions' and local Contractors' work. Applicants must describe their approach to building racial equity and inclusion at the community, agency, staff, and/or programmatic levels.

6. If applicable, describe how you use or plan to use telehealth or telemedicine, etc. to reduce barriers to care. (*Telehealth is defined as the use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration. Technologies*

include video conferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications. Telemedicine services - include both an originating site and a distant site. The originating site is the location of the patient at the time the service is being furnished. The distant site is the site where the physician or other licensed practitioner delivering the service is located.)

IV. Community Collaboration (15 Points)

1. Describe how your organization has built partnerships or anticipates collaborative partnerships with other organizations in your community that serve under- and uninsured individuals (e.g., homeless shelter, farmworker health program, hospital system). Include traditional and non-traditional organizations. Include collaborative partnerships directly related to your funding requests (e.g., Project Funding, Medical Access Plan, Behavioral Health). Please provide at least three examples.

2. Describe how your organization will provide or support the continuity of care with community providers. List agencies who refer patient to you and agencies you refer patients to when you are unable to provide services.

V. Performance Measures Narrative (20 Points Total)

All applicants must complete the performance grid. These measures and other pertinent performance data will be reported on monthly, quarterly, or annually as indicated.

Performance measures are based on the measures in the Uniform Data System, a standardized reporting system that Federally Qualified Health Centers use to submit data.

For each performance measure, the organization will include the following information:

- **Data Source:** Where will the organization obtain the information reported for each performance measure?
- **Collection Process and Calculation:** What method will the organization use to collect the information?
- **Data Limitations**: What may prevent the organization from obtaining data for the performance measures?

Evaluation Criteria for Primary and Preventive Care (MAP)	**Baseline Values/Measures as of 07/01/2023**	**Target to Be Reached by 06/30/2024**
	Projected Value	*Projected Target*
REQUIRED: Output Measure Number of **unduplicated patients served**. Patients are individuals who have at least one visit during the reporting period.		

Note: If the grant funds dental care, organizations will be required to report primary care patients served separated from dental patients served.		
Measure Type	Output	
ORH Required Reporting Frequency	Quarterly (at 3,6,9 and 12 months) **At the final performance report (24-month report) in addition to number of unduplicated patients served, contractors will also report unduplicated patient information in the following categories: patient age, patient insurance status and patient race/ethnicity.**	
Data Source		
Collection Process and Calculation		
Data Limitations		
Evaluation Criteria for Behavioral Health Care	**Baseline Values/Measures as of 07/01/2023**	**Target to Be Reached by 06/30/2024**
	Projected Value	*Projected Target*
REQUIRED: Output Measure Number of **unduplicated patients served**. Patients are individuals who have at least one visit during the reporting period. Note: If the grant funds dental care, organizations will be required to report primary care patients served separated from dental patients served.		
Measure Type	Output	
ORH Required Reporting Frequency	Quarterly (at 3,6,9 and 12 months) **At the final performance report (12-month report) in addition to number of unduplicated patients served, contractors will also report unduplicated patient information in the following categories: patient age, patient insurance status and patient race/ethnicity.**	
Data Source		
Collection Process and Calculation		
Data Limitations		

Measure Description	**Diabetes: Hemoglobin A1c Poor Control** Percentage of patients 18-75 years of age with diabetes who had hemoglobin HbA1c > 9.0% during the reporting period	
Guidance	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. Only include patients with an active diagnosis of Type 1 or Type 2 diabetes 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. This measure is calculated using the numerator and denominator defined below. This service cannot be conducted via telehealth.	
Measure - Denominator	Baseline Value as of **07/01/2023**	Target to be reached by **06/30/2024**
<u>Denominator</u>: Patients 18-75 years of age with diabetes with a medical visit during the measurement period. <u>Exclusions</u>: 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.		
Measure Type	Outcome	
ORH Required Reporting Frequency	Biannually (Reported at six and 12 months)	
Data Source		
Collection Process and Calculation		
Data Limitations		
Measure - Numerator	Baseline Value as of **07/01/2023**	Target to be reached by **06/30/2024**

Numerator: Patients whose most recent HbA1c level performed during the measurement period is greater than 9.0 % and patients who had no test conducted during the measurement period.		
Measure Type	Quality/Process	
ORH Required Reporting Frequency	Biannually (Reported at six and 12 months)	
Data Source		
Collection Process and Calculation		
Data Limitations		
Measure Description	**Controlling High Blood Pressure** Percentage of patients 18-85 years old who had a diagnosis of hypertension (HTN) overlapping the reporting period ***and*** whose most recent Blood Pressure (BP) was adequately controlled (less than 140/90 mm Hg) during the reporting period.	
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. Adequate control is defined as systolic Blood Pressure lower than 140 mm Hg **AND** diastolic blood pressure lower than 90 mm Hg. 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. Patients self-reporting their blood pressure is not acceptable. The provider must be able to visually see the results on the patient's device or the Provider must use a remote monitoring device. 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 - Denominator	Baseline Value as of **07/01/2023**	Target to be reached by **06/30/2024**
Denominator: Patients 18-85 years of age who had a diagnosis of essential hypertension overlapping the measurement period with a *medical* visit during the reporting period Exclusions to the denominator: 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.		
Measure Type	Outcome	
ORH Required Reporting Frequency	Biannually (Reported at six and 12 months)	
Data Source		
Collection Process and Calculation		
Data Limitations		
Measure - Numerator	Baseline Value as of **07/01/2023**	Target to be reached by **06/30/2024**
Numerator: Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the reporting period,		
Measure Type	Outcome	
ORH Required Reporting Frequency	Biannually (Reported at six and 12 months)	
Data Source		
Collection Process and Calculation		

Data Limitations		
Measure Description	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan** Percentage of patients aged 18 years and older with a visit during the reporting period with a BMI documented during the most recent visit or within the previous 12 months to that visit AND, when the BMI is outside normal parameters, a follow-up plan is documented during the visit or during the previous 12 months of that visit.	
Guidance	This performance measure, as a whole, cannot be completed in a telehealth visit. The only aspect that is allowable as a telehealth visit is the documented follow-up plan with the patient. Patient's self-reporting their height and weight is not acceptable. Report this measure for all patients seen during the reporting period. 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 a HIT/EHR can calculate BMI does not replace the presence of the BMI itself.	
Measure - Denominator	Baseline Value as of **07/01/2023**	Target to be reached by **06/30/2024**

Denominator: Patients who were 18 years of age or older with at least one medical visit during the reporting period. Exclusions: Patients who are pregnant. Patients receiving palliative or hospice care. Patients who refuse measurement of height and/or weight. Patients with a documented Medical Reason. 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		
Measure Type	Quality/Process	
ORH Required Reporting Frequency	Biannually (Reported at six and 12 months)	
Data Source		
Collection Process and Calculation		
Data Limitations		
Measure - Numerator	Baseline Value as of **07/01/2023**	Target to be reached by **06/30/2024**
Numerator: Patients with a documented BMI (not just height and weight) during their most recent visit ***or*** during the previous 12 months of that visit, **AND** 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.		
Measure Type	Quality/Process	
ORH Required Reporting Frequency	Biannually (Reported at six and 12 months)	
Data Source		
Collection Process and Calculation		
Data Limitations		
Measure Description	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months ***and*** received tobacco cessation intervention *if identified as a tobacco user.* This measure is calculated using the numerator and denominator defined below.	

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 - Denominator	Baseline Value as of **07/01/2023**	Target to be reached by **06/30/2024**
Denominator: All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the reporting period		
Measure Type	Quality/Process	
ORH Required Reporting Frequency	Biannually (Reported at six and 12 months)	
Data Source		
Collection Process and Calculation		
Data Limitations		
Measure - Numerator	Baseline Value as of **07/01/2023**	Target to be reached by **06/30/2024**
Numerator: Patients who were screened for tobacco use at least once within 24 months before the end of the reporting period AND if identified as a tobacco user, received tobacco cessation intervention * Exclusions: Documentation of medical reason(s) for not screening for tobacco use OR for not providing tobacco cessation intervention for patients identified as tobacco users (e.g., limited life expectancy, other medical reason)		
Measure Type	Quality/Process	
ORH Required Reporting Frequency	Biannually (Reported at six and 12 months)	
Data Source		
Collection Process and Calculation		
Data Limitations		
Measure Description	**Screening for Clinical Depression and Follow-Up Plan** Percentage of patients aged 12 years and older screened for depression on the date of the visit or 14 days prior to the date of the visit using an age-appropriate standardized depression screening tool AND, if screening was positive, had a	

	follow-up plan documented on the date of the visit.
Guidance	• Use the most recent screening results. • The follow-up plan must be related to a positive depression screening. • Documentation of a follow-up plan "on the date of the visit" can refer to any countable visit, NOT only a medical visit. • The depression screening must be completed on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized depression screening tool and must be reviewed and addressed in the office of the provider on the date of the visit. • If the screening result is positive, a follow-up plan must be documented on the date of the visit. A follow-up plan could be additional evaluation, referral, treatment, pharmacological intervention, or other interventions. • Document the screening tool used in the patient health record. Each standardized screening tool provides guidance on whether a particular score is considered positive for depression. • Follow-up for a positive depression screening must include one or more of the following: 1) Additional interventions designed to treat depression, such as behavioral health evaluation, psychotherapy, or additional treatment. 2) Referral to a provider for further evaluation for

	depression. Or 3) Pharmacological interventions, when appropriate. • DO NOT count patients who are re-screened as meeting the numerator criteria as a follow-up plan to a positive screen. • DO NOT count a PHQ-9 screening that follows a positive PHQ-2 screening during the measurement period as meeting the numerator criteria for a follow-up plan to a positive depression screening. • A suicide risk assessment does not qualify for the numerator as a follow-up plan.

Measure - Denominator	Baseline Value as of **07/01/2023**	Target to be reached by **06/30/2024**
Denominator: All patients aged 12 years and older with at least one medical visit during the reporting period Exclusions: Patients with an active diagnosis for depression or a diagnosis of bipolar disorder. Patient refuses to participate. Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status. Situations where the patient's cognitive capacity, functional or motivational may impact the accuracy of results.		
Measure Type	Quality Process	
ORH Required Reporting Frequency	Biannually (Reported at six and 12 months)	
Data Source		
Collection Process and Calculation		

Data Limitations	

Measure - Numerator	Baseline Value as of **07/01/2023**	Target to be reached by **06/30/2024**
Numerator: Patients screened for depression on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized tool AND if screened positive for depression, had a follow-up plan documented on the date of the visit Note: Patients who are already participating in ongoing treatment for depression will not be included in the universe count.		
Measure Type	Quality Process	
ORH Required Reporting Frequency	Biannually (Reported at six and 12 months)	
Data Source		
Collection Process and Calculation		
Data Limitations		

VII. **Budget and Budget Narrative (15 Points)**

The budget and budget narrative are a separate attachment and should be completed within the Excel document. Follow the instructions within each tab. Once complete, upload the Excel attachment to the REDCap survey.

Please note that there are multiple tabs to complete.

- **Personnel** – Complete this section only if you are requesting funds to support a staff position and must clearly align to community need, access to care or performance measures.

- **Line-Item Budget** – Complete the entire line-item budget if you are requesting operating funds. If you are only requesting MAP and/or BH funds, complete the first table only.
- **Budget Narrative** – Complete this section if you are requesting any operating funds. The narrative must clearly align to community need, access to care or performance measures. Each description should show the calculations for all budget line items and must clearly justify the need for these items. Ensure that all line items from the budget tab are included in the narrative.