|  |  |
| --- | --- |
| **Section** | **Rural Health Centers Program****Medical Access Plan, Innovation, and Planning and Implementation Grants****SFY 2018 - 2019** |
| **General Information**  | **RFA Title:** Rural Health Centers Support: Medical Access Plan, Innovation, and Planning and Implementation Grants **Funding Agency Name:** North Carolina Office of Rural Health (NC ORH)**Funding Agency Address:** 311 Ashe Avenue, Raleigh, NC 27606**Funding Agency Contacts/Inquiry Information:** Andrea Murphy, 919 527-6448, andrea.murphy@dhhs.nc.gov; and Robert Coble, 919 527-6474, robert.coble@dhhs.nc.gov **Funding Opportunities** - Medical Access Planning (MAP), Innovation, and Planning and Implementation Grants: 1. **MAP Grant-** Award date: 7/1/2018

**Application Closing Date and Submission Instructions:** Grant applications must be received via electronic survey by March 29, 2018. Newly recognized State-Designated RHCs may apply up to March 29, 2019.1. **Innovation Grant -** Award date: 7/1/2018

**Grant Application Closing and Submission Instructions:** Grant applications must be received via electronic survey by March 29, 2018. 1. **Planning and Implementation Grant -** Award date:7/1/2018

**Grant Application Submission Instructions:** Grant applications must be received via electronic survey by March 29, 2018.All electronic applications and questions regarding the application should be sent to your assigned ORH Regional Field Staff. Incomplete applications and applications not completed in accordance with the instructions provided below will not be reviewed. |
| **RFA Description** **­­­­****Eligibility** **Application Instructions** | The purpose of grants awarded under this program is to support state-designated rural health centers. The Office of Rural Health assists underserved communities and populations with developing innovative strategies for improving access, quality, and cost-effectiveness of health care. Distribution of primary care providers in North Carolina has historically been skewed toward cities and larger towns. Rural residents, who often face transportation issues, find accessing primary care services difficult. Through the establishment of rural health centers, ORH enables local communities to provide access to their underserved populations who would otherwise be unable to receive needed primary care services due to geographic, economic, or other barriers. Thus, rural health centers have become an integral part of the health care safety net for North Carolina’s rural and underserved residents. ***New and/or additional requirements may be added to any grant award throughout the SFY 2018 – 2019 grant period as we incorporate emerging topics, trends and best practices, including but not limited to Social Determinants of Health (SDOH), Health Information Exchange (HIE), Telehealth (including Telepsych), Integrated Care, etc.*** **Grant Funding Descriptions:** **1. Medical Access Plan** - Uninsured and underinsured residents are afforded access through the MAP program. MAP is a sliding fee scale program that helps residents of North Carolina access primary health care services when they meet specified financial criteria found in the current MAP manual and do not have primary health care coverage. Visits are reimbursable through MAP for medically necessary, on-site, face-to-face provider encounters less the patient copay amount.**2. Innovation Projects** – Funding will be awarded in four focus areas/tracks. All projects must show ability to create systems and processes that promote sustainability of the organization being funded. Innovative funding shall assist the applicant with accomplishing one of the following goals:**Track A**: Supports efforts to becomerecognized as a National Committee for Quality Assurance (NCQA)Patient Centered Medical Home (PCMH). Grant funds must support either: 1) an outside subject matter expert to assist with PCMH recognition or 2) costs associated with educating site personnel with becoming a PCMH Certified Content Expert. **Track B**: Supports the creation and implementation of sustainable technological infrastructure that enhances access to health care and improves its quality. These efforts may include technological infrastructure (hardware, software, etc.), administrative, and clinical innovations that sustain primary medical care delivery models through the adoption of Electronic Health Records (EHR) technology and using the North Carolina HealthConnex, formerly known as the Health Information Exchange. Applications may include methods for expanding the ability to collect, exchange, store, and disseminate health information while augmenting the practice’s capacity to provide access to and delivery of primary health care. **Track C:** Provides an opportunity for rural health centers to propose activities that increase and/or improve the practice’s efficiencies, effectiveness, transformation, sustainability, quality, or access to care. This track provides opportunity to visit other state-designated rural health centers to learn and share innovative strategies with similar outcomes. Travel and other related expenses for these learning and/or exploratory projects will be considered within this track.**Track D:** Provides rural health centers with funding to hire or retain professional services including but not limited to: legal aid, actuarial services, and other professional services deemed prudent and necessary for the making and analysis of business operations decisions affecting the rural health center.**3. Planning and Implementation Projects** - This seed funding is available to organizations deemed by ORH as a state-designated rural health center on or after July 1, 2015. Grant dollars will support planning and implementation activities associated with creating or implementing a community development plan that supports an operational move toward long-term sustainability. Funding requests may include, but are not limited to, support for attorney fees, provider compensation, operational subject matter experts (Patient Centered Medical Home, Alternative Payment Methodologies, etc.), and technology advancement. This is one-time funding. **Note that under Session Law 2015-241, each entity receiving state funds for the provision of health services will be required to be connected to the NC HealthConnex, NC HIE by June 1, 2018. Medicaid providers shall be connected by February 1, 2018.**To be eligible to apply for these funds, your organization must be deemed a State-Designated Rural Health Center by ORH. The maximum total grant award is dependent upon demonstrated need at the rural health center or by the organization and is contingent upon funding availability. **MAP and Innovation Projects:** ORH State-Designated 501(c)3 Rural Health Centers **Planning and Implementation Projects:** Organizations deemed by ORH as a state-designated, 501(c)3 rural health center after July 1, 2015 Please read the following grant instructions and requirements carefully. Applications that do not adhere to all instructions and requirements will be ineligible. You must submit your application through the online survey tool by clicking on the following link: <https://ncruralhealth.az1.qualtrics.com/jfe/form/SV_0UqiRFt9XONOKLb> **Application Deadline:** Applications for all funding types vary, please see **General Information** on page 1. Applicants may apply for multiple funding options within the same application. Applicants should work through their assigned ORH field support staff prior to seeking additional funding and prior to submitting grant applications for multiple funding options. Grant awards are based on the availability of State funding. The maximum total grant award is dependent upon demonstrated need at the rural health center. Grant funds must be used at physical locations where primary medical care is provided and may not be used for vehicles or to pay down loans.**Funding Cycle:** Awards are granted to applicants submitted between July 1, 2018 and March 29, 2019. All grantees must fully expend grant funds prior to June 30, 2019. All invoices for completed and projected work must be submitted to ORH for reimbursement no later than June 7, 2019.**Scoring Criteria**Applications will be reviewed and scored according to the following criteria:

|  |  |
| --- | --- |
| Grant Narrative: Overview of the Organization | 10 Points |
| Grant Narrative: Community Need, Project Description, and Improved Access to Care | 40 Points |
| Grant Narrative: Project Evaluation and Return on Investment | 40 Points |
| Budget | 10 Points |
| **Total Points Awarded** | **100 Points** |

 |
| **Application** | See documents below |

SFY 2018 - 2019 Rural Health Centers Program

**ORGANIZATIONAL INFORMATION & SIGNATURE SHEET**

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

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

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

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

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

Organization Type (check one)

🞎 Rural Health Clinic (95-210) 🞎 State-Designated Rural Health Center

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

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

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

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

**Summary of Request** – *Provide a brief one or two sentence description of your request*.

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

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

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

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

Grant Application Submitted By:

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

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

SFY 2018 - 2019 Rural Health Centers Program

**Organizational Profile**

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

Total FTEs (full time equivalent) of Staff Employed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (please refer to Appendix A for instructions on calculating number of FTEs)

**Clinical Staff Profile**

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

**Patient Mix**

Patient Insurance Status in your Organization:Enter the number of unduplicated patients, by category, who are projected to be served during the project period.  Enter an estimated baseline value as of July 1, 2018, in Column A; an estimated target for the total number of patients who will be served by June 30, 2019 in Column B; and the projected net additional patients seen in Column C for each insurance status.

|  |  |  |  |
| --- | --- | --- | --- |
| Insurance Type | Projected Baseline as of 07/01/2018 (Column A) | Projected Total Served as of 06/30/2019 (Column B) | Projected Net Additional Patients (Projected Total minus Projected Baseline) (Column C) |
| None/Uninsured Patients (include MAP) |  |  |  |
| Medicaid  |  |  |  |
| Children’s Health Insurance Program (CHIP) |  |  |  |
| Medicare (including duals) |  |  |  |
| Other public insurance (e.g. Tricare) |  |  |  |
| Privately Insurance (e.g. BCBS) |  |  |  |
| Total Unduplicated Patients (sum of groups above) |  |  |  |

**Patient Race/Ethnicity**

Patient Race/Ethnicity: Enter the number of unduplicated patients served within the past 12 months, by race/ethnicity. If you have data based on the calendar year (January -December 2017) it can be entered below.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Hispanic/Latino | Non-Hispanic/Latino | Unreported/Refused to Report Ethnicity | Total |
| Asian |  |  |  |  |
| Native Hawaiian  |  |  |  |  |
| Black/African American |  |  |  |  |
| American Indian/Alaska Native |  |  |  |  |
| White |  |  |  |  |
| More than one race |  |  |  |  |
| Unreported/Refuse to report race |  |  |  |  |

FY 2018 - 2019 Rural Health Centers Program Grant Application

**Summary of Evaluation Criteria & Baseline Data**

**SECTION I: Patient Insurance Status:** Enter the number of unduplicated patients by category, who will be served by the proposed project or during the project period. Enter a baseline value as of July 1, 2018 in Column A; a target for the total number of patients who will be served by June 30, 2019 in Column B; and the net additional patients seen in Column C for each insurance status.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Column ABaselineas of07/01/2018 | Column BTotal Servedas of06/30/2019 | Column CNet Additional PatientsCol B minus Col A |
| None/Uninsured Patients (include MAP) |  |  |  |
| Medicaid  |  |  |  |
| Children’s Health Insurance Program (CHIP) |  |  |  |
| Medicare (including duals) |  |  |  |
| Other public insurance (e.g. Tricare) |  |  |  |
| Privately Insurance (e.g. BCBS) |  |  |  |
| 7.Total Unduplicated Patients (sum of Lines 1-6) |  |  |  |

**Section II: Evaluation Criteria**

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

*For each measure, you will need to include the following information:*

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

**Evaluation Criteria**

|  |  |  |
| --- | --- | --- |
| **Evaluation Criteria Primary and Preventive Care** | **Baseline Values/Measures as of 07/01/2018** | **Target to Be Reached****by 06/30/2019** |
| *Example:* *Increase uninsured patient visits from 300 to 348 encounters per month by adding one evening clinic per week.* | *300 encounters per month* | *348 encounters per month* |
| **REQUIRED:** Output MeasureNumber of face-to-face MAP encounters **Data Source**: **Collection Process and Calculation:****Collection Frequency:** MONTHLY**Data Limitations**: |  |  |
| **REQUIRED:** Input MeasureNumber of Full Time Equivalent (FTEs) supported by this grant **Data Source**: **Collection Process and Calculation:****Collection Frequency:** ANNUALLY**Data Limitations**: |  |  |
| **REQUIRED:** Output MeasureNumber of unduplicated patients served**Data Source:****Collection Process and Calculation:****Collection Frequency**: QUARTERLY**Data Limitations:** |  |  |

|  |  |  |
| --- | --- | --- |
| **REQUIRED:** Output MeasureNumber of face-to-face encounters **Data Source**: **Collection Process and Calculation:****Collection Frequency:** MONTHLY**Data Limitations**: |  |  |
| **REQUIRED:** Quality MeasureLevel of Patient Centered Medical Home certification attained**Data Source:** SurveyMax**Collection Process and Calculation:****Collection Frequency:** QUARTERLY**Date Limitations:** |  |  |

**Controlling High Blood Pressure**

|  |  |  |
| --- | --- | --- |
| Measure | Baseline Value as of **07/01/2018** | Target to be reached by **06/30/2019** |
| Patients 18-85 years old that had a medical visit during the contract period who were diagnosed with essential hypertension any time prior to 1/1/2018 (that is, hypertension was diagnosed six months prior to the end of this reporting period or earlier). (Denominator) |  |  |
| Patient Population Exclusions | Patients with evidence of end-stage renal disease (ESRD), dialysis, or renal transplant before or during the contract period, patients with a diagnosis of pregnancy. |
| Measure Type | Outcome |
| Data Source |  |
| Collection Process and Calculation |  |
| Collection Frequency | Quarterly |
| Data Limitations |  |

|  |  |  |
| --- | --- | --- |
| Measure | Baseline Value as of **07/01/2018** | Target to be reached by **06/30/2019** |
| Patients 18-85 years old who had a diagnosis of hypertension *(who meet the population above)* **AND** whose blood pressure was less than 140/90 mm HG (Numerator)(Note that Adequate Control is defined as systolic blood pressure lower than 140 mm Hg **and** diastolic blood pressure lower than 90 mm Hg.) |  |  |
| Measure Type | Outcome |
| Data Source |  |
| Collection Process and Calculation |  |
| Collection Frequency | Quarterly |
| Data Limitations |  |

**Diabetes: Hemoglobin A1c Poor Control**

|  |  |  |
| --- | --- | --- |
| Measure | Baseline Value as of **07/01/2018** | Target to be reached by **06/30/2019** |
| Patients 18-75 years old with a medical visit during the contract period who have a diagnosis of Type 1 or Type 2 diabetes (Denominator) |  |  |
| Patient Population Exclusions | Patients with Gestational diabetes, steriod-induced diabetes, diagnosis of secondary diabetes due to another condition.  |
| Measure Type | Outcome |
| Data Source |  |
| Collection Process and Calculation |  |
| Collection Frequency | Quarterly |
| Data Limitations |  |

|  |  |  |
| --- | --- | --- |
| Measure | Baseline Value as of **07/01/2018** | Target to be reached by **06/30/2019** |
| Patients 18-75 with a diagnosis of Type 1 and Type 2 diabetes *(who meet the population above)* who met one of the following criterial* thier most recent hemoglobin A1c level is greater than 9.0 percent **OR**
* they had no test conducted during the contract period

OR* their test result is missing (Numerator)
 |  |  |
| Measure Type | Outcome |
| Data Source |  |
| Collection Process and Calculation |  |
| Collection Frequency | Quarterly |
| Data Limitations |  |

**Body Mass Index Screening and Follow – Up**

|  |  |  |
| --- | --- | --- |
| Measure | Baseline Value as of **07/01/2018** | Target to be reached by **06/30/2019** |
| Patients who are 18 years of age or older with a medical visit during the contract period (Denominator) |  |  |
| Exclusions | Patients who are pregnant, visits where the patient is receiving palliative care, refuses measurement of height and/or weight, is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient’s health status, or there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate. |
| Measure Type | Quality / Process |
| Data Source |  |
| Collection Process and Calculation |  |
| Collection Frequency | Quarterly |
| Data Limitations |  |

|  |  |  |
| --- | --- | --- |
| Measure | Baseline Value as of **07/01/2018** | Target to be reached by **06/30/2019** |
| Patients *(who meet the population above*) with a documented BMI (not just height and weight) during their most recent visit or during the previous six months of the most recent visit, **AND** meet one of the following criteria:* when the BMI is outside of normal parameters, a follow-up plan is documented during the visit or during the previous six months of the current visit

**OR** * the documented BMI is within normal parameters

 (Numerator) |  |  |
| Normal Parameters | Age 18-64 years and BMI was greater than or equal to 18.5 and less than 25Age 65 years and older and BMI was greater than or equal to 23 and less than 30 |
| Measure Type | Quality / Process |
| Data Source |  |
| Collection Process and Calculation |  |
| Collection Frequency | Quarterly |
| Data Limitations |  |

**Tobacco Use and Screening**

|  |  |  |
| --- | --- | --- |
| Measure | Baseline Value as of **07/01/2018** | Target to be reached by **06/30/2019** |
| All patients aged 18 years and older seen for at least two visits **or** at least one preventive visit during the contract period(Denominator) |  |  |
| Measure Type | Quality / Process |
| Data Source |  |
| Collection Process and Calculation |  |
| Collection Frequency | Quarterly |
| Data Limitations |  |

|  |  |  |
| --- | --- | --- |
| Measure | Baseline Value as of **0701/2018** | Target to be reached by **06/30/2019** |
| Patients *(who meet the population above)* who were screened for tobacco at least once in the last two years **AND** meet one of the following criteria:* patient was screened for tobacco use, was identified as a tobacco user and received documented tobacco cessation intervention

**OR** * patient was screened for tobacco and was not a tobacco user

 (Numerator)(Note that this measure is meant to capture patients who are screened for tobacco use and offered cessation intervention if they are a tobacco user. A tobacco user who is screened and *not* offered cessation intervention would not be included.) |  |  |
| Measure Type | Quality / Process |
| Data Source |  |
| Collection Process and Calculation |  |
| Collection Frequency | Quarterly |
| Data Limitations |  |

FY 2018 - 2019 Rural Health Centers Program Grant Application

**Grant Narrative**

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

1. **Provide a brief description of your organization:**

Insert Text Here

1. **What have you achieved in the past year to advance your mission and improve your organization’s capacity?**

Insert Text Here

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

 Yes

 No

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

o 1-10 hours/week

o 11-20 hours/week

o 21-30 hours/week

o 31-40 hours/week

o 41-50 hours/week

o >50 hours/week

**4. Do you provide prenatal care and/or delivery services?**

 Yes

 No

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

o 1-10 hours/week

o 11-20 hours/week

o 21-30 hours/week

o 31-40 hours/week

o 41-50 hours/week

o >50 hours/week

**5. Do you provide dental services?**

 Yes

 No

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

o 1-10 hours/week

o 11-20 hours/week

o 21-30 hours/week

o 31-40 hours/week

o 41-50 hours/week

o >50 hours/week

1. **Do you provide behavioral health services (e.g., mental health or substance abuse)?**

 No

 Yes. Comprehensive services

 Yes. Limited, such as screening, brief intervention and referral into treatment

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

o 1-10 hours/week

o 11-20 hours/week

o 21-30 hours/week

o 31-40 hours/week

o 41-50 hours/week

o >50 hours/week

1. **Do you provide specialty services (e.g., endocrinology, gastroenterology, neurology, and cardiology)?**

 Yes

 No

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

o 1-10 hours/week

o 11-20 hours/week

o 21-30 hours/week

o 31-40 hours/week

o 41-50 hours/week

o >50 hours/week

1. **Do you provide well woman care?**

 Yes

 No

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

o 1-10 hours/week

o 11-20 hours/week

o 21-30 hours/week

o 31-40 hours/week

o 41-50 hours/week

o >50 hours/week

1. **Do you provide primary care for children?**

 Yes

 No

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

o 1-10 hours/week

o 11-20 hours/week

o 21-30 hours/week

o 31-40 hours/week

o 41-50 hours/week

o >50 hours/week

1. **Does your clinic have the capacity to accept new patients?**

 Yes

 No

 If no, is there a waiting list? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. **What is the average length of time for a new patient to be seen by a provider?**
2. **List the health insurers or provider networks for which the provider is considered in-network. For example, BCBS of NC, Inc: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **What is the current staff turnover rate? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
4. **Have you attested to Meaningful Use? If yes, what state? If yes, Medicare or Medicaid? All providers? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
5. **Does your organization have an Electronic Health Record? If so, please provide the name and version. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
6. **Do you have broadband internet access? If yes, do you receive discounted cost through Healthcare Connect? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
7. **Where is your organization in the Patient Centered Medical Home (PCMH) continuum? Is an outside resource assisting with the process? If yes, provide the name of the outside resource (organization and/or individual).**

Insert Text Here

1. **Is your organization currently connected to the NC HealthConnex** (formerly the NC Health information Exchange)? If so, is data being submitted to NC HealthConnex? Does your organization have a need for additional technical assistance regarding NC HealthConnex (ex, report generation options, other potential opportunities for use of HIE data)? If your organization is not currently connected, is the organization actively working with the HIEA to execute a participation agreement?

Insert Text Here

1. **Does your organization have a current or past working relationship with AHEC? If yes, with which AHEC and person does that relationship exist? If your organization is currently working with an AHEC, include or attach the scope of work currently underway or a detailed listing that outlines topic areas addressed. The list or scope of work should include status updates and timelines for completion/implementation of the work for each topic area.**

Insert Text Here

1. **Provide a detailed description of at least one (1) collaborative partnership in which your organization is currently involved. If your organization does not currently participate in a collaborative partnership, provide a detailed description of at least one (1) organization, including that organization’s name and type, that your organization could pursue such a partnership. What does it look like? What would your organization like to accomplish with this partnership?**

Insert Text Here

1. **Please list *all* NPI numbers associated with your organization including each provider. Please list provider’s NPI by name and type (MD, DO, PA, NP, CNM, etc.).**

Insert Text Here

1. **Does your practice use a Social Determinants of Health Screening Tool?**

🞎 Yes

🞎 No

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

* 1. Health Leads USA recommended screening tool    <https://healthleadsusa.org/wp-content/uploads/2016/07/Health-Leads-Screening-Toolkit-July-2016.pdf>
	2. PRAPARE (Protocol for responding to and assessing patient’s assets, risks and experiences)  <http://www.nachc.org/research-and-data/prapare/>
	3. THRIVE (Tool for Health and Resilience in Vulnerable Environments)  <https://www.preventioninstitute.org/tools/thrive-tool-health-resilience-vulnerable-environments>
	4. Hunger VitalSign <http://academicdepartments.musc.edu/ohp/SFSP/FINAL-Hunger-Vital-Sign-2-pager1.pdf>
	5. IHELLP (Income, Housing, Education, Legal Status, Literacy, and Personal Safety) <https://www.aap.org/en-us/Documents/IHELLPPocketCard.pdf>
	6. WE-CARE Survey (Well-child care visit, Evaluation, Community resources, Advocacy, Referral, Education) <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Pages/Screening-Tools.aspx>
	7. iScreen Social Screening Questionnaire  <http://pediatrics.aappublications.org/content/pediatrics/suppl/2014/10/29/peds.2014-1439.DCSupplemental/peds.2014-1439SupplementaryData.pdf>  <http://pediatrics.aappublications.org/content/134/6/e1611>

Other, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Please include any other pertinent information or additional explanation:**

Insert Text Here

***Community Need, Project Description and Improved Access to Care 40 Points***

Describe the population served by your organization and their healthcare needs - include information on the incidence of poverty in the targeted community and other pertinent demographic data.

Provide a description of your proposed project, specific activities, and how your project will address the community need including Social Determinants of Health (SDOH) challenges.

Describe collaboration efforts with other safety net providers in your community, including but not limited to the local community hospital (Critical Access Hospital (CAH) or otherwise) and/or how this project will improve the coordination of patient care across multiple providers/provider types.

Provide citations/reference sources for all community demographics and health-status data.

Insert Text Here

**Community Need, Project Description, and Improved Access to Care:** Innovation

Insert Text Here

**Community Need, Project Description, and Improved Access to Care:** Planning and Implementation

Insert Text Here

***Project Evaluation and Return on Investment 40 Points***

Describe how you will evaluate *your organization’s* impact on access to care. At least one criterion should evaluate how the proposed project affects the population and/or community need (including anticipated impact on Social Determinants of Health (SDOH)). Discuss potential factors that could negatively affect your organization’s ability to reach your evaluation targets and describe how these factors might be mitigated.

Explain why the proposed funding is a good use of State funds. Detail any anticipated cost savings to either your organization or other health care providers (for example: reduced use of the ER).

Insert Text Here

**Budget 10 Points**

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

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

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

**For MAP Funding (Only):**

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

**Line 36 - “Approximately\_\_\_\_ (enter number) MAP encounters x $100 per encounter = $\_\_\_\_ [TOTAL AMOUNT OF AWARD]”**

This is the only Budget requirement for the MAP program.

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

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