**North Carolina Office of Rural Health**

**State Designated Rural Health Centers Application**

**SFY 2026**

**RFA TITLE:**State DesignatedRural Health Centers Support Grant

**FUNDING AGENCY NAME:**North Carolina Office of Rural Health (ORH)

**RFA OPENS: January 13, 2025**

**RFA DEADLINE:** **February 21, 2025, 5:00 p.m.**

|  |
| --- |
| Incomplete applications, or applications not completed in accordance with the following instructions, will not be reviewed.**Applicants must submit their application electronically through the Zengine portal. *Click link to access electronic version of application***: [**https://webportalapp.com/sp/ncdhhs\_rural\_health\_center\_operations**](https://webportalapp.com/sp/ncdhhs_rural_health_center_operations)**See additional details below on Pages 3 and 4.** |

**RFA TECHNICAL ASSISTANCE WEBINAR: January 24, 2025, from 1 - 2:30pm**

**Microsoft Teams** [Need help?](https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Faka.ms%2FJoinTeamsMeeting%3Fomkt%3Den-US&data=05%7C02%7CDorothea.Brock%40dhhs.nc.gov%7Cbcb2244da5f044e6081008dd185295bd%7C7a7681dcb9d0449a85c3ecc26cd7ed19%7C0%7C0%7C638693465155393692%7CUnknown%7CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%3D%3D%7C0%7C%7C%7C&sdata=ebORNUvnq56qGC1mcoiYy6aKGSp0oip5LkSZ2lOI2yo%3D&reserved=0)

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Phone conference ID: 165 893 323#

**PURPOSE:** These grant funds, supported through the North Carolina General Assembly, allow ORH to partner with local communities to provide funding to improve their ability to serve underserved populations who would otherwise be unable to access needed primary care services due to geographic, economic, or other barriers. State Designated Rural Health Centers have become an integral part of the health care safety net for North Carolina’s rural and underserved residents.

**FUNDING AVAILABILITY:** Requests are contingent upon availability of program funding. ORH anticipates that approximately 15 applicants will receive funding. Successful applicants will be required to attend a grant award workshop.

**ELIGIBILTY:**  The applicant organization must first assess if it 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 – Rural Determination can be found at: https://www.ruralhealthinfo.org/am-i-rural
* Health Professional Shortage Area determination - HPSA scores can be found at: <https://data.hrsa.gov/tools/shortage-area>
* Demonstrated unmet need
* County Distress Ranking – Tier 1 or 2 – County Distress Rankings can be found at: https://www.commerce.nc.gov/grants-incentives/county-distress-rankings-tiers
* Proof that the organization is not owned, controlled, or operated by another entity and holds an active 501 c3 Status. (*Independent Rural Health Clinics, and Provider Based Clinics operated by Rural and Critical Access Hospitals are eligible to apply)*
* Provider of primary health care services to all individuals in the defined service area regardless of ability to pay.
* Ability or plan to enroll eligible providers in Medicare and Medicaid reimbursement programs
* Documentation demonstrating that at least 10% of patient volume are Medicaid beneficiaries

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.

**AWARD INFORMATION**: Applicant awardees will be awarded for a 1-year period, with the option to renew for year 2 and year 3. Awardees are required to attend a grant award workshop and participate in a site visit or desk review within 3 months of the awarded start date. **Any remaining balances from Year 1 funds will not carry forward into Year 2 or 3.**  Future funding, including for years 2 and 3, are contingent upon substantially meeting performance and financial goals as mutually agreed upon between the division and the awardee.

**MAXIMUM AWARD AMOUNT:** Applicants may request up to $250,500.

**PROPOSED PROJECT PERIOD OR CONTRACT TERM:** State Fiscal Year 2026: July 1, 2025 – June 30, 2026

All grantees must fully expend grant funds by June 30, 2026. All invoices for completed and projected work must be submitted to ORH for reimbursement no later than June 7, 2026.

**GRANT FUNDING DESCRIPTION**

1. **Tier Definitions** - There are two tiers for applicants to consider. **Tier 1 includes Capacity-Building sites** who do not currently serve Medicaid and Medicare patients, but plan to do so within the first year of funding. If awarded, Capacity-Building sites will work with ORH and NC AHEC to complete their Medicaid application by the end of SFY 2026 to reach Tier 2. Tier 1 sites are eligible for Operational/ Infrastructure funds ONLY. Tier 1 sites are eligible for awards up to $100,000. **Tier 2 includes State Designated Rural Health Centers** who currently serve Medicaid and Medicare patients and meet the 10% Medicaid patient population threshold. Tier 2 sites are eligible for awards up to $250,500.
2. **Health service delivery site: Primary Care Access Plan (PCAP) and/or Behavioral Health Access Plan (BHAP) –**Proposal to provide a comprehensive package of healthcare services to rural uninsured/underinsured residents. These visits are reimbursable at a rate of $115.00 per **PCAP**encounter to the health center based on medically necessary, face-to-face provider encounters, which includes, but is not limited to the following: on-site x-rays, in-house labs, minor surgical procedures, services performed by practice providers, prophylaxis, and telehealth.  **BHAP**funds are available for behavioral health and mental health counseling services. The visits are reimbursable at a rate of $80.00 per encounter to the health center based on face-to-face behavioral health provider encounters. Eligible providers include but are not limited to licensed clinical social workers, advanced practice registered nurses, psychologists, and psychiatrists.
3. **Quality Improvement -** Applicant awardees are required to complete or update an annual practice assessment, action plan and identify mutually agreed upon activities for execution with an NC AHEC Practice Support Coach. Awardees should ensure activities prioritize identified operational performance needs, quality of care gaps, HIT optimization (EHR, telehealth, HIE), clinical and administrative workflow redesign, community health worker optimization, behavioral health integration development, etc. where applicable.

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

* Demonstrate a need for health care services for rural and underserved residents in their community.
* Demonstrate capacity to effectively address barriers to care for rural residents and provide quality services.
* Demonstrate capacity to provide a healthcare home and link to primary, dental, and behavioral health services and to respond to additional needs if/when necessary.
* Propose a plan to incorporate rural community and patient feedback into its service delivery approach or quality improvement efforts.
* Propose a plan to integrate SDOH screening questions and assist patients with unmet needs using NCCARE360.
* Describe the capacity to meet the ORH requirements and expectations outlined in the application.
1. **Operational/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 PCAP and/or BHAP. Tier 1 Capacity Building sites are eligible for Operational/ Infrastructure funding only.

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 the community, specifically leveraging the use of PCAP and BHAP funds.
* Propose a plan to blend behavioral health and/or primary care telehealth services fully or partially within the primary care practice involving the use of Community Health Workers.

**HOW TO OBTAIN FURTHER INFORMATION**: Questions regarding the application can be sent to Kim McNeil at kimberly.r.mcneil@dhhs.nc.gov

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

The highest scoring applicants will receive an award based on applicant scores. Awarded applicants will have the opportunity to receive two (2) additional years of funding, up to the amount of the SFY 2026 award, via a non-competitive grant application process.

|  |  |
| --- | --- |
| 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  |
| Work Plan/Performance Measures   | 20 Points  |
| Budget   | 15 Points  |
| Total Points Awarded  | **100 Points** |

**HOW TO APPLY: Applicants must submit their application electronically through the Zengine portal. You must create a profile to access the application. Profile will require creating a username and password.** Use this document as guidance for the electronic version of the application. This document is not an attachment to be included in the Zengine portal. All necessary attachments are noted within the requirements section of the document.

***Click link to access electronic version of application***: [**https://webportalapp.com/sp/ncdhhs\_rural\_health\_center\_operations**](https://webportalapp.com/sp/ncdhhs_rural_health_center_operations)

**Applicants are required to include the following attachments:**

* Organizational Chart and description of Quality Improvement Team
* Proof or copy of sliding fee scale
* Budget Template **(Note: this will be a separate Excel attachment with multiple tabs)** [Budget Template](https://ncconnect.sharepoint.com/sites/orh/ORHDocuments/Operations%20Team/SFY%202025-2026%20RFA/SDRHC%20Budget%20Template_SFY2025-2026.xlsx)
	+ Purchases for equipment over $500.00 are considered Capital expenses and should not be included.
* Annual Provider Certification Documents
	+ [Conflict of Interest Acknowledgement and Policy](file:///J%3A%5CRural_Health_Ops%5CPublic%5C2023-2024%5CProvider%20Documents%20-%20TEMPLATES%5CConflict%20of%20Interest%20Acknowledgement%20and%20Policy.pdf)
	+ [Conflict of Interest Verification](https://www.ncdhhs.gov/conflict-interest-verificationdoc/open)
	+ [IRS Tax Exemption Verification Form](https://www.ncdhhs.gov/irs-tax-exemption-form/download?attachment)
	+ [No Overdue Tax Debts](https://www.ncdhhs.gov/state-grant-certification-no-overdue-tax-debts/download?attachment)
	+ [Internal Control Questionnaire](https://www.ncdhhs.gov/internal-control-questionnaire/download?attachment)
		- Signed ICQ Attestation Page (review ‘Instructions’ tab in ICQ Excel document)
	+ [State Certification](https://www.ncdhhs.gov/state-certificationsdocx/open)
* Capacity building sites transitioning to SDRHC status are required to include the following attachments as well:
	+ *Documentation of a completed Medicaid application and Provider enrollment before RFA submission is acceptable.*
* EHR patient panel report by Insurance (report should not include PHI)
* Proof of eProcurement registration (see example below): [Vendor Search eVP (nc.gov)](https://evp.nc.gov/vendors/vendorsearchadvanceform/?id=a597d238-8fbb-ee11-a569-001dd83065dd)



**Organizational Information**

|  |  |
| --- | --- |
| Organization Name: |  |
| Organization EIN: |   |
| Organization NPI (if applicable): |  |
| Organization UEI (if applicable): |  |
| Mailing Address: |  |
|  City |  |
|  State |  |
|  Zip Code |  |
| Payment Remittance Address: |  |
|  City |  |
|  NC |  |
|  Zip Code |  |
| Organization Fiscal Year (Month/Year) REQUIRED: |  |
| Organization’s Website Address: |  |
| Organization Type: (check **all** that apply) | * Federally Qualified Health Centers Look-Alike (FQHC - LAL)
* Free and Charitable Clinic
* Health Department
* CMS Rural Health Clinic
* State Designated Rural Health Center
 | * School-Based and School-Linked Health Center
* Other Non-Profit Community Organization providing direct primary and preventive patient care to low-income, uninsured, underinsured and medically vulnerable populations.
 |

**Key Contact Information**

|  |  |
| --- | --- |
| Contract Administrator |  |
| Email: |  |
| Phone Number: |  |
| Authorized Signatory  |  |
| Email:  |  |
| Phone Number: |  |
| Chief Medical Officer or Lead Provider (Designated person to support the clinical quality measures the organization is required to report) |  |
| Email:  |  |
| Phone Number: |  |
| Quality Improvement Coordinator |  |
| Email Address: |  |
| Phone Number:  |  |

Please list key provider names, titles (MD, DO, PA, NP, CNM, etc.), NPI number, and FTEs associated with your organization/and other staff members at the site(s) where the grant will be utilized. The portal will contain an upload function to submit documentation for the provider table.

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

|  |  |
| --- | --- |
| Number of Service Delivery Sites (locations). This question is related to the entire organization:  |  |
| Name of Site(s) where the grant funds will be utilized: |  |
| Primary County Served (where the grant will be utilized): |  |
| Other Counties Served (if applicable): |  |
| HPSA Score of Primary County Served (if applicable): |  |
| Please submit your site’s HPSA score (If applicable):  |  |
| * HPSA scores can be found at: <https://data.hrsa.gov/tools/shortage-area>
* The HPSA score must correspond with the health care type being requested for funding. For example: If the funding supports primary care services, use the primary care HPSA score and not a mental health or dental HPSA score.
 |
| Intended Funding Tier: | Tier 1 (Capacity Building) OR Tier 2 (SDRHC) |
| Total Amount of Request: |  |
| Total Organizational Annual Budget: |  |

1. Provide a brief description of your organization. Include services provided, mission and hours of operation. (1,000-character limit)
2. What has your organization achieved in the past year to advance your mission and improve access to care? (1,000-character limit)
3. Provide a brief description of how the funds will be used for the upcoming project year (July 1, 2025 – June 30, 2026). Include what funding opportunities the organization will apply for (Primary Care Access Plan, Behavioral Health Access Plan, Operational/ Infrastructure). (1,000-character limit)
4. Does your organization currently provide comprehensive primary care services (e.g., preventive, primary, and/or acute) at the primary care delivery site?
* Yes
* No

If yes, approximately how many hours per week your organization offers these services.

* 1-10 hours/week
* 11-20 hours/week
* 21-30 hours/week
* 31-40 hours/week
* 41-50 hours/week
* >50 hours/week
1. Describe how your organization serves as a medical home. Patient Centered Medical Home (PCMH) recognition is encouraged, but not required. (1,000-character limit; character limit is inclusive of space and punctuation)
2. Does your organization currently provide comprehensive pediatric and child health care services (e.g., preventive, primary, and/or acute)?
* Yes
* No

If yes, approximately how many hours per week does your organization offer these services?

* 1-10 hours/week
* 11-20 hours/week
* 21-30 hours/week
* 31-40 hours/week
* 41-50 hours/week
* >50 hours/week
1. Does your organization provide prenatal care and/or delivery services?
* Yes
* No

 If yes, approximately how many hours per week your organization offer these services.

* 1-10 hours/week
* 11-20 hours/week
* 21-30 hours/week
* 31-40 hours/week
* 41-50 hours/week
* >50 hours/week
1. Does your organization provide behavioral health services (e.g., mental health or substance abuse services)?
* No
* Yes. Comprehensive services
* Yes. Limited, such as screening, brief intervention, and referral into treatment

If yes, approximately how many hours per week does your organization offer these services?

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

|  |  |
| --- | --- |
| **Yes, Refer or No** | **Additional Services** |
|   | Prenatal and Postpartum Care |
|   | Maternal Care and Delivery Services |
|   | Dental services |
|   | Specialty services (e.g., endocrinology, gastroenterology, neurology, or cardiology)? |
|   | Other: |

1. Does your organization have the capacity to accept new Medicaid and Underinsured/Uninsured patients?
* Yes
* No

 If not, is there a waiting list?

* Yes
* No

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

1. What impact has Medicaid Expansion had on your organization?
2. Does your organization utilize telehealth?
* Yes
* No

 If yes, which describes the telehealth application your organization is using? (Check all that apply)

* Live (synchronous) videoconferencing: a two-way audiovisual link between a patient and a care provider
* Store-and-forward (asynchronous) videoconferencing: transmission of a recorded health history to a health practitioner, usually a specialist.
* Remote patient monitoring (RPM): the use of connected electronic tools to record personal health and medical data in one location for review by a provider in another location, usually at a different time.
* Mobile health (mHealth): health care and public health information provided through mobile devices. The information may include general educational information, targeted texts, and notifications about disease outbreaks.
1. Does your organization have an Electronic Health Record?
* Yes
* No
1. If yes, provide the name and version: \_\_\_\_\_\_\_\_
2. Is your organization currently connected to NC HealthConnex (formerly the NC Health Information Exchange)?
* Yes
* No
1. In the NCCARE360 network, providers can electronically connect individuals and families who have unmet social needs to community resources. NCCARE360 also allows for easy feedback and follow-up to help close the care loop for individuals and families seeking help. Is your organization currently connected to and using NCARE360?
* Yes
* No
1. If yes, approximately how many individuals were served FY25?
	* please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Does your organization 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
1. If yes, what type of tool does your organization use? ()
* please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* We do not use a standardized assessment
1. 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, 2025 - June 30, 2026) 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, 2025, 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, 2025 - June 30, 2026, in Column E. Column F will calculate the projected net additional patients. The total unduplicated patients served row will automatically calculate.  Patients are individuals who have or are expected to have at least one visit during the reporting period. **Total number should Exclude immunization Clinics**. Number of unduplicated patients served, by age for all insurance types
2. age < 18 years old (children)
3. age 18 to 64 (adults)
4. age 65 and older (older adults)

**Attach EHR patient panel report by Insurance (report should not include PHI)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|   | 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 |  |  |  |  |

1. Patients by Race and Ethnicity: Enter the number of unduplicated patients by Race & Ethnicity that you currently serve (as of July 1, 2025). 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.

|  |
| --- |
| Organization’s Baseline Period Start Date: Organization’s Baseline Period End Date:  |
| Race | Column AHispanic/ Latino/a, or Spanish Origin\* | Column BNon-Hispanic/ Latino/a, or Spanish Origin\* | Column CUnreported/ Refused to Report Ethnicity |
| * 1. American Indian / Alaska Native
 |  |  |  |
| * 1. Asian (Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese)
 |  |  |  |
| * 1. Black/African American
 |  |  |  |
| * 1. Native Hawaiian / Other Pacific Islander (Guamanian or Chamorro, Samoan)
 |  |  |  |
| * 1. White
 |  |  |  |
| * 1. More than one race
 |  |  |  |
| * 1. Unreported / Refused to report race
 |  |  |  |

**\* Includes: Hispanic/Latino, Mexican, Mexican American, Chicano/a, Puerto Rican, Cuban**

1. 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.
2. **Work Plan (20 points)**
	* Create a work plan that describes the activities or steps that you will use to achieve success regarding the funding opportunities for which you plan to apply (Primary Care Access Plan, Behavioral Health Access Plan and/ or Operational/Infrastructure) during the project year (July 1, 2025 – June 30, 2026). Include timelines for hiring of staff and timelines for who is responsible for project deliverables. The work plan must be clear, concise, and numbered to coincide with the funding opportunity. If applying
3. **Community Need (20 Points)**
4. 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/*](https://www.healthenc.org/)](https://www.healthenc.org/)*(Eastern NC) and*[*https://www.wnchn.org/*](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*](https://schs.dph.ncdhhs.gov/data/hsa/)

1. 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.)*
2. **Improve Access to Care (25 Points)**
3. Describe in detail how your organization is positioned to effectively use the Primary Care Access Plan, Behavioral Health Access Plan and/or the Operational/Infrastructure funds to increase access to care for **underserved** residents in your defined service area.

1. Please indicate how much funding is requested for Primary Care Access Plan (PCAP) and Behavioral Health Access Plan (BHAP). (What percentage of uninsured/underinsured in your service area?) Please indicate “N/A” if only Project Funds are requested. *(PCAP visits are reimbursable at a rate of $115.00 per encounter to the health center based on medically necessary face-to-face provider encounters, including to, but not limited to the following: onsite x-rays, in-house labs, surgical procedures, services performed by practice providers, prophylaxis, and telemedicine. BHAP**funds available for behavioral health and mental health counseling services. The visits are reimbursable at a rate of $80.00 per encounter to the health center based on face-to-face behavioral health provider encounters.)*

1. Please list your agency’s plan to achieve 100% expenditure of PCAP, BHAP, **and/or** Project Funds. Include information about activities planned throughout the year, community engagement/outreach activities, and how referrals are made into your program.

1. 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.

1. 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.

1. 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.)*

1. **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., Primary Care Access Plan, Behavioral Health Access Plan, and/or Operational/ Infrastructure). Please provide at least three examples.

1. 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.
2. **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 into Zengine (contract management software).

**Please note that there are multiple tabs to complete.** Detailed instructions are provided for each tab.

* **Work Plan** – Complete this section by creating objecting for each line item of the funding request (PCAP, BHAP, and/ or Operating).
* **Personnel**– Complete this section only if you are requesting funds to support staff through these grant funds. All positions 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 PCAP and/or BHAP 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.
1. **Performance Measures**

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

Performance measures are based on the measures in the Uniform Data System, a standardized reporting system used 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?

Grantees are asked to identify which patient population their quarterly report includes by selecting one option:

* Sub-Population:  The data reported would include data from a specific group of patients supported by the grant.  Examples include School-Based Health Centers, Dental Clinics, Maternal Care patients, and other special projects. Also, those grantees that are on the encounter-based reimbursement track (track A) would only report from the pool of patients seen for those encounters.
* One-Site Population:  The data reported would include only those patients seen at a specific site location.
* Multi-Site Population:  The data reported would include patients from more than one site location within that health care organization.

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| **Number of Patients Served (PCAP and non-PCAP)** | **Baseline Values/Measures as of 07/01/2025**  | **Target to Be Reached** **by 06/30/2026** |
|    | *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. **Exclude Shot / Vaccination Clinics**.Q4 also requires Patients Served Data to be statified as follows:Number of unduplicated patients served, by age1. age < 18 years old (children)
2. age 18 to 64 (adults)
3. age 65 and older (older adults)

Number of unduplicated patients served, by insurance1. None/Uninsured (include PCAP)
2. Medicaid
3. Children’s Health Insurance Program (CHIP)
4. Medicare (includes duals)
5. Other Public Insurance (e.g. Tricare)

 f) Private (e.g. BCBS) |    |    |
| 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 the number of unduplicated patients served, grantees will also report unduplicated patient information in the following categories: patient age, patient insurance status and patient race/ethnicity.  |
| Data Source  | Grantee reports quarterly using survey. |
| Collection Process and Calculation  |    |
| Data Limitations  |   |

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| **Number of PCAP Patient Encounters (and Non-PCAP Patient Encounters)** | **Baseline Values/Measures as of 07/01/2025**  | **Target to Be Reached** **by 06/30/2026** |
|    | *Projected Value*  | *Projected Target*   |
| **REQUIRED:  Output Measure** Number of face-to-face patient encounters. Report in-clinic and virtual visits/telehealth separately. Number of non-PCAP face-to-face patient encounters. Report in-clinic and virtual visits/telehealth separately. Note: Telehealth is a growing model of care delivery. State and federal telehealth definitions and regulations regarding the acceptable modes of care delivery, types of providers, informed consent, and location of the patient and/or provider are not applicable in determining virtual visits here.Note: Clinic Visits and Virtual Visits are mutually exclusive, do not double count.Report virtual visits where: * + - * The health center provider virtually provided care to a patient who was elsewhere (i.e., not physically at their health center).
			* The health center authorized patient services by a non-health-center provider or volunteer provider who provided care to a patient who was at the health center through telehealth, and the health center paid for the services. (Do not report a clinic visit.)
			* A provider who was not physically present at the health center provided care to a patient, if this is consistent with their scope of project. The provider would need access to the health center’s HIT/EHR to record their activities and review the patient’s record.
			* Interactive, synchronous audio and/or video telecommunication systems permitting real-time communication between the provider and a patient were used. Do not count other modes of telehealth services (e.g., store and forward, remote patient monitoring, mobile health) or provider-to-provider consultations.
			* The visit is coded and charged as telehealth services, even if third-party payers may not recognize or pay for such services. Generally, these charges would be comparable to a clinic visit charge.
			* Do not count as a virtual visit, situations in which the health center does not pay for virtual services provided by a non-health center provider (referral).

Do not report encounters that are screenings, tests, or vaccines (such as for COVID-19) as visits. |    |    |
| 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 the number of unduplicated patients served, grantees will also report unduplicated patient information in the following categories: patient age, patient insurance status and patient race/ethnicity.  |
| **Metric Definition Source** | Office of Rural Health (ORH); HRSA Uniform Data System (UDS) 2024 p. 18-20 and 63-64 “Visits”  |
| Data Source  | Grantee reports quarterly using survey. |
| Collection Process and Calculation  |    |
| Data Limitations  |   |
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| **Measure Description**  | **Diabetes: Hemoglobin A1c Poor Control** Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c (HbA1c) greater than 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.
* If the HbA1c test result is in the patient health record, the test can be used to determine the numerator criteria.
* Report patients who have an active diagnosis of diabetes even if their medical visits during the year were unrelated to the diagnosis.
* Include patients in the numerator whose most recent HbA1c level is greater than 9.0%, for whom the most recent HbA1c result is missing, or for whom no HbA1c tests were performed or documented during the reporting period.
* Even if the treatment of the patient’s diabetes has been referred to a non–health center provider, the health center is expected to have the current lab test results in its records.
 |
| **Measure - Denominator**  | Baseline Value as of **07/01/2025** | Target to be reached by **06/30/2026** |
| Denominator: Patients 18-75 years of age (by the end of the reporting period) with diabetes with a medical visit during the measurement period.   Exclusions: Patients who were in hospice care for any part of the measurement period. Patients 66 and older who are living long term in a nursing home any time on or before the reporting period. Patients 66 and older with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria: advanced illness with one inpatient visit or two outpatient visits or taking dementia medications during the measurement period or the year prior. Patients who received palliative care during the measurement period.  Numerator: Patients whose most recent HbA1c level performed during the measurement period was greater than 9.0 %, or was missing, or was not performed during the reporting period.Grantee’s ability to adhere to these UDS exclusions may vary.  |      |      |
| Measure Type  | Outcome  |
| ORH Required Reporting Frequency   | Biannually (Reported at six and 12 months)  |
| Data Source  | Grantee reports quarterly using survey. |
| Collection Process and Calculation  |    |
| Data Limitations  |   |
| **Measure - Numerator**  | Baseline Value as of **07/01/2025** | Target to be reached by **06/30/2026**  |
| Numerator: Patients whose most recent HbA1c level performed during the measurement period is greater than 9.0 % or were missing or were not performed during the reporting period. |      |      |
| Measure Type  | Quality/Process  |
| ORH Required Reporting Frequency   | Biannually (Reported at six and 12 months)  |
| Data Source  | Grantee reports quarterly using survey. |
| Collection Process and Calculation  |    |
| Data Limitations  |   |

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| **Measure Description**  | **Controlling High Blood Pressure** Percentage of patients 18-85 years old who had a diagnosis of hypertension (HTN) starting before and continuing into, or starting the first six months of the measurement 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.
* Only blood pressure readings performed by a provider, or an automated blood pressure monitor, or device are acceptable for the numerator criteria with this measure.
* Blood pressure readings are acceptable if: taken in person by a clinician; measured remotely by an electronic monitoring device capable of transmitting the blood pressure data to the clinician; or taken by an automated blood pressure monitor or device and conveyed by the patient to the clinician (this is not considered patient self-reporting).
* It is the clinician’s responsibility and discretion to confirm the remote monitoring device used to obtain the blood pressure is considered acceptable and reliable and whether the blood pressure reading is considered accurate before documenting it in the patient’s medical record.
* If there are multiple blood pressure readings on the last day the patient was seen, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading.
* 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.
* DO NOT include blood pressure readings taken during an acute inpatient stay or emergency department visit.
* 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.
 |
| **Measure - Denominator**  | Baseline Value as of **07/01/2025**  | Target to be reached by **06/30/2026** |
| Denominator: Denominator: Patients 18 through 85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first 6 months of the measurement period with a medical visit during the measurement periodExclusions: Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Patients with a diagnosis of pregnancy during the measurement period. Patients who were in hospice for any part of the reporting period. Patients 66 and older (by the end of the reporting period) who were living long-term in a nursing home any time on or before the end of the measurement period. Patients 66-80 (by the end of the reporting period) with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria: advanced illness with one inpatient visit or two outpatient visits or taking dementia medications during the measurement period or the year prior. Patients 81 and older with an indication of frailty for any part of the reporting period. Patients who received palliative care during the measurement period.Grantee’s ability to adhere to these UDS exclusions may vary.  |      |      |
| Measure Type  | Outcome  |
| ORH Required Reporting Frequency   | Biannually (Reported at six and 12 months)  |
| Data Source  | Grantee reports quarterly using survey. |
| Collection Process and Calculation  |    |
| Data Limitations  |    |
| **Measure - Numerator**  | Baseline Value as of **07/01/2025**  | Target to be reached by **06/30/2026**  |
| Numerator: Patients whose most recent blood pressure is adequately controlled (systolic blood pressure less than 140 mmHg and diastolic blood pressure less than 90 mmHg) during the reporting period   |      |      |
| Measure Type  | Outcome  |
| ORH Required Reporting Frequency   | Biannually (Reported at six and 12 months)  |
| Data Source  | Grantee reports quarterly using survey. |
| Collection Process and Calculation  |    |
| Data Limitations  |   |

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| **Measure Description**  | **Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan**   |
| **Guidance** | * An eligible professional or their staff is required to measure both height and weight. Both height and weight must be measured during the reporting period.
* BMI may be documented in the patient health record at the health center or in outside patient health records obtained by the health center.
* If the documented BMI is outside of normal parameters, then a follow-up plan is to be documented during the visit or during the reporting period.
* If more than one BMI is reported during the measurement period, and any of the documented BMI assessments is outside of normal parameters, documentation of an appropriate follow-up plan is to be used to determine whether performance has been met.
* Document the follow-up plan based on the most recent documented BMI outside of normal parameters.
* DO NOT use self-reported height and weight values.
* Documentation in the medical record must show the actual BMI or the template normally viewed by a clinician must display BMI.
* A follow-up plan may include, but is not limited to documentation of education, referral (for example, a registered dietitian nutritionist [RDN], occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional, or surgeon) for lifestyle/behavioral therapy, pharmacological interventions, dietary supplements, exercise counseling, and/or nutrition counseling.
* If the only visits during the reporting period are telehealth or telephone, exclude the patients from the denominator.

Do not count as meeting the numerator criteria 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 **07/01/2025**
 |
| Denominator: Patients who were 18 years of age or older on the date of the visit with at least one medical visit during the reporting period. Do NOT include patients who only had virtual visits during the year in the assessment of this measure (denominator). Exclusions: Patients who are pregnant at any time during the reporting period. Patients receiving palliative or hospice care at any time during the reporting period. Patients who refuse measurement of height and/or weight. Patients with a documented medical reason for not documenting BMI or for not documenting a follow-up plan. Elderly patients (65 years or older) for whom weight reduction or 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 or 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 statusGrantee’s ability to adhere to these UDS exclusions may vary.  |      | Target to be reached by **06/30/2026**  |
| Measure Type  | Quality/Process  |      |
| ORH Required Reporting Frequency   | Biannually (Reported at six and 12 months)  |
| Data Source  | Grantee reports quarterly using survey. |
| Collection Process and Calculation  |    |
| Data Limitations  |    |
| **Measure - Numerator**  | Baseline Value as of **07/01/2025**  |
| Numerator:  Patients with a documented BMI during their most recent visit ***or*** during the reporting period, and BMI is within normal parameters **AND** Patients with a documented BMI during the most recent visit or during the reporting period, and when the BMI is outside of normal parameters, a follow-up plan is documented at the visit where the BMI was outside of normal parameters or during the reporting period. \* Normal parameters for age 18 and older, BMI greater than or equal to 18.5 kg/m2 and less than 25 kg/m2  |      | Target to be reached by **06/30/2026**  |
| Measure Type  | Quality/Process  |      |
| ORH Required Reporting Frequency   | Biannually (Reported at six and 12 months)  |
| Data Source  | Grantee reports quarterly using survey. |
| Collection Process and Calculation  |    |
| Data Limitations  |   |
| **Measure Description**  | **Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention** Percentage of patients aged 12 years and older who were screened for tobacco use one or more times within reporting period ***and*** who received tobacco cessation intervention during the reporting period or in the 6 months prior to the reporting period *if identified as a tobacco user* |
| **Guidance** | * If patients use any type of tobacco (i.e., smokes or uses smokeless tobacco), tobacco cessation intervention is expected (counseling and/or pharmacotherapy).
* If patients use any type of tobacco (i.e., smokes or uses smokeless tobacco), tobacco cessation intervention (counseling and/or pharmacotherapy) is expected. The measure uses the U.S. Food and Drug Administration definition of tobacco, which includes e-cigarettes, hookah pens, and other electronic nicotine delivery systems. Therefore, the measure **does** **consider the use of e-cigarettes** and other electronic nicotine delivery systems to be tobacco use.
* A patient needs one preventive visit to be considered for the dominator. Preventive visits are defined by the value sets listed under Preventive Visit During Measurement Period in the measure specifications. If a patient has not had a preventive visit, they need two other qualifying visits to be considered for the denominator. Other qualifying visits are defined by the value sets listed under Qualifying Visit During Measurement Period in the measure specifications.
* To promote a team-based approach to patient care, the tobacco cessation intervention can be performed by another health care provider; therefore, the tobacco use screening and tobacco cessation intervention DO NOT need to be performed by the same provider.
* If a patient has multiple tobacco use screenings during the 12-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.
* Report in the numerator records that demonstrate that the patient had been asked about their use of all forms of tobacco during the reporting period
* If the cessation intervention is pharmacotherapy, then the prescription must be active (one that has not expired) or ordered during the measurement period.
* Include in the numerator patients with a negative screening *and* those with a positive screening who had cessation intervention if a tobacco user.
* Include patients who receive tobacco cessation intervention by any provider, including those who:
	+ 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.

DO NOT count as meeting the numerator criteria providing written self-help materials only.  |
| **Measure - Denominator**  | * Baseline Value as of **07/01/2025**
 |
| All patients aged 12 years and older at the start of the SFY seen for at least two qualifying encounters in the reporting period OR at least one preventive care qualifying encounter during the reporting periodExclusions: Patients who were in hospice care for any part of the reporting period.  |      | Target to be reached by **06/30/2026** |
| Measure Type  | Quality/Process  |      |
| ORH Required Reporting Frequency   | Biannually (Reported at six and 12 months)  |
| Data Source  | Grantee reports quarterly using survey. |
| Collection Process and Calculation  |    |
| Data Limitations  |    |
| **Measure - Numerator**  | Baseline Value as of **07/01/2025** |
|  Numerator: Patients who were screened for tobacco use at least once during the reporting period and NOT identified as a tobacco userANDPatients who were screened for tobacco use at least once during the reporting period and, if identified as a tobacco user, received tobacco cessation intervention during the reporting period or during the 6 months prior to the reporting period Note: Include in the numerator patients with a negative screening and those with a positive screening who had cessation intervention if a tobacco user. |      | Target to be reached by **06/30/2026**  |
| Measure Type  | Quality/Process  |      |
| ORH Required Reporting Frequency   | Biannually (Reported at six and 12 months)  |
| Data Source  |  Grantee reports quarterly using survey. |
| 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 up to 14 days prior to the date of the visit using an age-appropriate standardized depression screening tool AND, if positive, a follow-up plan is documented on the date of, or up to two days after the date of, the qualifying the visit |
| **Guidance** | * Patients who have ever been diagnosed with depression or bipolar disorder prior to the eligible visit will be excluded from the measure.
* 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 or up to two days after the visit. A follow-up plan could be additional evaluation, referral, treatment, pharmacological intervention, or other interventions.
* Standardized depression screening tools are normalized and validated for the age-appropriate patient population in which they are used, must be documented in the patient health record, and must be used to meet the numerator criteria. 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.
* Use the most recent screening results.
* The follow-up plan must be related to a positive depression screening.
* Follow-up for a positive depression screening must include one or more of the following:
	+ Additional interventions designed to treat depression, such as behavioral health evaluation, psychotherapy, or additional treatment.
	+ Referral to a provider for further evaluation for depression.
	+ Pharmacological interventions, when appropriate.
* Although a Patient Health Questionnaire (PHQ-9) may follow a PHQ-2 as a new screening, if the result is positive, then a CQM-compliant follow-up plan on the date of the visit is still required.
* Screening may occur outside of a countable visit.
* Documentation of a follow-up plan “on the date of the visit” can refer to any countable visit, NOT only a medical visit.
* A suicide risk assessment DOES NOT qualify for the numerator as a follow-up plan.
* 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. |
|  **Measure - Denominator** | * Baseline Value as of **07/01/2025**
 |
| Denominator: All patients aged 12 years and older with at least one visit during the reporting periodExclusions: Patients who have been diagnosed bipolar disorder at any time prior to the visit, regardless of whether the diagnosis is active or not. Patients who refuse to participate. Medical reasons, including: * Patients who are in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status.
* Patients with documentation of medical reasons for not screening the patient for depression (e.g. cognitive, functional, or motivational limitations) that may impact the accuracy of results.

Grantee’s ability to adhere to these UDS exclusions may vary.  |    | Target to be reached by **06/30/2026** |
| Measure Type | Quality Process |    |
| ORH Required Reporting Frequency  | Biannually (Reported at six and 12 months) |
| Data Source | Grantee reports quarterly using survey |
| Collection Process and Calculation |   |
| Data Limitations |   |
| **Measure - Numerator** | Baseline Value as of **07/01/2025** |
| Numerator: Patients who were 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 screened negative for depressionAND Patients who were 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, a follow-up plan is documented on the date of or up to two days after the date of the visit. Note: Include in the numerator patients with a negative screening and those with a positive screening who had a follow-up plan documented.  |    | Target to be reached by **06/30/2026** |
| Measure Type | Quality Process |    |
| ORH Required Reporting Frequency  | Biannually (Reported at six and 12 months) |
| Data Source | Grantee reports quarterly using survey |
| Collection Process and Calculation |   |
| Data Limitations |  |
| **Measure Description** | **Early Entry into Prenatal Care:** Percentage of prenatal care patients who entered prenatal care during their first trimester.This measure is calculated using the numerator and denominator defined below. |
| **Guidance** | * Report patients who were prenatal care patients during the reporting period and whose first visit occurred when they were estimated to be pregnant up through the end of the 13th week after the first day of their last menstrual period.
* Only report patients who had their first comprehensive prenatal exam with the health center or with the referral provider as having begun prenatal care. Health center visits that include pregnancy and other lab tests, dispensing vitamins, taking a health history, and/or obtaining a nutritional or psychosocial assessment only DO NOT count as the start of prenatal care.
* Determine the trimester by the trimester of pregnancy that the patient was in when they began prenatal care either at one of the health center’s service delivery locations or with another provider, including a referral provider.
* Report a patient who begins prenatal care with the health center or is referred by the health center to another provider.
* Report a patient who begins prenatal care on their own with another provider and then transfers to the health center.
* Patient self-report of trimester of entry is permitted.

Report the patient twice as a prenatal care patient in those rare instances when a patient receives prenatal care services for two separate pregnancies in the same calendar year. |
| **Measure - Denominator** | * Baseline Value as of **07/01/2025**
 |
| Denominator: Patients seen for prenatal care during the reporting period.  |  | Target to be reached by **06/30/2026** |
| Measure Type | Quality/Process |  |
| ORH Reporting Frequency  | Biannually (Reported at six and 12 months) |
| Data Source | Grantee reports quarterly using survey |
| Collection Process and Calculation |  |
| Data Limitations |  |
| **Measure - Numerator** | Baseline Value as of **07/01/2025** |
| Numerator: Patients who began prenatal care at the health center or with a referral provider, or who began care with another prenatal provider, during their first trimester. |  | Target to be reached by **06/30/2026** |
| Measure Type | Quality/Process |  |
| ORH Reporting Frequency  | Biannually (Reported at six and 12 months) |
| Data Source | Grantee reports quarterly using survey. |
| Collection Process and Calculation |  |
| Data Limitations |  |
|  |  |