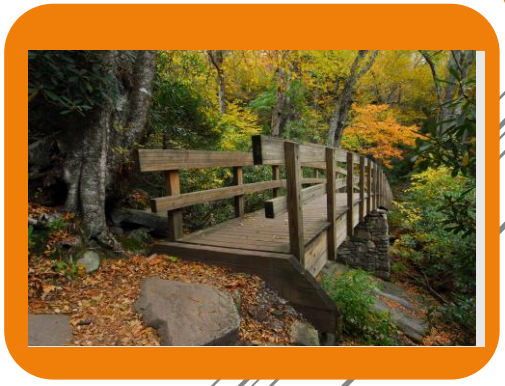
NORTH CAROLINA RURAL HEALTH CENTERS OPERATIONS GUIDANCE

North Carolina Department of Health and Human Services Office of Rural Health



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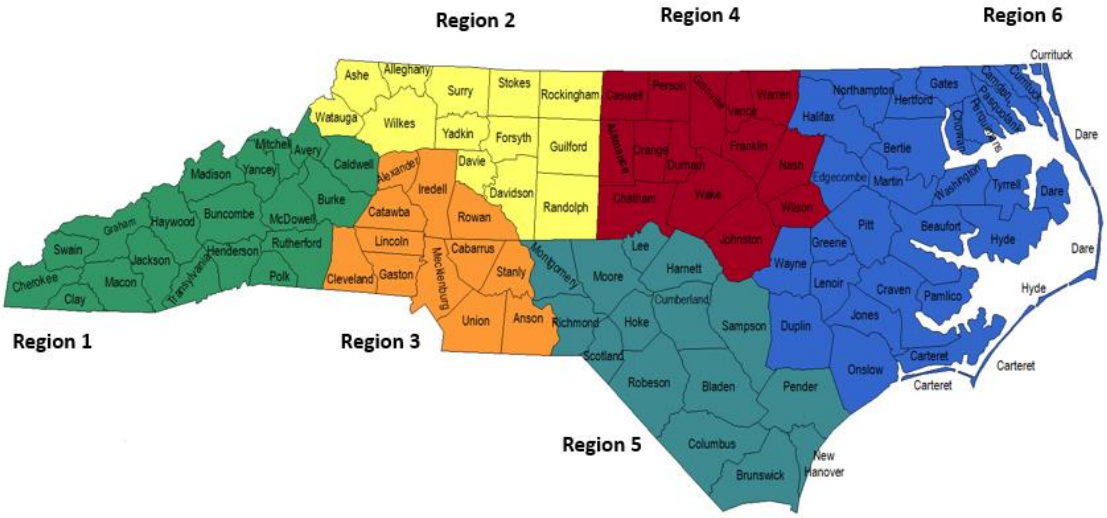
A. PURPOSE

The purpose of this manual is to provide consolidated resources to assist state divisions, community partners, the community at-large, stakeholders, and other entities in understanding the State Designated Rural Health Center Program in North Carolina. Additionally, this manual serves to standardize North Carolina State Designated Rural Health Center services and to describe strategies used by the Office of Rural Health (ORH) to designate new rural health centers, provide additional resources that support effective operations for rural health centers of excellence, and transition currently funded rural health centers when State Designation is no longer needed.



B. INTRODUCTION

Background: Jim Bernstein, the founding director of the Office of Rural Health (ORH), contributed more than 35 years to North Carolina's rural and underserved communities to develop health services for low-income and vulnerable populations. In addition to developing a statewide network of Rural Health Centers, ORH works with the Division of Health Benefits (NC's Medicaid agency) and other agencies within the North Carolina Department of Health and Human Services to develop community-based approaches to improve care and care outcomes for underserved populations. These efforts include statewide and regional efforts to improve primary care, behavioral health, long-term care, and hospital and school health services. ORH has been responsible for program operations, technical assistance, training, data, and reporting for the early development phases in the creation of Community Care of North Carolina (CCNC).[1]

Since its inception, the core belief guiding ORH is "If improvement in [health] care or service is the goal, then those who are responsible for making it happen must have ownership of the improvement process." Distribution of primary care providers in North Carolina has historically been skewed toward cities and larger towns. Rural residents face transportation issues and often find accessing primary care services difficult.

North Carolina is fortunate to have three types of programs aimed at increasing access to primary care for uninsured and underserved residents in rural communities: Federally Qualified Health Centers (FQHCs), Centers for Medicare and Medicaid Certified Rural Health Clinics (CMS RHCs), and State Designated Rural Health Centers (SDRHCs). This manual will focus on SDRHCs; specifically, the process to become one, the annual designation process, and the transition to a different primary care delivery model.

C. North Carolina State Designated Rural Health Center (SDRHC)

ORH assists underserved communities and populations with developing innovative strategies for improving access, quality, and cost-effectiveness of health care. Distribution of primary care providers in North Carolina has historically been skewed toward cities and larger towns. Rural residents, who often face transportation issues, find accessing primary care services difficult. Through the establishment of State Designated Rural Health Centers (SDRHC), ORH partners with local communities to provide funding to serve underserved populations who would otherwise be unable to access needed primary care services due to geographic, economic, or other barriers. Thus, SDRHCs have become an integral part of the health care safety net for North Carolina's rural and underserved residents.

ORH defines an SDRHC as a health care safety net organization that is a 501(c)3 non-profit, community-owned organization with an active board that has as its primary mission to provide primary health care services to those residing in its community. SDRHCs must be located within communities that are both rural and underserved and must currently be delivering primary health care services.

The primary purpose of the state designation is to support new access points and stabilize current access at sites that do not already receive support through the Federally Qualified Health Center (FQHC) or designation.

ORH worked with community stakeholders to discuss the needs of the surrounding area and confirm the community commitment to create an access point for primary care to ensure sustainability and "buy-in." Despite the tremendous growth in the SDRHC program over the past decade and the considerable contribution SDRHCs are making toward alleviating or eliminating access to care problems, rural communities continue to receive underserved designations. For some rural communities, the inability to access the health care delivery system may be due to the lack of health care providers in the area or primary care locations that can serve those without insurance. Historically, rural communities have had difficulty attracting and retaining health professionals. The lack of health professionals in rural communities is disproportionately dependent on Medicare and Medicaid as the principal payors for health services.[2]

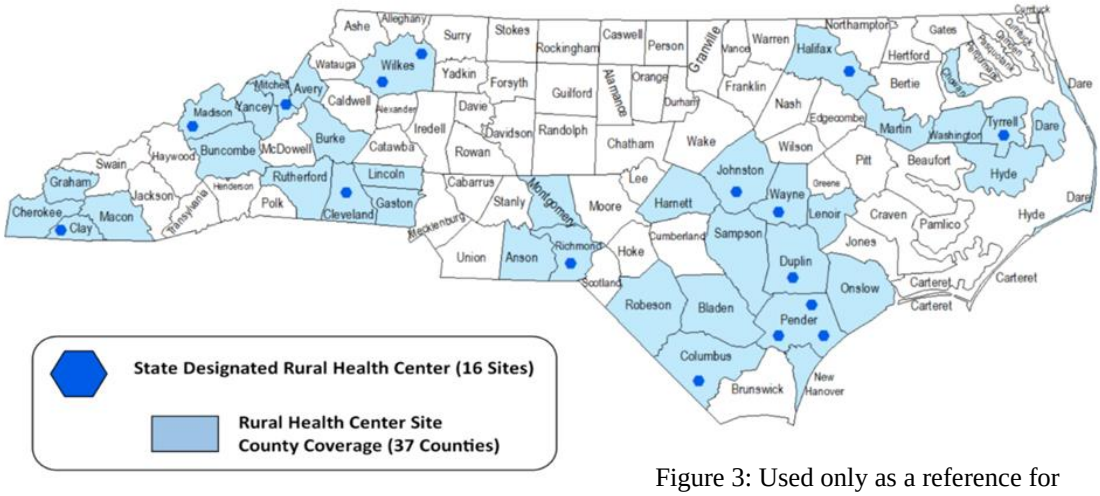


Figure 3: Used only as a reference for locations of NC Rural Health Centers

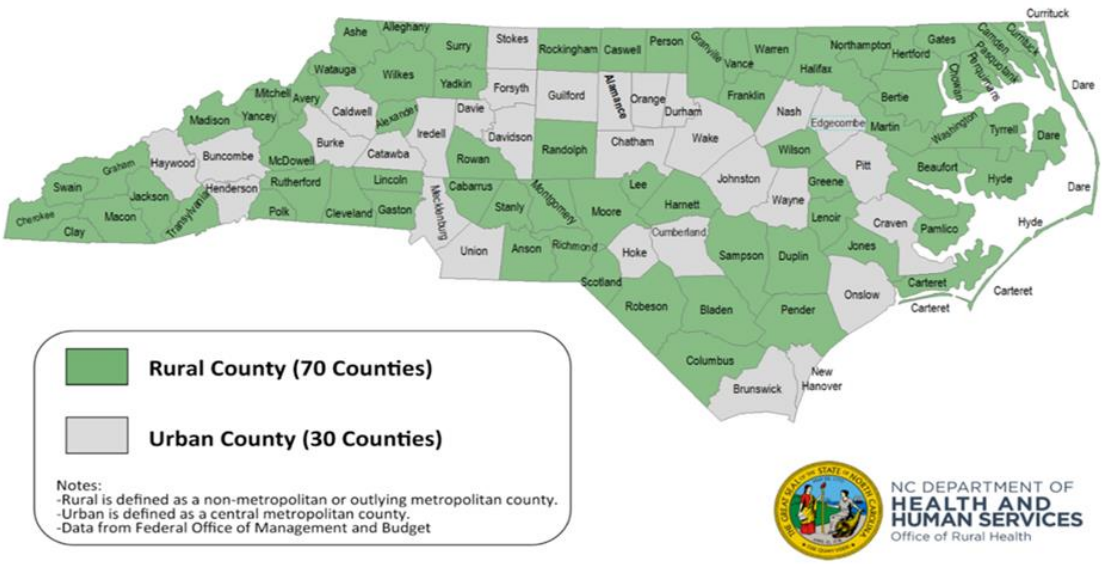
Organization Eligibility

To determine SDRHC eligibility, the applicant organization must first assess whether it meets important criteria. The purpose of the SDRHC program is to increase access to primary care for rural uninsured and underinsured residents. The following factors are considered:

- **A. Rural determination**
- **B. Health Professional Shortage Area determination**
- **C. Demonstrated unmet need.**
- **D. County Distress Ranking – Tier 1 or 2**
- **E. Determination that the organization is not owned, controlled, or operated by another entity and holds an active 501 c3 Status.**
- **F. Provision of primary health care services to all individuals in the defined service area regardless of ability to pay**
- **G. Ability or willingness to enroll eligible providers in Medicare and Medicaid reimbursement programs.**

A. <u>Rural Determination: Defining Rural</u>

ORH uses the criterion in RHIhub to determine whether a specific location/address is considered rural. Applicant may access the "Am I Rural" tool from the Rural Health Information HUB. *Previously funded sited may be grandfathered from rural determination provided there is justification to support continued need in the service area.*



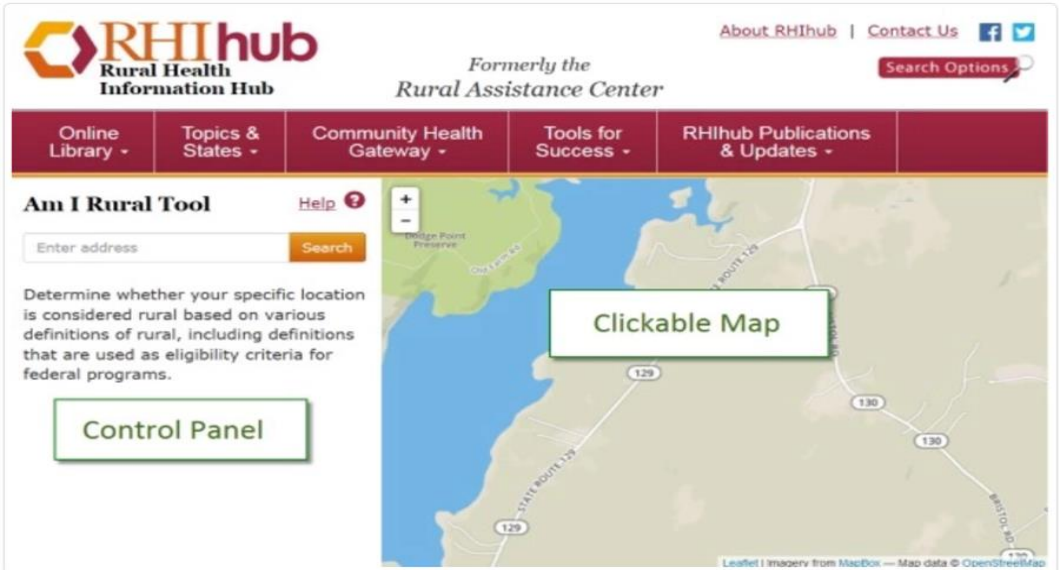


Image 2: RHI Hub

The use of this tool will identify whether the location is eligible for the following:

- Federal Office of Rural Health Policy (FORHP) grant programs
- Health Professional Shortage Areas (HPSAs) rural classification
- Medically Underserved Areas/Populations (MUAs/MUPs) rural classification
- Centers for Medicare & Medicaid Services Rural Health Clinics status

B. Health Professional Shortage Area Determination

SDRHCs are required to be in a rural underserved area. In addition, all facilities are to be in non-urbanized areas as defined by the Bureau of the Census or known as a Health Professional Shortage Area (HPSA)**.** *Previously funded sites can be grandfathered from updated HPSA scores provided there is justification to support continued need in the service area.*
Eligibility consideration will be based on locations with the highest HPSA score in the three disciplines: Primary Care, Dental Care, and Mental Health. Scores will reflect where there is a greater need and where there is a shortage of providers.

What are the ranges in scores?

Primary Care HPSAs can receive a score between 0-25. The score calculations are based on the following:

- Population-to-provider ratio
- Percent of population below 100% Federal Poverty Level (FPL)
- Infant Health Index (based on Infant Mortality Rate (IMR) or Low Birth Weight (LBW)Rate
- Travel time to nearest source of care outside the HPSA designation area.

Mental Health HPSAs can receive a score between 0-25. The score calculations are based on the following:

- Population-to-provider ratio
- Percent of population below 100% Federal Poverty Level (FPL)
- Elderly Ratio (percent of people over age 65)
- Youth Ratio (percent of people under age 18)
- Alcohol Abuse Prevalence
- Substance Abuse Prevalence
- Travel time to nearest source of care outside the HPSA designation area

How to find your HSPA Score:
Organizations can access the HPSA Find link https://data.hrsa.gov/tools/shortage-area/hpsa-find to determine the HSPA score in their area.

Medically Underserved Area and Medically Underserved Population (MUA/P) can receive a score between 0-100. An area or population with and Index of Medical Underservice (IMU) of 62.0 or below qualifies for designation as a MUA/P.

How are scores determined:

The Health Resources Service Administration (HRSA) designates HPSAs. As part of HRSA's cooperative agreement with the State Primary Care Offices (PCOs), the PCOs conduct needs assessment in their states (North Carolina), then determine what areas are

eligible for designations, and submit the designation application to HRSA for review and approval.

HRSA reviews the HPSA applications (*The State PCOs do not submit applications for Auto-HPSAs or Federal Correctional Facilities)* submitted by the State PCOs, and if the applications meet the statutory and regulatory designation eligibility criteria, then HRSA derives a HPSA score.

These shortages may be geographic, population, or facility-based:[9]

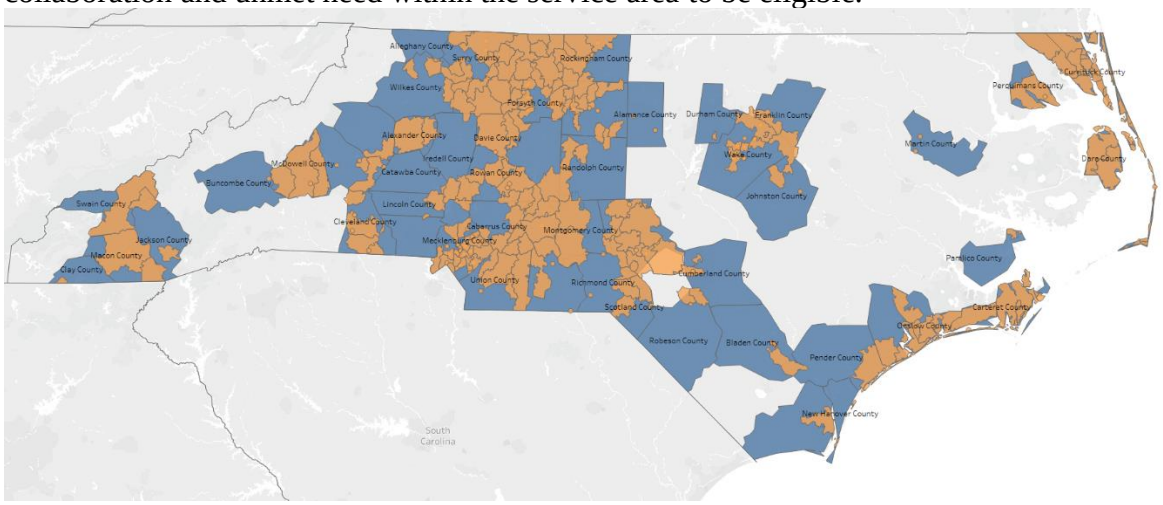
- **Geographic Area**
  - A shortage of providers for the entire population within a defined geographic area.
- **Population Groups**
  - A shortage of providers for a specific population group(s) within a defined geographic area (e.g., low income, migrant farmworkers, and other groups).
- **Facility-based**
  - Public or non-profit private medical facilities serving a population or geographic area designated as a HPSA with a shortage of health providers (Correctional Facility, State/County Mental Hospitals).

C. Demonstrate Unmet Need

ORH focuses on increasing access to primary care services using State appropriations. Organizations that receive Federal funds to support care within its service area are ineligible for this State funded program. Applicant organizations must meet the following criteria to be eligible for funding consideration:

1. Location in a Medically Underserved Area (MUA) that has a shortage of primary care health services for residents within a geographic area. MUAs may include a whole county, a group of neighboring counties, or ZIP codes.
2. If the population to be served already has access to an alternative safety net site within five (5) miles or a penetration level of the low-income population that is 75 percent or greater, the applicant organization must sufficiently document both

collaboration and unmet need within the service area to be eligible.



Graphic represents rural communities with unmet need for health services.

Use the link below to determine whether your service area includes the identified zip codes.
Zip Codes with Unmet Need

D. County Distress Ranking

The North Carolina Department of Commerce annually ranks the state's 100 counties based on economic well-being and assigns each a tier designation ranking from Tier 1 (most distressed) to Tier 3 (least distressed). This tiered system is incorporated into various state programs to encourage economic activity in the less prosperous areas of the state.[12]

Use the link below to determine whether your organization is in one of the County's Tier designations (Tier 1 or Tier 2 designation). Your location must be designated a Tier 1 or Tier 2 for consideration as an SDRHC. *Previously funded sites can be grandfathered from updated county ranking provided there is justification to support continued need in the service area.*

https://www.nccommerce.com/grants-incentives/county-distress-rankings-tiers

E. A non-profit organization not owned, controlled, or operated by another entity.

Independent Rural Health Clinics, and Provider Based Clinics operated by Rural and Critical Access Hospitals are eligible.

The organization is not a subsidiary of another organization. At a minimum, the applicant organization must demonstrate that it maintains a Project Director/Chief Executive

Officer (CEO) who will carry out independent, day-to-day oversight of activities solely on behalf of an active governing board of the 501(c)(3).

A corporation which is exempt from taxation under Section 501(c)(3) of the Internal Revenue Code is called a "charitable or religious corporation" in the North Carolina Nonprofit Corporation Act. Determine whether your organization is established as a tax-exempt organization (nonprofit) under Internal Revenue Code Section 501(c)3.

This term also includes a corporation which is organized exclusively for one or more purposes specified in Section 501(c)(3) and which must distribute its assets upon its dissolution to another "charitable or religious corporation" or to the United States or another state.

Exempt Organization: Section 501(c)(3) is the portion of the US Internal Revenue Code that allows for federal tax exemption of nonprofit organizations, specifically those that are considered public charities, private foundations, or private operating foundations.[13]
https://www.irs.gov/charities-non-profits/charitable-organizations

F. Provide access to primary care healthcare services to all individuals in the defined service area regardless of the ability to pay.

G. Maintain the ability or willingness to enroll eligible providers in Medicare and Medicaid reimbursement programs.

Organizations not currently billing Medicare and Medicaid will be given capacity funding for one year. Continuation of funding and SDRHC status is contingent upon completing the Medicare and Medicaid reimbursement process.

OPERATING FRAMEWORK REQUIREMENTS FOR ENTITIES SEEKING TO BECOME A NEW STATE DESIGNATED RURAL HEALTH CENTER AND FOR CONTINUING SDRHCS:

Application: Complete the North Carolina Office of Rural Health State Designation Application Process. (Attachments) – Include supporting documentation based on the above eligibility requirements.

New Rural Health Center Applicant Eligibility: An organization that meets the above criteria, is not currently funded through ORH, and seeks to cover a service area and target population that is uninsured and underserved is eligible to apply for State designation. The organization must have one or more permanent service delivery sites. The organization may have received funds from other ORH programs but not as a State Designated Rural Health Center (SDRHC). Funding may supplement but not supplant other local, state, or federal funding.

SDRHC Continuing Applicants: Organization must be a current SDRHC in good standing, meet all eligibility criteria, and seek to continue serving its current service area. If the continuing applicant seeks to modify the service site, this modification may affect eligibility and is therefore subject to approval.

All applicants are required to attach an attestation along with their application indicating that their site is currently offering primary care services, has an established board of directors, is actively using an identified EHR system, and is in compliance with the State of North Carolina. Continuing applicants seeking to serve a different service access point or service area must include justification in the application.

Applicants applying for ORH funding opportunities must submit the following supporting documentations as attachments in the application:

- 3 Letters of support from community partners or stakeholders (encouraged to link to one or more proposed activities)
- Copy of Bylaws or documentation of 501c3 status
- Weblink to the most recent county or regional community health needs assessment (CHNA)
- Organizational Chart and description of Quality Improvement Team
- Project Narrative - Narrative Link
- **Budget Template and Narrative (Note: this will be a separate Excel attachment with multiple tabs)** Budget Link
- Attestation agreement
  Attestation Link

Additional Requirements

Step 1: All awarded applicants are required to participate in the North Carolina Area Health Education Center Practice Assessment process with the expectation of completing an action plan. The action plan ensures that specific goals and objectives are met and for a decision that continued funding is in the best interest of ORH. Failure to participate and fulfill the required action plan process may result in termination of award unless the recipient has demonstrated good cause as to why it has not participated in the AHEC Practice Assessment and action planning process. The AHEC Practice Assessment covers: access services, care coordination, optimal use of health information technology, team-based relationships, patient and family engagement, quality improvement, culture/evidence-based care, financial health leadership, and financial health management. Organizations can access the AHEC Practice Assessment Categories.pptx that provides a description of each category.

Step 2: The applicant organization has established an organizational structure and key management team (CEO, CFO, Director, Operational Manager, Health Information

Management, Quality Improvement Coordinator/Specialist etc.) to include oversight and reporting responsibilities.

Step 3: The applicant organization demonstrates that it maintains a staffing plan of having at least one (1) healthcare provider onsite for primary care services (e.g., Medical Doctor (MD) and a Family Nurse Practitioner (FNP).

Step 4: The applicant organization has been delivering primary health care services to patients within the proposed service area for a minimum of six (6) months and must be able to provide the necessary data for target populations: (1) Patient income status, (2) health insurance status, (3) patient demographic characteristics, (4) patient distribution by ZIP codes, (5) patient-related charges (collection and adjustments, patient encounters) (6) encounters for special populations – migratory or seasonal agricultural workers, veterans, homeless population), (7) patient visit criteria (medical visits, labs, behavioral, etc.), (8) staffing utilization (FTE reports, contracted staffing, and/or subcontract staffing).

Step 5: The applicant organization has a current electronic health record (EHR) system or practice management system with the ability to run reports for clinical measures, face-to-face encounters, and unduplicated patients. If the applicant organization does not have a current EHR System or Practice Management System in place, the organization must have a system in place to track health information or run reports to the satisfaction of the ORH Operations Team. The applicant organization has knowledge of and access to (or will have access to) Medicaid's electronic system to file claims.

Step 6: The applicant organization must identify and determine payers' categories for its patient populations.

Step 7: The applicant organization must bill for services and describe how it conducts billing and collections, including policies and procedures for fee reduction, sliding fee scale discount program, waivers and participation in public and private assistance programs and insurance.

Step 8: The applicant organization can describe an emergency preparedness plan for maintaining continuity of services and responding to urgent primary health care needs after hours and during disasters and emergencies.

Step 9: The applicant organization should demonstrate that the medical needs and services align with the most recent Community Health Needs Assessment (CHNA) priorities or developments toward the Community Health Improvement Plan (CHIP) of its service area. The application organization must explain the extent to which its services align with the current plan(s).

Step 10: The applicant organization can describe its current use of telehealth.

Step 11: The applicant organization can demonstrate the ability to participate in NCCARE360, the statewide coordinated care platform to electronically connect those with identified needs to local community resources.

Step 12: The applicant organization must follow all procedures and policies for SDRHCs as noted in the grant, policies and procedures section.

Step 14: The applicant organization has established or demonstrates the ability to establish an agreement to provide referrals for inpatient hospital care, specialized diagnostic labs, interpretation for foreign languages, interpretation for hearing impaired/devices to assist communication with blind patients, and ambulance services. If not currently in place, the applicant organization must have this arrangement in place within six (6) months of operation.

Step 15: The applicant organization has established or demonstrates the ability to establish an organizational strategic plan, or business plan. These documents can be used to communicate an organization's process of defining the organizational goals, actions, goal evaluation, sustainability, and allocation of resources. Examples include: (1) Recruitment and retention strategies for providers and staff, (2) Board member composition and development, (3) Skills and resources needed to achieve goals, (4) Financial health and management, (5) Performance evaluation, (6) Patient satisfaction, (7) Community partners and engagement, (8) Succession planning, and (9) Expansion and renovation.

As a condition of receiving state funds, ORH encourages collaborative partnerships and for SDRHCs to promote a community working environment. NC DHHS is committed to racial equity as part of an overall emphasis on diversity and inclusion that is critical to the sustainability and successful implementation of the agency's mission. 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.

Additional references are outlined in Appendix B section.

PROFILE: FUNDING, POLICIES AND PROCEDURES FOR NC SDRHCS

Funding for active SDRHCs is allocated through a contractual agreement with ORH.

The maximum total grant award is dependent upon demonstrated need and operating structure at each of the SDRHCs and is contingent upon funding availability.

Types of Grant Funding Available to SDRHCs:

Medical Access Plan (MAP)- Grant funds available for primary health care coverage to qualifying individuals. The visits are reimbursable at a rate of $100.00 per encounter to the SDRHC based on medically necessary on-site, face-to-face provider encounters, and may include on-site x-rays, in-house labs, surgical procedures, services performed by practice providers, prophylaxis, and telemedicine.

Behavioral Health Funds – Grant funds available for behavioral health and mental health counseling services for qualifying individuals. These services are integrated into the primary care setting. The visits are reimbursable at a rate of $75.00 per an encounter to the SDRHC based on on-site, face-to-face behavioral health provider encounters. Behavioral health providers include licensed social workers, advanced practice registered nurses, psychologists, and psychiatrists.

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

Funding should assist with one or more of the following operational or infrastructure priorities:

- Propose the creation and implementation of sustainable staff and 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 prevention and response efforts
- Propose an efficient strategy that uses local resources and collaborates with other partners to respond to health care gaps in the community
- Propose a plan to blend behavioral health services fully or partially within the primary care practice

Capital Grant Funds – Capital funding is only available to SDRHCs, not capacity funded organizations. This funding allows for SDRHCs to invest in healthcare infrastructure, including the construction, renovation, and expansion of healthcare facilities. Capital investments may also be made through the purchase and installation of

major equipment and technology. Capital Grant funding does not support staff salaries or other operating/recurring costs. Requests should not duplicate Community Health, Farmworker Health, or Rural Health Center operating projects. Capital Grant funding is requested through a separate application process.

Maintaining State Designated Rural Health Center Status

Policies and Procedures for SDRHCs

As a condition of receiving state funds, the SDRHC agrees to compliance standards of the NC Division of Controllers Office, NC Office of Management and Budget standards, and ORH Operations Program. The requirements are detailed below:

A. Compliance Standards

Completion of all NC DHHS Contract Approval Forms

- Conflict of Interest Acknowledgement and Policy
- Conflict of Interest Verification
- IRS Tax Exemption Verification
- State Certifications
- Proof of Insurance Verification
- Vendor Electronic Payment

B. Contractual Agreement

- Each Contractual Agreement is assigned a contract number. SDRHCs must render services noted in the scope of work and performance measures and within the budget as described in the contract.
- A Contractual Agreement is not considered in effect until all parties have signed the Agreement (electronic signature required). The Agreement must be signed by authorized personnel. Authorized personnel are those persons identified in writing by the SDRHC and ORH as having authority to sign such legally binding agreements.
- The funding cycle is annually from July 1 through June 30. As a grantee, the SDRHC must fully expend grant funds prior to June 30. All invoices for the completed and projected work must be submitted to ORH for reimbursement no later than **June 10 of each grant year.**
- **SDRHC grantees agree to attend required training events including the year-end meeting in conjunction with the Primary Care Annual Conference, Grantee Kick-Off and other compliance meetings as scheduled.**

C. Program Operations

Medical Access Plan (MAP), Monthly Expense Report, Behavioral Health, Operating/Infrastructure, Capacity Funds, and Capital Funds

- Rural Health Centers are required to follow the manual guidance for the Medical Access Plan (MAP) patient eligibility and enrollment process to provide medically necessary on-site face-to face provider encounters: On-site X-rays, In-house labs, Surgical procedures, Services performed by practice provider(s), Prophylaxis, Telemedicine (including telephonic/virtual visits). The reimbursement rate per encounter is $100.00.
- Rural Health Centers that participate in the Behavioral Health Plan (BHP) for behavioral health and mental health counseling services are required to follow the manual guidance for patient eligibility and enrollment process. The visits are through on-site face-to-face with a behavioral health provider licensed social worker, advanced practice registered nurse, psychiatrist, psychologist). The reimbursement rate per an encounter is $75.00.
- ORH Operations Team provides annual trainings in MAP, BH, and MER for new grantees and on an as-needed basis.
- ORH Operations Team provides updates and email correspondence to all grantees and community partners.
- ORH provides template worksheets for each program area (MAP, BH, Operating/Infrastructure Funds) for each rural health center. Centers are expected to complete and submit worksheets monthly to process for reimbursement by the 10th of each month.
- Rural Health Centers that receive Operating/Infrastructure Funds are required to submit a Monthly Expense Report (MER) by the 10th of each month with supporting documentation of expenses.
- The Rural Health Centers worksheets that are submitted to be processed for reimbursement must include signature of a person who is officially designated to sign legal documents on behalf of the rural health center, as well as signature of someone who can attest to the signature.
- Rural Health Centers that are seeking Capital Funds must apply via an online application process for consideration and approval of grant funds for capital projects. Rural Health Centers must also submit a budget template with supporting documentation (2 quotes from vendors). The total grant award is dependent upon documented and demonstrated need at the rural health center and is contingent upon funding availability.

Audits: Desk Review and Site Visit

- The NC Department of Health and Human Services requires that the NC Office of Rural Health (ORH) perform annual contract monitoring desk reviews and/or site reviews for grantees. A contract monitoring desk review and a contract monitoring site review require the same supporting/back-up documentation. Supporting/back-up documentation is

submitted to ORH prior to a desk review while documentation is reviewed on-site during a site review.

- Rural Health Centers will receive an email notification for scheduling either a desk review or site visit by the contract monitor assigned to their grant. The ORH checklist will be created for each rural health center grantee that includes requirements for the selected month's information needed to proceed with the rural health center desk review or site visit. For instance, list of MAP patients from site electronic health report or practice management system and the selected monthly expense report with required supporting documentation.
- Each grantee funded through ORH is required to complete and attest to an Internal Control Questionnaire (ICQ). This is a standard process with the Office of State Controller (Audit, Risk, and Compliance Services). This tool is used for processing and monitoring risk assessment of a grantee to determine the frequency in site visits and desk reviews.

Rural Health Center Practice Assessment

In accordance with the mission of the North Carolina Office of Rural Health to support equitable access to health in rural and underserved communities, a partnership was agreed upon with AHEC to provide practice support state-designated rural health centers. The assessment will enable the centers to optimize primary medical care services delivery at their practices based on eight (8) components: (1) Access, (2) Care Coordination, (3) Optimal Use of Health Information Technology, (4) Team Based Relationships, (5) Patient and Family Engagement, (6) Quality Improvement Culture and Evidence-Based Care, (7) Financial Health Leadership, and (8) Financial Health Management.

The practice assessment process is projected to occur annually, however depending on organization's goals and objectives, action plans can be ongoing into the following year.

Clinical Performance Measurement - Quarterly Surveys

The North Carolina Office of Rural Health works collaboratively with the active Rural Health Centers to assist with monitoring and evaluation of their clinic performance measures and supportive programs. In addition to this technical supportive service, ORH's Data team produces reports that inform internal and external partners about progress on the following quality measures: BMI Screening, Tobacco Cessation, Uncontrolled Diabetes and Controlled Hypertension. The nonclinical measures include the following: Uninsured patients, number of MAP and BH patients

served, unduplicated patients by insurance status, and the number of FTE supported these are not reported in the quarterly surveys. The collection of the data is documented in the Program's Performance Measures Database (PPMD). The system serves as a primary repository of data and information to help ORH management and the Operations Team track and review measures, report relevant clinical progress, align next steps for continuing efforts to advance quality improvement and accountability for all programs and administrative fiscal and funding components.

Data reports are requested quarterly. Rural Health Centers set baseline and target values prior to onset of a new fiscal year. Baseline values represent the value reported by each rural health center for the start of the contract period. The target values represent the value to be obtained by the rural health center at the end of the contract period. Each quarter, grantees report actual values represent actual calculated number for each area.

- Quarter One: July 1 through September 30.
- Quarter Two: July 1 through December 31.
- Quarter Three July 1 through March 31.
- Quarter Four: July 1 through June 30.

SDRHCs Baselines measures:

The 2005 IOM report, Quality Through Collaboration: The Future of Rural Health Care, argued that rural healthcare had largely been on the periphery of national healthcare discussions, saying: "In general, the smaller, poorer, and more isolated a rural community is, the more difficult it is to ensure the availability of high-quality health services. Because quality is directly linked to desired health outcomes, and health care payers are increasingly using quality measures as a factor – we require our SDRHC to submit data on the number of patient encounters and clinical quality measure for key chronic disease conditions.

Measures include: (1) Number of face-to-face MAP patient encounters, (2) Number of face-to-face Behavioral Health encounters (3) Number of unduplicated patients serviced (MAP and non-MAP patients), (3) Controlling High Blood Pressure, (4) Hemoglobin A1c Control, (5) Body Mass Index Screening and Follow-Up, and (6) Tobacco Use and Screening.

- **New applicants** can calculate their baseline measures from the suggested approaches listed below.
  - provide projected targets for each of their clinical measures.
  -

- **Continuing** SDRHC will use quarterly survey actuals as the baseline value from Quarter 4 measures from the previous SFY for all measured areas.

MAP/BH and Patients Served Targets:

Below are suggested approaches based on comparative data to assist SDRHCs to determine their target measures.

Suggested Approach(es): SDRHCs can select one or more to use for the target measures.

1. Use the most recent county or regional community health needs assessment review to obtain information for the uninsured/underinsured population identified in the geographic area. SDRHCs will include based on table example

2. Although some organizations differ in size and capacity, the SDRHC can use the total clinical team to patient ratio to project the target measure and include in the table below (Reference County Health Ranking ratios).

3. Use the most recent county health ranking and include the data for the uninsured population for the county and for North Carolina.

4. Continuing SDRHCs can use their quarterly survey actuals and increase the number value by 10% each year for their MAP and unduplicated target numbers.

Example: MAP Actual: 750 Baseline: 700 Target: 775 (increased by 10%)

Unduplicated Actual: 4,500 Baseline 3,500 Target: 4,950

Clinical Target Measures:

Clinical operations policy requires that the clinic have guidelines for the medical management of health problems which include the conditions requiring medical consultation and/or patient referral, it is highly suggested that the management of chronic health problems factor into the plan to measure progress for the clinical measures.

Continuing SDRHCs that did not meet targets: If the SDRHC did not meet its targeted value measures, it is recommended to use the same target values noted in the quarter 4 measures as new projected target numbers. Example: Baseline: 50% Target: 55% Actual: 52% - new projected target will be 55%.

Continuing that met their targets: If the SDRHC met its target value measures, it is recommended for the SDRHC determine new values to reflect an increase or decrease based on the clinical measurement for the new projected target. Example: Baseline: 50% Target: 55% Actual: 55%- new projected target can be 58%, the number should not be the same as your baseline.

Exceeded targets: If the continuing SDRHC exceeded its target value measures, it is recommended for the continuing SDRHC to use the actual quarter 4 measures as its new projected target. Example: Baseline: 50% Target: 55% Actuals: 75%- new projected target will be 75%

The SDRHCs eligibility and baseline target requirements may be revised at the discretion of ORH without Notice.

(Appendix B includes additional information).
Reference ONLY: The State Fiscal Years (SFY) spans July 1 to June 30; Calendar Year (CY) spans January 1 to December 31, and Federal Fiscal Year (FFY) spans October 1 to September 30.

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APPENDIX A

- **North Carolina State Designated Rural Health Center Application**
- **Budget Template**

APPENDIX B – Resources, Tools, Worksheets, and Tips

NORTH CAROLINA OFFICE OF RURAL HEALTH STATE DESIGNATED RURAL HEALTH CENTER SUPPORT

Service Area Teams (SAT)

ORH uniquely formed Regional Service Area Teams (SAT) to expand upon ORH's mission and to align with the North Carolina Department of Health and Human Service strategic plans, priorities, and organizational values (see NC Department of Health and Human Services, Strategic Plan 2019-2021).[24] (https://www.ncdhhs.gov/divisions/human-resources/strategic-goals).

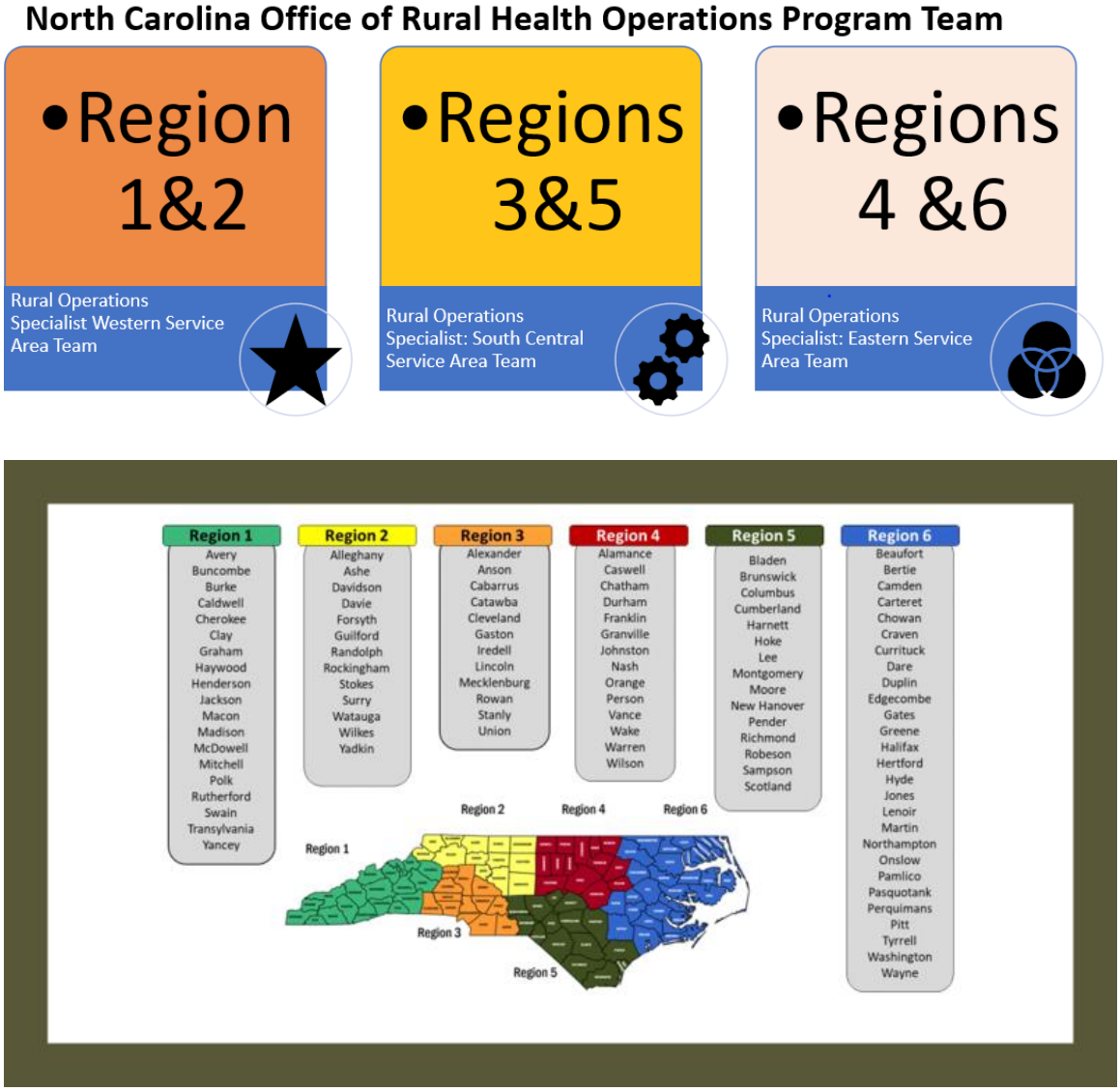
The Service Area Teams are assigned by the North Carolina Medicaid regions (see table on page 32) and work in collaboration with the Operations Team to create internal continuity around services provided around the regions, to assist communities with project implementation, implementation of Healthy Opportunities, to highlight funding resources, and to provide technical assistance. Service Area Teams allow ORH to establish meaningful relationships with rural health centers and other safety net organizations. The SATs provide support to the communities through the following:

Coordination: Teams engage in a significant amount of coordination efforts and meetings for capacity building, to align resources, and support projects and initiatives to address community needs. The team identify opportunities for collaboration between ORH programs. The SAT develop new partnerships based on request by regions or organizations.

Information: Teams provide information such as community and financial impact, data, charts, trends, needs assessments, available programs and services directly related to the county or region and facilitate connections where possible.

Problem Solving: Teams work with other organizations, community groups, and state agencies to develop and implement solutions that create sustainability, empowerment, and community engagement.

The table below represents North Carolina Medicaid list of counties by region.[25]



PROGRAM SERVICES

Technical Assistance is one of the core services offered by the Office of Rural Health. This section describes our program services for rural health centers and other safety net organizations.

1-The Analytics and Innovations (AI) Team at the Office of Rural Health (ORH) strives to assist ORH programs and grantees with using data and leveraging technologies in ways that **help improve monitoring, evaluation efforts, performance measures, economic impact, mapping, other descriptive statistics, and innovative strategies**.

In addition, the AI team:

- Provides technical assistance for communities and Safety Net providers seeking to improve access and quality of care for vulnerable populations through integrated systems of care and innovative and strategic planning.[14]
- Leverages resources and funding through State, federal agencies, and private foundations to support community health initiatives and demonstration projects that benefit the uninsured, Medicaid recipients, and other vulnerable populations.[14]
- Works with federal, state and local entities to identify shortage areas of primary care, dental or behavioral health care providers. These areas are designated as health professional shortage areas (HPSA) according to federal guidelines, making them eligible to qualify for federal funding and services.[14]
- Performance Measures- The Office of Rural Health (ORH) has defined and currently tracks over 50 distinct performance measures to assist in monitoring and evaluation of its programs as well as to enhance its ability to inform partners and

grantees about progress regarding programs and selected services rendered. Measuring performance also assists ORH to determine if goals are met, compare the progress of programs and individual grantees with other state and national averages, reveal areas where improvements are needed, and identify and share successes. ORH grantees report on several process, outcome, and quality measures, some of which include: **Patients Served, FTEs, Diabetes Control, Hypertension Control, Tobacco Screening and Cessation Intervention, Body Mass Index (BMI) Screening and Follow Up, Screening for Clinical Depression and Follow-Up.**[14] Where possible, these performance measure definitions were sourced from National Quality Forum (NQF) endorsed measures and align whenever possible with the Health Resources & Services Administration's (HRSA) UDS measure definitions.

2-Community Health Workers (CHWs) have been recognized for their ability to help individuals and communities find resources to improve their health. The North Carolina Community Health Worker Program has been established at the Office of Rural Health to continue the work of North Carolina Community Health Worker Initiative which began in 2014 through the Division of Public Health. The stakeholders of the initiative created a final report with recommendations to create a sustainable infrastructure for Community Health Workers (CHWs) that includes specific roles, core competencies and standardized training.[15]

The Office of Rural Health continues this effort by working with key stakeholders to implement the recommendations that include: [15]

- Piloting innovative models to contribute to the evidence base and impact on population health in rural and other areas
- Developing protocols within care teams that recognize the contribution of CHWs
- Consulting and training for community-based organizations, healthcare settings and other agencies working with CHWs
- Identifying necessary tools needed for success
- Supporting standardized Core Competency Training
- Supporting the establishment of NC CHW Certification and Accreditation Board
- Supporting and recognizing a NC CHW Network

(Appendix B: Links to additional resources for CHW)

3-The Community Health Program strengthens North Carolina's health care Safety Net infrastructure to ensure that the state's low income and vulnerable residents (Uninsured, Underinsured, Medicare and Medicaid) have access to affordable and appropriate high-quality care.[16]

Purpose:

- Increase access to preventive and primary care services for medically vulnerable patients in primary care locations
- Establish primary care safety net services in counties where no such services exist
- Create new services or augment existing primary care and preventive medical services

- Increase capacity to serve low-income patients by enhancing or replacing facilities, equipment, or technologies

Grantees

The following Safety Net organizations, by statute, are eligible for Community Health Grant Funding:

- Federally Qualified Health Centers (FQHC) and s
- Free and Charitable Clinics
- Public Health Departments that provide Primary Care
- Rural Health Clinics
- School-Based Health Centers

4-The Medication Assistance Program (MAP), through participating health centers, provides access to free prescription drugs for uninsured, low-income individuals. The Office of Rural Health does not provide direct patient services. If individuals cannot afford their prescriptions, individuals can contact a MAP site to find out if they qualify for medication assistance.[17]

5-The North Carolina Farmworker Health Program works to improve the health of migrant and seasonal farmworkers and their families by providing funding, training and technical assistance to a statewide network of outreach and health care providers. The program serves farmworkers because:[18]

- Over 150,000 farmworkers and their family members are estimated to reside in North Carolina.
- Agriculture is a $70-billion-a-year industry in North Carolina and is dependent on a healthy workforce.
- Agriculture is one of the most dangerous occupations in the United States, posing numerous occupational health risks.
- Farmworker populations are traditionally underserved because of barriers to care including transportation, language, cost and isolation.

(Appendix B: Links to additional resources for NC FHP)

6-The Office of Rural Health's (ORH) Rural Hospital Program supports 12 Small Rural Hospitals and 20 Critical Access Hospitals (CAHs).[19]

- A CAH has a special designation from the Centers for Medicare and Medicaid Services. CAHs have 25 beds or fewer and receive cost-based reimbursement.
- Small Rural Hospitals have 49 available beds or fewer.

ORH administers two federal grants on behalf of Small Rural Hospitals and CAHs to improve their viability, quality of services and integration with the rest of the health care system. These grants are the Rural Hospital Flexibility Grant Program (Flex) and the Small Rural Hospital Improvement Grant Program (SHIP).[19]

(Appendix B: Links to additional resources for Rural Hospital Program)

7- Provider Recruitment and Placement Services remains dedicated to the recruitment and retention of primary care providers, dental professionals, and behavioral health providers to the rural and underserved areas of North Carolina. All placement services are provided at no charge. ORH works with federal, state and local entities to identify shortage areas of primary care, dental or behavioral health care providers. These areas are designated as health professional shortage areas (HPSA) according to federal guidelines, making them eligible to qualify for federal funding and services.[20]

(Appendix B: Links to additional resources for Provider Recruitment and Placement Services Program)

8-The Health Information Technology (HIT) Team works directly with the North Carolina Safety Net to assess needs and provide technical assistance throughout the state to improve the use of Electronic Health Records, Telehealth, and the use of NC HealthConnex, the state designated health information exchange.[21]

(Appendix B: Links to additional resources for the HIT Program)

9-The NC Statewide Telepsychiatry Program (NC-STeP) was developed in response to Session Law 2013-360, directing the Office of Rural Health (ORH) to oversee a statewide telepsychiatry initiative. The program was instituted so that an individual presenting at a hospital emergency department with an acute behavioral health crisis will receive a timely specialized psychiatric assessment via video conferencing technology.[22]

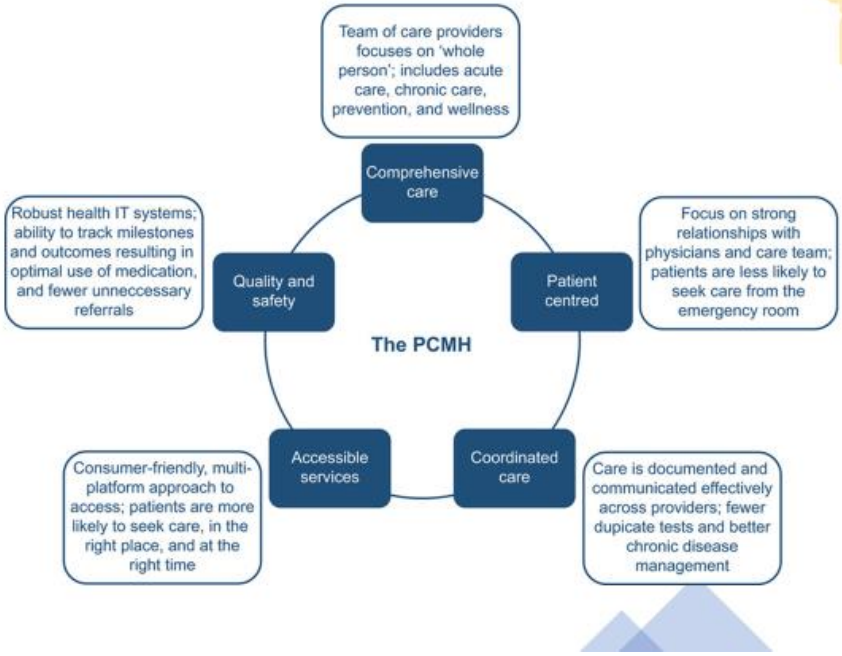
(Appendix B: Links to additional resources for the NC-STeP Program)

SUSTAINABILITY MODELS

In the ever-changing healthcare structure, we realize that the State Designated Rural Health Centers are at different capacity levels with specific needs. This section identifies some proposed examples of sustainability concepts as a guide for the State Designated Rural Health Centers (SDRHCs). There are multiple models and concepts that can apply differently to each of the SDRHCs for competitive advantages and continuous improvement. The Operation Team is tasked to work closely with the SDRHCs and to assist with providing resources and information for sustainable developments.

I. PATIENT CENTERED MEDICAL HOME

IMAGE [26]



The patient-centered medical home (PCMH) is a model of care where patient is engaged in a direct relationship with a chosen provider who coordinates a cooperative team of health care professionals, takes collective responsibility for the comprehensive integrated care provided

to the patient, and advocates and arranges appropriate care with other qualified providers and community resources as needed.[27]

PCMH practices develop transdisciplinary care teams to improve care coordination and care management of patient populations, aiming to improve safety, efficiency and quality in patient care. By becoming a recognized PCMH, practices can improve care delivery and take advantage of private or public incentive payments that reward patient-centered medical homes.[27]

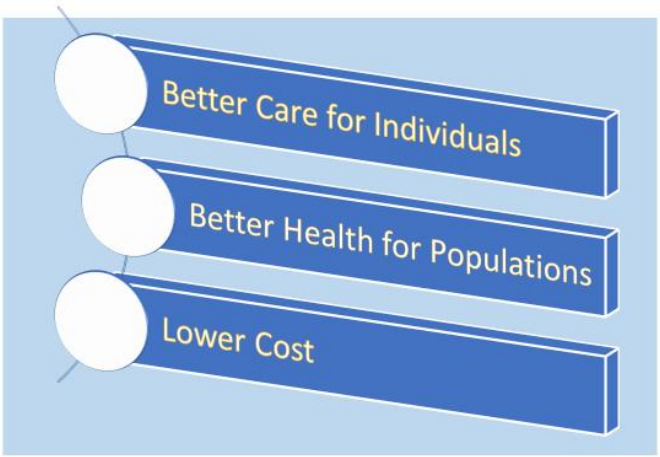
NC Rural Health Centers have an option to partner with the North Carolina Area Health Education Center to support and review the criteria expectations for an organization to achieve PCMH designation.

II. VALUE-BASED MODEL

The Centers of Medicare and Medicaid Services (CMS) launched the Hospital Value-Based Purchasing Program (VBP), this shift towards a value-based care delivery model holds providers accountable for healthcare costs. CMS currently defines value-based care as paying for health care services in a manner that directly links performance on cost, quality, and the patient's experience of care.[32]

What is value-based programs?

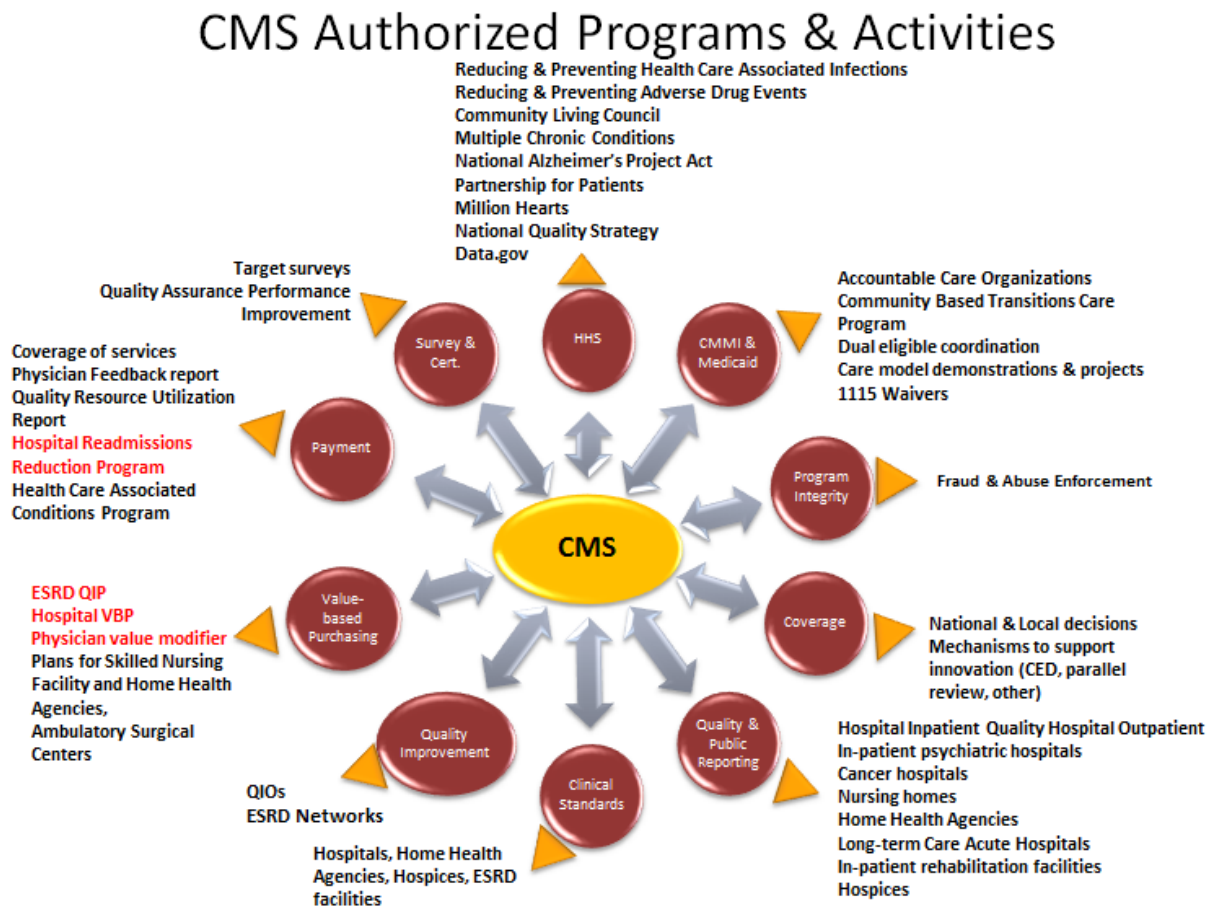
Value-based programs reward health care providers with incentive payments for the quality of care they give to people with Medicare. These programs are part of our larger quality strategy to reform how health care is delivered and paid for. Value-based programs also support our three-part aim:[32]



Why are value-based programs important?

Value-based programs are important because they move toward paying providers based on the quality rather than the quantity of care, they give patients.[32]

How do value-based programs work with other CMS quality efforts?



Image[32]

How can Rural Health Centers use value-based programs?

- Select uniform quality and cost metrics and create a template for manage care plans.
- Use the reports to analyze quantitative and qualitative results for each program and align the services and programs with provider incentives.
- Work in partnership with state, regional and local agencies for person-centered planning.

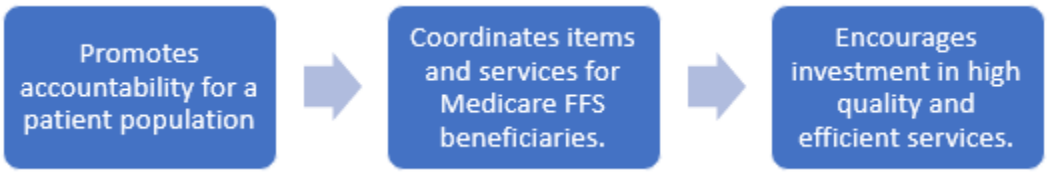
- Use a methodology for tracking claims, services, high risks population, hospital admission and areas for quality improvement with providers. One of the greatest challenges in a value-based system is identifying measurable outcomes to track success (ex: patient hospitalization duration, complications during hospitalization, and events following discharge).

III. ACCOUNTABLE CARE ORGANIZATIONS (ACO)

The Medicare Shared Savings Program:

The Shared Savings Program offers providers and suppliers (e.g., physicians, hospitals, and others involved in patient care) an opportunity to create an Accountable Care Organization (ACO). An ACO agrees to be held accountable for the quality, cost, and experience of care of an assigned Medicare fee-for-service (FFS) beneficiary population. The Shared Savings Program has different tracks that allow ACOs to select an arrangement that makes the most sense for their organization.[33]

The Shared Savings Program is an important innovation for moving CMS's payment system away from volume and toward value and outcomes. It is an alternative payment model that:



What is an accountable care organization?

An ACO is a network of doctors and hospitals that shares financial and medical responsibility for providing coordinated care to patients in hopes of limiting unnecessary spending. The focus is the primary care physician (PCP) and for ACO to work seamlessly there needs to be shared information.[33]

How are ACOs paid?

Providers are rewarded for efficiency and keeping costs down with incentives, such as bonuses. The providers and hospitals must meet specific quality benchmarks focusing on prevention and managing patients' chronic diseases. [33]

If an ACO is unable to save money, it could be accountable for the costs of investments made to improve care, such as adding a new nurse care manager. An ACO also must pay a penalty if it does not meet performance and savings benchmarks. ACOs sponsored by physicians or rural providers can apply to receive payments in advance to help the organization build the infrastructure necessary for coordinated care. [33]

How do ACOs work for patients?

The providers and hospitals will refer patients to hospitals and specialists within the ACO network. Patients still have the option to see other providers of their choice outside the network without paying more. The providers that are part of an ACO are required to inform patients that may use another provider if they are uncomfortable participating. The patient may decline to have their data shared within the ACO. [33]

Next Generation ACO Model

The Next Generation ACO Model is an initiative for ACOs that are experienced in coordinating care for populations of patients. It allows these provider groups to assume higher levels of financial risk and reward than are available under the Shared Savings Program (MSSP). [34]

The goal of this model is to test whether strong financial incentives for ACOs, coupled with tools to support better patient engagement and care management, can improve health outcomes and lower expenditures for Original Medicare fee-for-service (FFS) beneficiaries.

Included in the Next Generation ACO Model are strong patient protections to ensure that patients have access to and receive high-quality care. Like other Medicare ACO initiatives, this model will be evaluated on its ability to deliver better care for individuals, better health for populations, and lower growth in expenditures. This is in accordance with the Department of Health and Human Services' "Better, Smarter, Healthier" approach to improving our nation's health care and setting clear, measurable goals and a timeline to move the Medicare program -- and the health care system at large -- toward paying providers based on the quality rather than the quantity of care they provide to patients.[34]

IV. CONTRACTS WITH THIRD-PARTY PAYERS

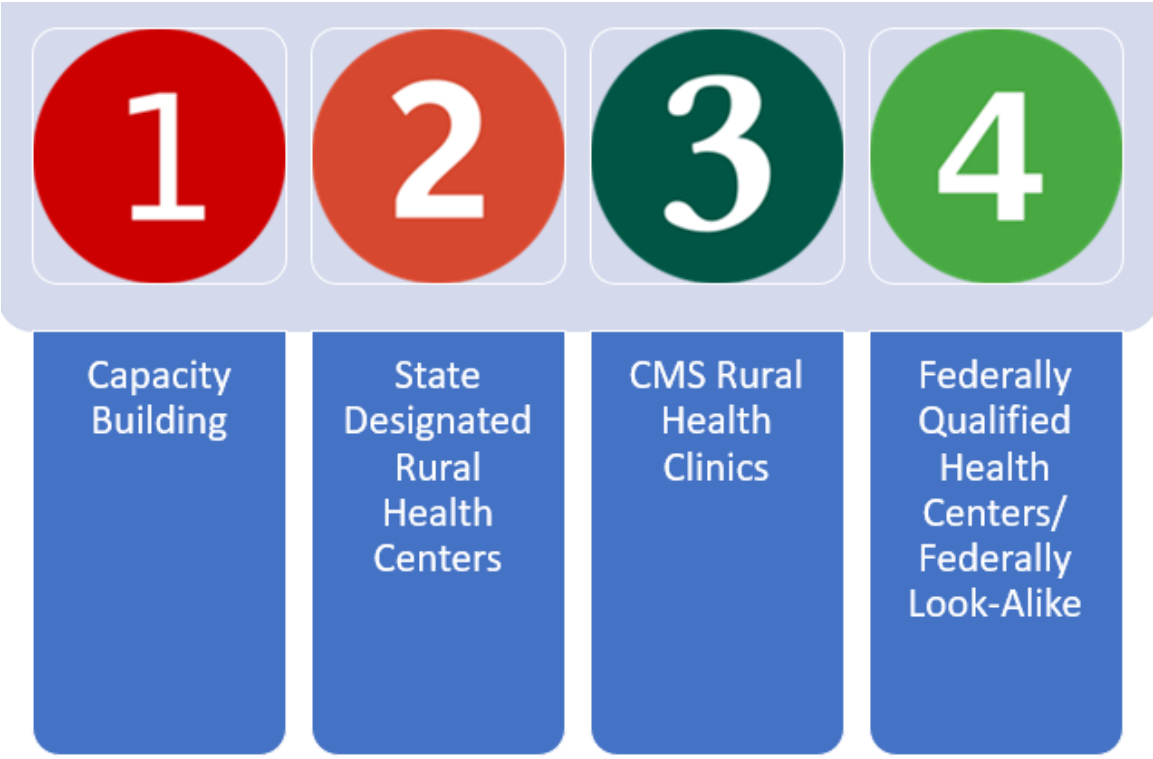
Another financial methodology model that the Rural Health Centers can explore is working with third party payers to negotiate beyond the fee schedule and reimbursable rates.[35]

V. Sustainable Competitive Advantage

The table below is a tool as an example of a sustainable operational process. ORH can work collaboratively with community stakeholders, health care coalitions, and the State-Designated Rural Health Centers to expand their services for a lasting impact in the communities.

The numbers (1,2,3,4) represent the next stage of transitioning toward sustainability.

Listed Below: Capacity Building example to initiate the process starting point from a Community Coalition(s) or a Free and Charitable Clinic. This example can be implemented with other organizations listed below.



Capacity building 1

State Designated Rural Health Clinic (2) transition based on need for an organization starting a rural health clinic.

CMS Rural Health Clinic (3) transition based on serving Medicare beneficiaries in rural areas and increasing the use of nurse practitioners (NPs), physician assistants (PAs), and certified nurse midwives (CNMs). The use of Medicare payment of all-inclusive rate (AIR) for medically necessary face-to-face primary health services and qualified preventive health services.

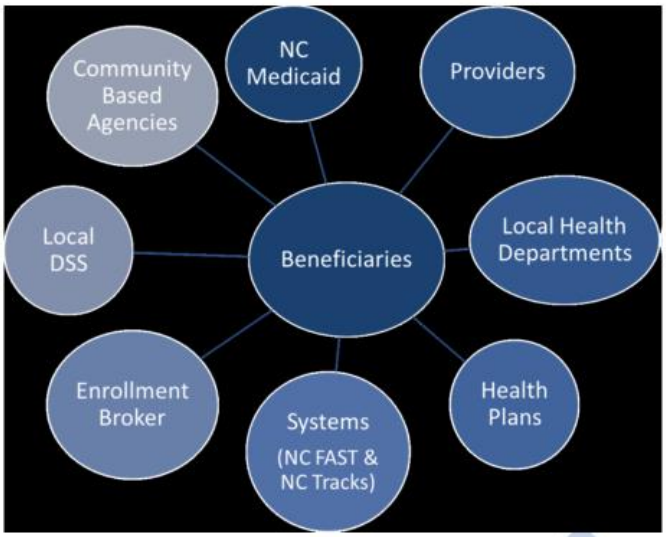
Federally Qualified Health Centers/Federally (4) receives enhanced reimbursement from the Health Resources and Services Administration (HRSA) beyond Medicare and Medicaid benefits.

Note: Additional resources will be included under Appendix B for sustainability tools and resources.

NORTH CAROLINA'S TRANSFORMATION TO MEDICAID MANAGED CARE

In 2015, the North Carolina General Assembly enacted Session Law 2015-245, which directed the Department of Health and Human Services (DHHS) to transition Medicaid and NC Health Choice from fee-for-service to managed care. [28]

The key partners play an important role in the transition. The roles and the responsibilities are as following: (1) Beneficiaries are at the center of process, (2) NC Medicaid provide Medicaid supervision, oversight of health plans and other partners, (3) Health Plans will provide health and related services to their members, (4) Providers will contract with the health plans; must continue to enroll as an NC Medicaid or NC Health Choice provider, (5) Local DSS determine Medicaid eligibility, update beneficiary information, Medicaid case management, (6) NC FAST & NC Tracks, these systems will continue to transmit beneficiary information; NC FAST will remain the system of record, (7) Enrollment Broker, the third party entity to provide enrollment assistance and help choosing a plan; outreach and education to beneficiaries, (8) Local Health Departments continue to provide services under Medicaid Direct; may contract with health plans for some services, (9) Community based-agencies disseminate information to help educate the public on changes to Medicaid; provide feedback to DHHS from clients they serve. [28]



PREPAID HEALTH PLAN CONTRACTS

The Department entered into six contracts for prepaid health plans ("health plans") on Feb. 4, 2019. On Oct. 8, 2019, the Department expanded the regions awarded to Carolina Complete Health, Inc. to include region 4 in addition to the previously awarded regions 3 and 5. Contracts are between the Department and the following health plan providers, with the type of contract indicated: https://medicaid.ncdhhs.gov/transformation/health-plans/health-plan-contacts-and-resources

AmeriHealth Caritas of North Carolina – Statewide Health Plan
Website: www.amerihealthcaritasnc.com

Blue Cross and Blue Shield of North Carolina – Statewide Health Plan
Website: www.healthybluenc.com/north-carolina/home.html

UnitedHealthcare of North Carolina – Statewide Health Plan
Website: www.uhccommunityplan.com/nc/medicaid/medicaid-uhc-community-plan

WellCare of North Carolina – Statewide Health Plan
Website: www.wellcare.com/nc

Carolina Complete Health, Inc. – Regional Contracts – Region 3 Health Plan, Region 4 Health Plan, Region 5 Health Plan
Website: www.carolinacompletehealth.com

NC TRACKS: What is a multi-payer system?

NC Tracks is used by the Division of Health Benefits (DHB); the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS); and the Division of Public Health (DPH).[29]
Providers enrolled in DHB, DMH/DD/SAS and DPH health plans submit claims for payment of covered health care services through the NC Tracks Provider Portal. NC Tracks coordinates processing among the payers to ensure the proper assignment of the payer, benefit plan and pricing methodology for each service on a claim. NC Tracks processes health care claims for about 70,000 enrolled DHHS providers who serve over 1 million North Carolina citizens. [29]
Providers who are contracted by Local Management Entities (LMEs) to enroll and perform state funded DMH/DD/SAS services submit their claims to the LME.[29]

MEDICAID SERVICES

North Carolina Medicaid is a health insurance program for low-income individuals, children, seniors and people with disabilities.[30]

North Carolina Medicaid covers mandatory benefits plus services the state has added for its citizens. Benefits may be different depending on age, income and health care needs. In general, Medicaid may cover the following services: [30]

- Doctors, OB/GYNs, health departments and rural health clinics
- Laboratory and radiology
- Hospitals, anesthesia, and ambulatory surgical centers
- Outpatient specialized therapy
- Prescriptions (except prescriptions for Medicare beneficiaries)
- Vision and hearing
- Dental and orthodontia (for children)
- Podiatry
- Nursing home care
- Personal care and other home health services
- Medical equipment, such as wheelchairs
- Orthotics and prosthetics
- Mental and behavioral health care
- Transition from facilities to home-based and community care
- Most medically necessary services for children under the age of 21
- Medicare premiums, copayments, and deductibles

HEALTH CHOICE SERVICES

The North Carolina Health Choice (NCHC) is a health insurance program for children of families who make too much to qualify for Medicaid, but too little to afford private insurance.[31]

NCHC benefits include:

NCHC does not include[31]

- Long-term care services
- Services for beneficiaries living or traveling outside of the US
- Early and Periodic Screening, Diagnosis and Testing (ESPDT)
- Dental services are restricted according to criteria adopted by Department of Health and Human Services to implement this subsection.

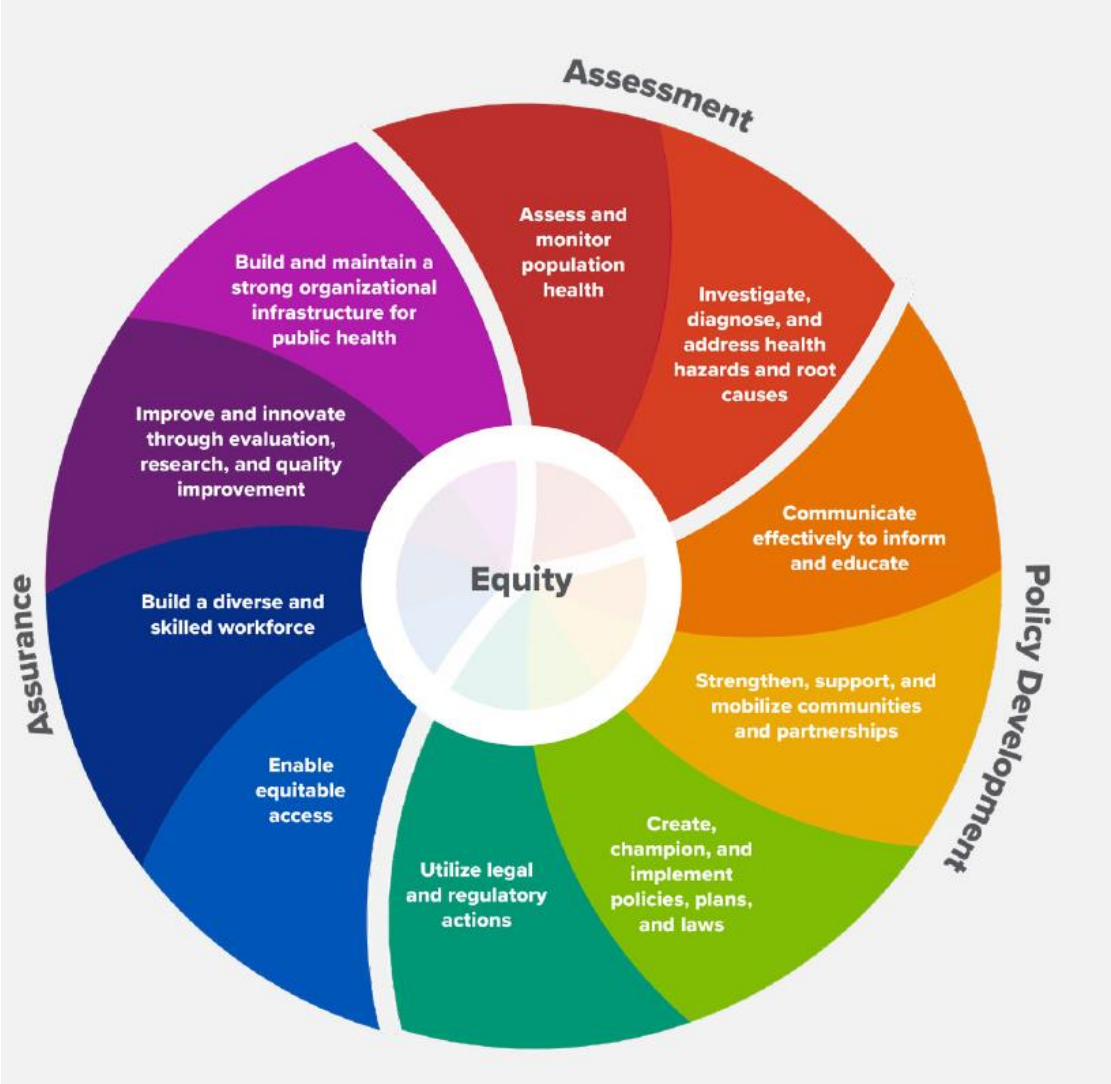
RURAL PRACTICES MOVING TOWARDS CENTERS OF EXCELLENCE MODELING 10 ESSENTIAL PUBLIC HEALTH SERVICES.

The North Carolina Office of Rural Health describes "Rural Centers of Excellence" as organizations that excel in using best practices, research, innovation, partnerships, support, and training to meet the needs in the rural communities. The 10 Essential Public Health Services provide a framework to promote the health of all people in all communities. See tables 1 & 2 below:

Table 1:

ESSENTIAL PUBLIC HEALTH SERVICE #1 Assess and monitor population health status, factors that influence health, and community needs and assets	**ESSENTIAL PUBLIC HEALTH SERVICE #2** Investigate, diagnose, and address health problems and hazards affecting the population
ESSENTIAL PUBLIC HEALTH SERVICE #3 Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it	**ESSENTIAL PUBLIC HEALTH SERVICE #4** Strengthen, support, and mobilize communities and partnerships to improve health
ESSENTIAL PUBLIC HEALTH SERVICE #5 Create, champion, and implement policies, plans, and laws that impact health	**ESSENTIAL PUBLIC HEALTH SERVICE #6** Utilize legal and regulatory actions designed to improve and protect the public's health
ESSENTIAL PUBLIC HEALTH SERVICE #7 Assure an effective system that enables equitable access to the individual services and care needed to be healthy	**ESSENTIAL PUBLIC HEALTH SERVICE #8** Build and support a diverse and skilled public health workforce
ESSENTIAL PUBLIC HEALTH SERVICE #9 Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement	**ESSENTIAL PUBLIC HEALTH SERVICE #10** Build and maintain a strong organizational infrastructure for public health

Table 2:



To achieve optimal health for all, the Essential Public Health Services actively promote policies, systems, and services that enable good health and seek to remove obstacles and systemic and structural barriers, such as poverty, racism, gender discrimination, and other forms of oppression, that have resulted in health inequities.

Source: https://phnci.org/uploads/resource-files/EPHS-Graphic-English.pdf

The website resources section has been established to provide applicants with additional contents that will help applicants submit a competitive application. It includes a wide variety of information such as referencing CMS, HRSA resources, telehealth, listing of professional organizations at the national level, nonprofit resources, board member development, training, and data resources.

Website Resources

American Public Health Association (APHA)

Improve the health of the public and achieve equity in health status.

- https://www.apha.org/about-apha

Board Development Resources

National Council of Nonprofits

- https://www.councilofnonprofits.org/tools-resources-tags/board-development

Board self-assessment tool: Performance of the Board, board composition, structure, and meetings. The culture: leadership culture and dynamics; Board leadership responsibilities (mission, vision, strategic direction, program oversight, financial oversight, executive supervision and oversight, funding and public image); creating a checklist for the practice, organizational demographics, organizational practices, and board practices.

- https://www.compasspoint.org/tools-and-resources/boards-and-governance#GovernanceDocuments

- https://www.nmac.org/wp-content/uploads/2015/04/Board-Development.pdf

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Centers of Medicare and Medicaid Services (CMS)

Listing of Medicare and Medicaid Services Programs, regulations, guidance, outreach education, research, and statistical data.

- https://www.cms.gov/

Medicare Accountable Care Organizations

- https://www.usa.philips.com/healthcare/finance/reimbursement/aco-map

List of Medicare Shared Savings Program in North Carolina

https://data.cms.gov/medicare-shared-savings-program/accountable-care-organizations/data Next Generation Innovative Model dataset

- https://innovation.cms.gov/innovation-models/map#model=next-generation-aco-model

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Community Health Assessment

- https://www.healthycommunities.org/node/186808https://nciom.org/healthy-north-carolina-2030/#:~:text=The%20goal%20of%20the%20Healthy,of%20health%20in%20the%20state.

County Health Rankings and Roadmap

- https://www.countyhealthrankings.org/app/north-carolina/2020/overview

Center for Disease Control and Prevention (CDC)

Community Health Assessments and Health Improvement Plans

- https://www.cdc.gov/publichealthgateway/cha/plan.html
- https://www.phaboard.org/wp-content/uploads/PHAB-Acronyms-and-Glossary-of-Terms-Version-1.02.pdf
- https://www.chausa.org/docs/default-source/community-benefit/2015-cbassesmentguide.pdf?sfvrsn=2 10 Essential Public Health Services - https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html

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Community Health Worker

Website: https://www.ncdhhs.gov/divisions/office-rural-health/community-health-workers

Community Health Workers in North Carolina: Creating an Infrastructure of Sustainability

- **English**
- https://files.nc.gov/ncdhhs/DHHS-CWH-Report_Web%205-21-18.pdf

- **Spanish**
- https://files.nc.gov/ncdhhs/DHHS-CWH-Report_SPANISH_Web.pdf

Rural Health Information Hub – Community Health Worker Toolkit

- https://www.ruralhealthinfo.org/toolkits/community-health-workers

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Community Paramedicine Toolkit

Rural Health Information Hub- Community Paramedicine Toolkit

- https://www.ruralhealthinfo.org/toolkits/community-paramedicine/1/introduction

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North Carolina Community Health Center Association

The North Carolina Community Health Center Association (NCCHCA) was formed in 1978 by the leadership of community health centers, NCCHCA is comprised of membership from 38 health center grantees (including one migrant voucher program) and 2 organizations. NCCHCA is singularly focused on the success of health centers. NCCHCA is the HRSA funded state Primary Care Association (PCA) and Health Center Controlled Network (HCCN). The non-profit, consumer governed Federally Qualified Health Centers (FQHCs) we represent provide integrated medical, dental, pharmacy, behavioral health, and enabling services to over one-half million patients in North Carolina. FQHCs receive federal assistance for sliding-fee discounts to assure no one is denied access to care. NCCHCA represents FQHCs to state and federal officials and provides training and technical assistance on clinical, operational, financial, administrative, and governance issues.

- https://www.ncchca.org/about-us/

North Carolina Association of Local Health Departments

The mission is to promote health, prevent disease, protect the environment in order to ensure the public's health in North Carolina through leadership, vision, advocacy, and commitment to the principles of public health practice in our local communities and throughout the state.

- https://www.ncalhd.org/

National Association of County and City Health Officials

The mission of the National Association of County and City Health Officials (NACCHO) is to improve the health of communities by strengthening and advocating for local health departments. NACCHO is the only organization dedicated to serving every local health department in the nation. NACCO serves 3000 local health departments and is the leader in providing cutting-edge, skill-building, professional resources and programs, seeking health equity, and supporting effective local public health practice and systems.

- https://www.naccho.org/programs

North Carolina Sheps Center

Access to Specialty Care for Medicare Beneficiaries in Rural Communities. University of Minnesota Rural Health Research Center: Policy Brief:5. https://3pea7g1qp8f3t9ooe3z3npx1-wpengine.netdna-ssl.com/wp-content/uploads/2019/12/UMN-Access-to-Specialty-Care_12.4.pdf

- Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill.2014."170 Rural Hospital Closures: January 2005-Present (128 since 2010). Retrieved from https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/
- Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill. (2014). Data. Retrieved from https://www.shepscenter.unc.edu/data/

NC Rural Center

The NC Rural Center's mission is to develop, promote, and implement sound economic strategies to improve the quality of life of rural North Carolinians. We serve the state's 80 rural counties, with a special focus on individuals with low to moderate incomes and communities with limited resources.

- https://www.ncruralcenter.org/

NCCARE 360

NCCARE360 provides the opportunity for health to all North Carolinians by providing public access to resources and helping health and community-based organizations make electronic referrals, communicate in real time, securely share client information, and track outcomes together.

- https://nccare360.org/

Health Information Technology Program

- NC DHHS Telehealth - **https://www.ncdhhs.gov/about/department-initiatives/telehealth**
- **NC Telehealth Playbook - https://www.ncdhhs.gov/media/10611/download**
- Mid-Atlantic Telehealth Resource Center (MATRC) - **https://www.matrc.org/matrc-telehealth-resources-for-covid-19/**
- Broadband Resources - **https://www.ncbroadband.gov/covid19broadband/**
- Community Care of North Carolina - **https://www.communitycarenc.org/newsroom/coronavirus-covid-19-information**
- NC Area Health Education Centers (AHEC) - **https://www.ncahec.net/news/resources-and-courses-on-covid-19/**
- HITEQ Center - **https://hiteqcenter.org/Resources/HITEQ-Resources/telehealth-policy-during-coronavirus-covid-19-pandemic**

Other Resources

- NC Telehealth Network
  NC HealthConnex

Grant Opportunities

- Telehealth Funding Opportunities

What is NC HealthConnex?
NC HealthConnex is the state-designated health information exchange for North Carolina that is managed by the North Carolina Health Information Exchange Authority (NC HIEA). NC HealthConnex compiles patients' health information to build a more comprehensive electronic health record. It also facilitates conversations between authorized health care providers allowing them to access and share health-related information statewide, to improve the coordination of care.

The NC HIEA and North Carolina Area Health Education Centers (NC AHEC) are offering a library of virtual training modules for health care providers on various NC HealthConnex services. As the state-designated health information exchange, NC HealthConnex enables providers to:

- Access patients' comprehensive records to reduce duplicative testing and support more accurate diagnoses and treatment.
- Communicate with other providers using a secure, encrypted messaging service in the NC HealthConnex web portal.

- Improve coordination across all levels of care.

To get started, providers can register for a series of six video trainings, each providing an orientation to the features and services available. Registration for the following modules is required to receive a link to the training.

- Module 1: NC HealthConnex Overview
- Module 2: Unpacking the Welcome Packet
- Module 3: PAA (Participant Account Administrator) Role and Responsibilities
- Module 4: Clinical Portal Overview
- Module 5: Direct Secure Messaging Within the NC HealthConnex Clinical Portal
- Module 6: Patient Education

What Does NC HealthConnex Mean for Behavioral Health?
Many mental health providers do not have access to critical patient information such as labs and allergies and can be isolated from sharing information with other health care providers. This fragmented care can sometimes lead to delays in an accurate diagnosis or a harmful drug interaction. Today, behavioral and mental health providers in North Carolina are not only encouraged to join NC HealthConnex, it is required. See www.nchealthconnex.gov for more information.

North Carolina Farmworker

The program supports increasing the access to primary and preventative health care services for migrant and seasonal farmworkers and their families in North Carolina. The program also supports the development of sustainable services for farmworkers by encouraging local partnerships and collaborations to facilitate the inclusion of farmworkers in services that are available for the general community.

- https://www.ncfhp.org/

Rural Health Hospital/ Critical Access Hospital

The Office of Rural Health's (ORH) Rural Hospital Program supports 12 Small Rural Hospitals and 20 Critical Access Hospitals (CAHs).

- A CAH has a special designation from the Centers for Medicare and Medicaid Services. CAHs have 25 beds or fewer and receive cost-based reimbursement.
- Small Rural Hospitals have 49 available beds or fewer.

ORH administers two federal grants on behalf of Small Rural Hospitals and CAHs to improve their viability, quality of services and integration with the rest of the health care system. These grants are the Rural Hospital Flexibility Grant Program (Flex) and the Small Rural Hospital Improvement Grant Program (SHIP)

- https://www.ncdhhs.gov/divisions/office-rural-health/office-rural-health-programs/north-carolina-rural-hospital-program

The Federal Office of Rural Health Policy (FORHP)

FORHP administers grant programs designed to build health care capacity at both the local and state levels. For states, these grants provide funds to improve quality and stability for rural hospitals, and they support State Offices of Rural Health (SORH) in their efforts to enhance and coordinate rural health initiatives statewide. At the local level, FORHP programs encourage an evidence-based approach to population health that can be replicated from one community to the next, and the development of collaborative networks among rural health care providers to achieve project goals.

- https://www.hrsa.gov/about/organization/bureaus/orhp/index.html

National Rural Health Resource Center. Technical Assistance and Services Center.

The National Rural Health Resource Center provides technical assistance, information, tools and resources for the improvement of rural health care. It serves as a national rural health knowledge center and strives to build state and local capacity. The Center focuses on five core areas:

- Transition to Value and Population Health
- Collaboration and Partnership
- Performance Improvement
- Health Information Technology
- Workforce

- https://www.ruralcenter.org/tasc

National Organization of State Offices of Rural Health (NOSORH)

The National Organization of State Offices of Rural Health (NOSORH) was established in 1995 to assist State Offices of Rural Health (SORH) in their efforts to improve access to, and the quality of, health care for 57 million rural Americans. NOSORH enhances the capacity of SORH to do this by supporting the development of state and community rural

health leaders; creating and facilitating state, regional and national partnerships that foster information sharing and spur rural health-related programs/activities; and enhancing access to quality healthcare services in rural communities. The NOSORH mission is to promote the capacity of State Offices of Rural Health and their stakeholders to improve health in rural America through leadership development, advocacy, education, and partnerships.

- https://nosorh.org/about-nosorh/

National Rural Health Association

The National Rural Health Association has been serving rural communities by advancing and publicizing rural health issues and seeking to solve rural health care challenges. NRHA is the only national organization with a clear mission to:

- Improve the delivery of health services in rural areas through its many members and staff
- Help rural citizens build, maintain, and improve the institutions that can meet their health care needs by providing research, education, leadership, and informational support

- https://www.ruralhealthweb.org/

North Carolina Healthcare Association (NCHA)

NCHA represents North Carolina's individual and multi-hospital health systems — teaching, rural, small community, suburban, specialty, and continuing care facilities — providing, acute care, rehabilitative, behavioral, psychiatric and veterans' services. Our members provide a broad range of services — not just within their walls, but across the continuum and throughout their communities.

- https://www.ncha.org/

North Carolina Statewide Telepsychiatry Program (NC-STeP)

- The most recent annual report to the Joint Legislative Oversight Committee on Health and Human Services please click here.

East Carolina Center for Telepsychiatry and e-Behavioral Health
North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

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Provider Recruitment and Placement

Search for Provider Opportunities in NC

- 3RNet: https://www.3rnet.org/For-Professionals ORH Placement Posting Request Form: https://ncruralhealth.az1.qualtrics.com/jfe/form/SV_4SXftvPt98BCd37
- Practice Incentives: https://www.ncdhhs.gov/providers/provider-info/health-care/recruitment-for-providers
- National Health Service Corps: https://nhsc.hrsa.gov/
- North Carolina Loan Repayment Program (NC LRP):
- NC LRP Guidelines and a digital copy of the Application here: NC LRP Guidelines Link
  Only electronic applications will be accepted. You can apply by using this link: Qualtrics NC LRP Application Link

- High Needs Service Bonds- This incentive has been designed for those with no loans. HNSB offers qualifying providers without educational (student) loan debt taxable service bonuses in exchange for providing comprehensive primary care services in eligible facilities serving those in rural and underserved communities with high needs.
- Please review Guidelines and a digital copy of the HNSB application here: HNSB Guidelines Link
  Only electronic applications will be accepted and you can apply by using this link: Qualtrics HNSB Application Link

State Loan Repayment Program (SLRP)
SLRP focuses on behavioral health providers who provide primary and psychiatric care to people in rural and underserved communities. The Office of Rural Health receives federal funds to administer this program. This program is different from the North Carolina Loan Repayment Program (NC LRP), though the names are similar.
The next SLRP anticipated application cycle will be in 2021. Please review the Guidelines and more information located at the following webpage: Link to SLRP webpage

J-1 Visa Waiver Program
The North Carolina Office of Rural Health is the interested government agency designated to implement the J-1 Visa Waiver provision for foreign medical graduates provided by Section 220 of Public Law 103-416. ORH does not work directly with physician candidates to locate an eligible site. J-1 Visa Waiver applications must come directly from the hiring entity, not the applicant, along with a signed contract.

- The J-1 Visa Waiver program does not offer a financial incentive; however, it does offer an opportunity for foreign medical professionals to provide health care services in rural and underserved areas in North Carolina.

J-1 Visa Waiver Guidelines (Effective Date 7/30/2020)
J-1 Visa Waiver Program Profile

National Interest Waiver (NIW) Program
The national interest waiver is for foreign physicians, who are seeking an exemption from the labor certification process and job offer requirement. The NIW application is to request an attestation letter from ORH.

- The NIW program does not offer a financial incentive; however, it does offer an opportunity for foreign medical professionals to provide health care services in rural and underserved areas in North Carolina.
- We do not provide the contact information to the communities, hospitals, or Health Professional Shortage Areas.

The NIW guidelines and application: National Interest Waiver Guidelines Document Link

Partners of Placement Services

- Area Health Education Center
  North Carolina Community Health Center Association
  North Carolina Academy of Family Physicians
  North Carolina Psychiatric Association

Additional Resources

- North Carolina Foundation for Advanced Health Programs
  National Health Service Corps
  https://wwwapps.ncmedboard.org/Clients/NCBOM/Public/LicenseeInformationSearch.aspxNorth Carolina Medical Board - Licensee Search: https://portal.ncmedboard.org/verification/search.aspx
- North Carolina State Board of Dental Examiners
  DHHS Mental Health, Developmental Disabilities and Substance Abuse Services
  North Carolina Community Health Center Association
  NC Academy of Family Physicians
  North Carolina Academy of Physician Assistants: NCAPA
  Nurse Practioner – North Carolina Board of Nursing - https://www.ncbon.com/
- NC Social Work Certification and Licensure Board: Home NC Social Work Certification and Licensure Board: Home
-

North Carolina Medical Society Community Practitioner Program - https://ncmedsoc.org/healthync/community-practitioner-program/

Patient Center Medical Home

Patient Center Medical Home Initiative - The National Committee for Quality Assurance (NCQA)

- https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/

American College of Physicians (ACP)

What is the Patient-Centered Medical Home?

- https://www.acponline.org/practice-resources/business-resources/payment/delivery-and-payment-models/patient-centered-medical-home/understanding-the-patient-centered-medical-home/what-is-the-patient-centered-medical-home

Agency Health Research and Quality (AHRQ) PCMH Primary Care Practice Facilitation Curriculum

https://www.ahrq.gov/sites/default/files/wysiwyg/ncepcr/tools/PCMH/pcpf-module-25-pcmh-principles.pdfHRSA Accreditation and Patient-Centered Medical Home Recognition Initiative

- https://bphc.hrsa.gov/qualityimprovement/clinicalquality/accreditation-pcmh/index.html

National Resource Center for Patient/Family-Centered Medical Home

- https://medicalhomeinfo.aap.org/Pages/default.aspx

Using Health Literacy Tools to Meet PCMH Standards (Toolkit)

- https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/pcmh-crosswalk.pdf

NCQA Patient-Centered Medical Home (PCMH) Standards and Guidelines. (September 1,2019).

- https://www.wypca.org/wp-content/uploads/PCMH-Recognition_Front-Matter-and-Policies-and-Procedures-Version-5.pdf

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Rural Health Information

- Rural Health Information Hub. "Social Determinants of Health. Retrieved from https://www.ruralhealthinfo.org/toolkits/disabilities/1/social-determinants

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National Coalition of STD Directors. Billing Samples

- http://stdtac.org/

Robert Wood Johnston Foundation County Health Rankings Model

The County Health Rankings are based on a model of community health that emphasizes the many factors that influence how long and how well the population live. The Rankings use more than 30 measures that help communities understand how healthy their residents are today (health outcomes) and what will impact their health in the future (health factors).

- https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model

Institute of Healthcare Improvement

Models, Tools, and Resources

Better care for individual, better health for populations and lower per capita costs

- http://www.ihi.org/about/pages/ihivisionandvalues.aspx

National Councils of Nonprofits

- https://www.councilofnonprofits.org/

North Carolina Center of Nonprofits

- https://www.ncnonprofits.org/

Substance Abuse and Mental Health Services Administration (SAMHSA)

- https://www.samhsa.gov/

National Association for Rural Mental Health (NARMH)

Is a professional organization that serves the field of rural behavioral health.

- https://www.narmh.org/

Community Partnership Development Toolkit

Building strategic partnership, effective outreach strategies, and communication.

- https://publications.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=14333&lid=3
- https://www.chcs.org/media/Partnership-Assessment-Tool-for-Health_-FINAL.pdf
- http://www.aapcho.org/wp/wp-content/uploads/2012/02/Giachello-MakingCommunityPartnershipsWorkToolkit.pdf
- https://publichealth.gwu.edu/sites/default/files/downloads/Redstone-Center/Partner%20Build%20Grow%20Action%20Guide%20Tools.pdf
- https://communityactionpartnership.com/wp-content/uploads/2018/07/Category2_CommunityEngagement_FINAL.pdf

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Health Resources & Services Administration (HRSA)

- https://www.hrsa.gov/

Integrated Health Resources

The integrated health results from a practice team of primary care and behavioral health clinicians and other staff working with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.

https://www.thenationalcouncil.org/integrated-health-coe/resources/

REFERENCE FOR QUALITY MEASURES AND REPORTING DATA

Follows the State Fiscal Year (July to June) for reporting.

Measure Description	Number of FTEs supported
Goal and Objective	1.B: (Goal: 1 - Obj: B) Capacity Building
Measure Type	Input
Reporting Frequency	Annually
Preferred Trend	Maintain
Metric Result	Number
Metric Definition	Number of FTEs supported by Rural Health Center Operational Support Grants. * Baseline FTEs are captured in RFA at start of contract. Actual FTEs are captured via Survey at end of Q4 and verified by the Contracts Team.
Data Source	Report quarterly using survey

Measure Description	**Percentage of RHCs achieving any level Patient Centered Medical Home (PCMH) certification**
Goal and Objective	1.2 - Use data to hold ourselves and our partners accountable for equity.
Measure Type	Quality
Reporting Frequency	Grant application Annually at Q4 (This question is asked on the grant application and again at Q4 to measure progress.)
Preferred Trend	Increase
Metric Result	Percentage
Metric Definition	Denominator: Total number of rural health centers supported. Numerator: Number of rural health centers achieving any level of Patient Centered Medical Home (PCMH) certification
Metric Definition Source	Office of Rural Health (ORH)
Data Source	Office of Rural Health (ORH) direct communication with grantee (Operations Team)

Measure Description	Number of patients served (MAP and non-MAP)
Goal and Objective	1.2 - Use data to hold ourselves and our partners accountable for equity.
Measure Type	Output
Reporting Frequency	Quarterly
Preferred Trend	Maintain or Increase (as indicated in contract)
Metric Result	Number
Metric Definition	Number of unduplicated patients served (MAP and non-MAP). Patients are individuals who have at least one visit during the reporting period. **Exclude Shot Clinics**. (Note that the *baseline* numbers reported reflect the patient population that was seen at the site over the last 12 months.) Number of unduplicated patients served. Patients are individuals who have at least one visit during the reporting period. **Exclude Shot Clinics**. <u>Q4 also requires Patients Served Data to be statified as follows:</u> Number of unduplicated patients served, by age a. age < 18 years old (children) b. age 18 to 64 (adults) c. age 65 and older (older adults) Number of unduplicated patients served, by insurance a. None/Uninsured (include MAP) b. Medicaid c. Children's Health Insurance Program (CHIP) d. Medicare (includes duals) e. Other Public Insurance (e.g. Tricare) f. Private (e.g. BCBS)
Data Source	Grantee reports quarterly using survey (Qualtrics).

Measure Description	Number of MAP and non-MAP patient encounters (report in-clinic and virtial visits separately)
Goal and Objective	1.B: (Goal: 1 - Obj: B) Capacity Building; 1.2 - Use data to hold ourselves and our partners accountable for equity.
Measure Type	Output
Reporting Frequency	Quarterly
Preferred Trend	Maintain
Metric Result	Number
Metric Definition	Number of MAP face-to-face patient encounters. Report in-clinic and virtual visits/telemedicine separately. Number of non-MAP face-to-face patient encounters. Report in-clinic and virtual visits/telemedicine separately.
Metric Guidance	Note: Telemedicine 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. <u>Report virtual visits where</u>: - 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 telemedicine, 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 telemedicine 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. Exclude shot clinics. Note: Clinic Visits and Virtual Visits are mutually exclusive, do not double count.
Data Source	Grantee reports quarterly using survey (Qualtrics).

Measure Description	**Number of Behavioral Health provider face-to-face patient encounters (report in-clinic and virtual visits separately)**
Goal and Objective	1.B: (Goal: 1 - Obj: B) Capacity Building; 1.2 - Use data to hold ourselves and our partners accountable for equity.
Measure Type	Output
Reporting Frequency	Quarterly
Preferred Trend	Maintain
Metric Result	Number
Metric Definition	Total number of behavioral health provider face-to-face patient encounters (report in-clinic and virtual numbers separately). • Number of <u>in-clinic</u> behavioral health provider face-to-face patient encounters. • Number of <u>virtual</u> behavioral health provider face-to-face patient encounters.
Metric Guidance	Note: Telemedicine 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. Behavioral Health Provider examples: psychiatrist, licensed clinical psychologist, licensed clinical social worker, psychiatric nurse practitioner, other licensed or unlicensed mental health providers Behavioral Health Group Visits: A behavioral health provider who provides services to several patients simultaneously receives credit for a visit for each individual only if the service is documented in each patient's health record. Examples of "group visits" include family therapy or counseling sessions, group mental health counseling, and group substance use disorder counseling where several people receive

	services that are documented in each patient's health record. Other considerations: • The health center normally records applicable charges for each patient, even if another grant or contract covers the costs. • If only one patient is billed (for example, when a family member participates in a patient's counseling session), count only the billed individual as a patient and count the visit for only that one patient. • When a behavioral health provider conducts services via telemedicine, the provider can be credited with a visit only if the service is documented in the patient's health record. The session will normally be billed to the patient or a third party. • DO NOT count group medical visits.
Data Source	Grantee reports quarterly using survey (Qualtrics).

Measure Description	**Controlling High Blood Pressure** Percentage of patients 18-85 years old who had a diagnosis of hypertension (HTN) overlapping the reporting period ***and*** whose most recent Blood Pressure (BP) was adequately controlled (less than 140/90 mm Hg) during the reporting period.
Goal and Objective	1.4 - Support local capacity to overcome persistent health inequities.
Measure Type	Outcome
Reporting Frequency	Quarterly (at Q2 and Q4 only)
Preferred Trend	Increase
Metric Result	Percentage
Metric Definition	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 period Exclusions: Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period. Exclude patients whose hospice care overlaps the measurement period. Exclude patients 66 and older who are living long term in an institution for more than 90 days during the measurement period. Exclude patients 66 and older with frailty for any part of the measurement period: advanced illness (with one inpatient visit or two outpatient visits) or taking dementia medications during the measurement period or the year prior. Numerator: Patients whose most recent blood pressure is adequately controlled (systolic blood pressure is less than 140 mmHg and diastolic blood pressure less than 90 mmHg) during the reporting period Grantee's ability to adhere to these UDS exclusions may vary.
Metric Guidance	• Note that this is a "positive" measure. For this measure, the higher the number of patients with controlled hypertension the better the performance on the measure. • Adequate control is defined as systolic Blood Pressure lower than 140 mm Hg **AND** diastolic blood pressure lower than 90 mm Hg. • Include patients who have an active diagnosis of hypertension even if their medical visits during the year were unrelated to the diagnosis.

	• Include blood pressure readings taken at any visit type at the health center as long as the result is from the most recent visit. • Only blood pressure readings performed by a clinician in the provider office are acceptable for numerator compliance with this measure. Blood pressure readings from the patient's home (including readings directly from monitoring devices) are not acceptable. • Patients self-reporting their blood pressure is not acceptable. The provider must be able to visually see the results on the patient's device or the Provider must use a remote monitoring device. • If no blood pressure is recorded during the reporting period, the patient's blood pressure is assumed "not controlled" and isn't counted in the numerator If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading.
Metric Definition Source	HRSA Uniform Data System (UDS) 2022 p. 121-122; CMS eMeasure ID: CMS165v10; National Quality Forum#: eCQI indicates "N/A" (formerly 0018)
Data Source	Grantee reports quarterly using survey (Qualtrics).

Measure Description	**Diabetes: Hemoglobin A1c Poor Control** Percentage of patients 18-75 years of age with diabetes who had hemoglobin HbA1c greater than 9.0% during the reporting period
Goal and Objective	1.4 - Support local capacity to overcome persistent health inequities.
Measure Type	Outcome
Reporting Frequency	Quarterly (at Q2 and Q4 only)
Preferred Trend	Decrease
Metric Result	Percentage
Metric Definition	Denominator: Patients 18-75 years of age with diabetes with a medical visit during the measurement period Exclusions: Exclude patients who were in hospice care for any part of the measurement period. Exclude patients 66 and older who are living long term in an institution for more than 90 days during the measurement period. Exclude patients 66 and older with frailty for any part of the measurement period: advanced illness(with one inpatient visit or two outpatient visits) or taking dementia medications during the measurement period or the year prior. Exclude patients who received palliative care during the measurement period. Numerator: Patients whose most recent HbA1c level performed during the measurement period is greater than 9.0 % and patients who had no test conducted during the measurement period. This service cannot be conducted via telehealth.

	Grantee's ability to adhere to these UDS exclusions may vary.
Guidance	• Note that this is a "negative" measure. For this measure, the lower the number of adult diabetics with poorly controlled diabetes, the better the performance on the measure. • Also note that unlike the Hypertension measure, this measure calls for reporting on patients with diabetes regardless of when they were first diagnosed. • Only include patients with an active diagnosis of Type 1 or Type 2 diabetes. DO NOT include patients with a diagnosis of secondary diabetes due to another condition (such as gestational diabetes) in the denominator. • Include patients in the numerator whose most recent HbA1c level is greater than 9 percent, the most recent HbA1c result is missing, or when no HbA1c tests were performed or documented during the reporting period.
Metric Definition Source	HRSA Uniform Data System (UDS) 2022 p. 123-124; CMS eMeasure ID: CMS122v10; National Quality Forum #: eCQI indicates "N/A" (formerly 0059)
Data Source	Grantee reports quarterly using survey (Qualtrics).

Measure Description	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan** Percentage of patients aged 18 years and older with BMI documented during the most recent visit or within the previous 12 months to that visit and who had a follow-up plan documented if the most recent BMI was outside of normal parameters.
Goal and Objective	1.4 - Support local capacity to overcome persistent health inequities.
Measure Type	Quality (Process)
Reporting Frequency	Quarterly (at Q2 and Q4 only)
Preferred Trend	Increase
Metric Result	Percentage
Metric Definition	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.)

	Exclusions: Patients who are pregnant. Patients receiving palliative or hospice care. Patients who refuse measurement of height and/or weight. Patients with a documented Medical Reason, such as: illness or physical disability, mental illness, dementia, confusion, nutritional deficeney , 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 status Numerator: Patients with a documented BMI (not just height and weight) during their most recent visit ***or*** during the previous 12 months of that visit, **AND** when the BMI is outside of normal parameters*, a follow-up plan is documented during the visit or during the previous 12 months of the current visit. The follow-up plan must be ON or AFTER the most recent documented BMI. * Normal parameters for age 18 and older, BMI between 18.5 and 25 kg/m2. Grantee's ability to adhere to these UDS exclusions may vary.
Guidance	• DO NOT use self-reported height and weight values. • This performance measure cannot be completed in a telehealth visit. The only aspect that is allowable as a telehealth visit is the documented follow-up plan with the patient. Patient's self-reporting their height and weight is not acceptable. • Report this measure for all patients seen during the reporting period. • An eligible professional or their staff is required to measure both height and weight. Both height and weight must be measured within 12 months of the current encounter and may be obtained from separate visits. Do not use self-reported values. • BMI may be documented in the medical record at the health center or in outside medical records obtained by the health center. • If more than one BMI is reported during the measurement period, use the most recent BMI to determine if the performance has been met. • Document the follow-up plan based on the most recent documented BMI outside of normal parameters. • Documentation in the medical record must show the actual BMI or the template normally viewed by a clinician must display BMI. • Do not count as meeting the measurement standard charts or templates that display only height and weight. The fact that a HIT/EHR can calculate BMI does not replace the presence of the BMI itself.

Metric Definition Source	HRSA Uniform Data System (UDS) 2022 p. 96-97; CMS eMeasure ID: CMS69v10; National Quality Forum#: 0421e
Data Source	Grantee reports quarterly using survey (Qualtrics).

Measure Description	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 12 months ***and*** received tobacco cessation intervention *if identified as a tobacco user*
Goal and Objective	1.4 - Support local capacity to overcome persistent health inequities.
Measure Type	Quality (Process)
Reporting Frequency	Quarterly (at Q2 and Q4 only)
Preferred Trend	Increase
Metric Result	Percentage
Metric Definition	Denominator: All patients aged 18 years and older seen for at least two visits in the reporting period OR at least one preventive visit during the reporting period Exclusions: Documentation of medical reason(s) for not screening for tobacco use OR for not providing tobacco cessation intervention for patients identified as tobacco users (e.g., limited life expectancy, other medical reason) Numerator: Patients who were screened for tobacco use at least once within 12 months AND if identified as a tobacco user, received tobacco cessation intervention. INCLUDE in the numerator thos patients with a negative screening AND those patients with a positive screening who had cessation intervention if a tobacco user. Tobacco Cessation services can be utilized through telehealth services.
Guidance	• Include in the numerator patients with a negative screening ***and*** those with a positive screening who had cessation intervention if a tobacco user. • If patients use any type of tobacco (i.e., smokes or uses smokeless tobacco), the expectation is that they should receive tobacco cessation intervention (counseling and/or pharmacotherapy). • Electronic nicotine delivery systems (ENDS), including electronic cigarettes for tobacco cessation, are not currently classified as tobacco. They are not to be evaluated for this measure. • 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. • The medical reason exception applies to the screening data element of the measure or to any of the tobacco cessation intervention data elements. • If a patient has a diagnosis of limited life expectancy, that patient has a valid denominator exception for not being screened for tobacco use or for not receiving tobacco use cessation intervention (counseling and/or pharmacotherapy) if identified as a tobacco user. • Include in the numerator records that demonstrate that the patient had been asked about their use of all forms of tobacco within 12 months before the end of the measurement period. • Include patients who receive tobacco cessation intervention, including: o Received tobacco use cessation counseling services, ***or*** o 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.

Metric Definition Source	HRSA Uniform Data System (UDS) 2022 p.98; CMS eMeasure ID: CMS138v10; National Quality Forum#: 0028e
Data Source	Grantee reports quarterly using survey (Qualtrics).

Measure Description	**Screening for Clinical Depression and Follow-Up Plan** Percentage of patients aged 12 years and older screened for depression on the date of the visit or 14 days prior to the date of the visit using an age-appropriate standardized depression screening tool AND, if screening was positive, had a follow-up plan documented on the date of the visit.
Guidance	• Use the most recent screening results. • The follow-up plan must be related to a positive depression screening. • Documentation of a follow-up plan "on the date of the visit" can refer to any countable visit, NOT only a medical visit. • The depression screening must be completed on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized depression screening tool and must be reviewed and addressed in the office of the provider on the date of the visit. • If the screening result is positive, a follow-up plan must be documented on the date of the visit. A follow-up plan could be additional evaluation, referral, treatment, pharmacological intervention, or other interventions. • Document the screening tool used in the patient health record. Each standardized screening tool provides guidance on whether a particular score is considered positive for depression. • Follow-up for a positive depression screening must include one or more of the following: 1) Additional interventions designed to treat depression, such as behavioral health evaluation, psychotherapy, or additional treatment. 2) Referral to a provider for further evaluation for depression. Or 3) Pharmacological interventions, when appropriate. • DO NOT count patients who are re-screened as meeting the numerator criteria as a follow-up plan to a positive screen. • DO NOT count a PHQ-9 screening that follows a positive PHQ-2 screening during the measurement period as meeting the numerator criteria for a follow-up plan to a positive depression screening. • A suicide risk assessment does not qualify for the numerator as a follow-up plan.

Measure - Denominator	Baseline Value as of **07/01/2023**	Target to be reached by **06/30/2024**

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

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

Data Source	
Collection Process and Calculation	
Data Limitations	