**NCDHHS Notice of Funding Availability Reporting Form**

**NC DHHS Division/Office issuing this notice**: Office of Rural Health

**Date of this notice:** October 20, 2025

**Grant Applications will be accepted beginning October 20, 2025**

**Application Deadline: 5:00PM on December 19, 2025**

**Working title of the funding program:** Community Health Grants

**Purpose: Description of the function of the program and reason why it was created:**

These grant funds, supported through the North Carolina General Assembly, are for assuring access to primary and preventive care to meet the health needs of vulnerable, underserved and medically indigent patients, with emphasis on providing primary and preventative medical services to **uninsured or medically indigent patients**. An important component of this work is to strengthen the safety net through increased levels of collaboration and integration of services to meet and sustain the needs of those served more effectively. When an eligible primary care medical home safety net organization provides integrated care, grant funding may also support dental, pharmacy, maternal, and behavioral health services.

Primary care safety net organizations that currently provide primary and preventive health care for underserved and medically indigent patients in North Carolina are eligible to apply for this funding to pay for patient care through encounter-based reimbursement (Track A) or through reimbursement for eligible expenses (Track B). Telehealth services and equipment are eligible expenses in both tracks. Applicants must select ONE track.

**Track A:** Encounter-based reimbursement. Payment per patient encounter for low-income, uninsured, and underinsured residents, who do not have health care coverage or access to primary health care services. Visits are reimbursable for medically necessary, on-site, face-to-face provider encounters. Face-to-face encounters may also include telehealth patient encounters with a provider. Indirect costs are not eligible.

*NOTE - Per the Free Clinics Federal Tort Claims Act (FTCA) Program Policy Guide, grant funding that applies to reimbursement, payment, or compensation for the delivery of health services to patients falls within the statutory prohibition, while grant funding that is not intended for or applied to this purpose does not. Free clinics who are FTCA recipients that choose a “per encounter’ reimbursement methodology may void their FTCA liability protection.*

**Track B**: Reimbursement for eligible expenses. Payment may include salary/fringe benefits for clinical staff, medical/office supplies and equipment, and capital expenses, including equipment for telehealth services. Indirect costs are not eligible.

*Regardless of track selected, applicant organizations must ensure that Community Health Grant funding does not duplicate or supplant any other funding.*

**Maximum Award Amount:**

Applicants may request up to $150,000 per year of the grant.

**Funding Availability:**

Funding requests are contingent upon availability of program funding. The highest scoring applicants will receive a three-year award based on applicant scores. ORH anticipates that approximately 33 applicants will receive three-year funding. Successful applicants will be required to attend a grant award workshop.

**Proposed Project Period or Contract Term:**

State Fiscal Year 2027: July 1, 2026 – June 30, 2027

**Eligibility:**

All primary care safety net organizations that currently provide direct primary and preventive care and serve as a medical home are eligible to apply. This includes:

* Federally Qualified Health Centers and Look-Alikes (FQHCs),
* Free and Charitable Clinics,
* Health Departments,
* Non-Profit, Hospital-Owned Primary Care Clinics,
* State-Designated Rural Health Centers,
* School-Based and School-Linked Health Centers,
* AHEC Clinics,
* Other Non-Profit Community Organizations that provide direct primary and preventive patient care to low-income, uninsured, underinsured and medically vulnerable populations.

Only one application can be submitted per eligible organization. An eligible organization must submit one application rather than applications by service site, “doing business as” or under separate EINs that are all connected to the same eligible organization.

This application is for eligible organizations wishing to apply for new Year 1 funding. Organizations seeking Year 2 and/or Year 3 continuation funding must follow the ***separate*** Continuation Application process which will open mid-January.

Eligible organizations that currently provide direct primary and preventive care *may use these funds to support any of the following:*

* Health promotion, health maintenance, health counseling,
* Disease prevention,
* Patient education,
* Diagnosis and treatment of acute and chronic illnesses,
* Integrated care services (dental, pharmacy, behavioral health, care coordination/care management by a primary care entity),
* Women’s health, maternal and child health that supports health care services in a primary care setting,
* Collaborative, community-based, whole person-centered health care delivery models,
* Telehealth patient care,
* Care coordination and navigation, including activities related to Medicaid Expansion,
* Community Health Workers.

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

* Complete the contract process.
* Submit a monthly expense report in a specified format for reimbursement.
* Submit performance measures and reports, established by the Office of Rural Health, throughout the grant term.
* Use an electronic financial software application (EXCEL spreadsheets are not an acceptable format)
* Document collaboration among safety net and social support organizations specifying the distinct roles of each organization and the designated fiscal responsibilities.
* Connect or have a plan to connect NC HealthConnex (*To meet the state’s mandate, a provider is “****connected****” when its clinical and demographic information is sent to NC HealthConnex at least twice daily.) For further information, please see the HIEA website*: <https://hiea.nc.gov>)
* Comply with ORH’s policies and procedures for contract development, execution, and management.

Eligible organizations that have a current Community Health Grant award entering Year 2 or Year 3 on July 1, 2026, must have a new project scope or serve a different patient population if submitting an application in response to this Request for Application.

**Deadline for Submission: December 19, 2025**

Grant applications must be received electronically through the Zengine portal. All applications are due by 5:00 PM on December 19, 2025. Only applications submitted in the Zengine portal will be accepted. Incomplete applications, or applications not completed in accordance with the following instructions, will not be reviewed.

**How to Apply:**

Access the Zengine application portal using the link below:

* Use the Zengine portal application link to create a profile to access the application. You must create a profile to access the application. Profile will require creating a username and password. The Zengine portal to submit your application opens on October 20, 2025, and closes at 5:00 PM on December 19, 2025.

**Click link to access electronic version of application**:

<https://webportalapp.com/sp/ncdhhs_orh_community_health_new>

Applications must be complete, and agencies must respond to all application requirements. Incomplete applications, or applications not completed in accordance with the instructions, will not be reviewed.

All applicants will receive a confirmation notice after an application has been successfully submitted.

**For assistance with the Zengine portal contact: Sharema Williams:** **sharema.williams@dhhs.nc.gov**

**Technical Assistance Webinars:**

Webinars for all Community Health Grant applicants will be held on the following dates:

Organizations are invited to participate in one or both webinars.

**November 6, 2025, at 11:00 am**

**Microsoft Teams** [Need help?](https://aka.ms/JoinTeamsMeeting?omkt=en-US)

[**Join the meeting now**](https://teams.microsoft.com/l/meetup-join/19%3Ameeting_NzNmZGQ4OTktMTQ5ZS00ODNmLWEwNDUtOTgzNTY2OGRjYmQy%40thread.v2/0?context=%7b%22Tid%22%3a%227a7681dc-b9d0-449a-85c3-ecc26cd7ed19%22%2c%22Oid%22%3a%22221f56c0-5811-4df1-bcca-9de268774ace%22%7d)

Meeting ID: 250 849 512 560 4

Passcode: o5oK9XG7

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[Find a local number](https://dialin.teams.microsoft.com/c102d528-0544-4660-b869-294e85047e28?id=854209980)

Phone conference ID: 854 209 980#

**Join on a video conferencing device**

Tenant key: ncgov@m.webex.com

Video ID: 113 402 813 9

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**November 17, 2025, at 11:00 am**

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Meeting ID: 266 522 869 350 9

Passcode: uD33FH9D

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+1 984-204-1487,,508852337# United States, Raleigh

[Find a local number](https://dialin.teams.microsoft.com/c102d528-0544-4660-b869-294e85047e28?id=508852337)

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**To obtain further information:** Funding Agency Contact/Inquiry Information:

 **Nicole Fields-Pierre:** **nicole.fields-pierre@dhhs.nc.gov**

**For assistance with the application link:**

**Sharema Williams:** **sharema.williams@dhhs.nc.gov**

|  |  |
| --- | --- |
| **Section** | **Description** |
| **General Information**  | **RFA Title**: **Community Health Grants SFY 2027** **Opening Date: October 20, 2025****Closing Date: December 19, 2025, at 5:00PM**Funding Agency Name: Office of Rural HealthFunding Agency Address: 2009 Mail Service Center, Raleigh, NC, 27606Funding Agency Contact/Inquiry Information: Nicole Fields-Pierre, nicole.fields-pierre@dhhs.nc.gov **Deadline for Application Submission:** Grant applications must be submitted electronically using the on-line application link provided by the Office of Rural Health. All applications are due by 5:00PM on December 20, 2024. Incomplete applications or applications not completed in accordance with the following instructions, will not be reviewed.**How to Apply:** Access the Zengine application portal using the link below:* Use the Zengine portal application link to create a profile to access the application. You must create a profile to access the application. Profile will require creating a username and password. The Zengine portal to submit your application opens on October 20, 2025, and closes at 5:00 PM on December 19, 2025.

**Click link to access electronic version of application**: <https://webportalapp.com/sp/ncdhhs_orh_community_health_new> Applications must be complete, and agencies must respond to all application requirements. Incomplete applications, or applications not completed in accordance with the instructions, will not be reviewed.All applicants will receive a confirmation in the Zengine portal once the application has been successfully submitted.All awarded organizations must follow ORH’s policies and procedures for contract development, execution, and management.**For assistance with the application link contact: Sharema Williams:** **sharema.williams@dhhs.nc.gov****Maximum Award Amount:** Applicants may request up to $150,000 per year of the grant. **Funding Availability:** Funding requests are contingent upon availability of program funding. The highest scoring applicants will receive a three-year award based on applicant scores. ORH anticipates that approximately 33 applicants will receive three-year awards. **Proposed Project Period or Contract Term:** State Fiscal Year 2027: July 1, 2026 – June 30, 2027 |
| **Technical Assistance Webinars** | **Technical Assistance Webinars:** Webinars for all Community Health Grant applicants will be held on the following dates:Organizations are invited to participate in one or both webinars.**November 6, 2025, at 11:00 am** **Microsoft Teams** [Need help?](https://aka.ms/JoinTeamsMeeting?omkt=en-US) [**Join the meeting now**](https://teams.microsoft.com/l/meetup-join/19%3Ameeting_NzNmZGQ4OTktMTQ5ZS00ODNmLWEwNDUtOTgzNTY2OGRjYmQy%40thread.v2/0?context=%7b%22Tid%22%3a%227a7681dc-b9d0-449a-85c3-ecc26cd7ed19%22%2c%22Oid%22%3a%22221f56c0-5811-4df1-bcca-9de268774ace%22%7d) Meeting ID: 250 849 512 560 4 Passcode: o5oK9XG7 **Dial in by phone** +1 984-204-1487,,854209980# United States, Raleigh [Find a local number](https://dialin.teams.microsoft.com/c102d528-0544-4660-b869-294e85047e28?id=854209980) Phone conference ID: 854 209 980# **Join on a video conferencing device** Tenant key: ncgov@m.webex.com Video ID: 113 402 813 9 [More info](https://www.webex.com/msteams?confid=1134028139&tenantkey=ncgov&domain=m.webex.com) **November 17, 2025, at 11:00 am** **Microsoft Teams** [Need help?](https://aka.ms/JoinTeamsMeeting?omkt=en-US) [**Join the meeting now**](https://teams.microsoft.com/l/meetup-join/19%3Ameeting_OTAzYTFhMTEtYjdiOC00N2MzLTg2YWItYTE2YTk1ZDYwNDIz%40thread.v2/0?context=%7b%22Tid%22%3a%227a7681dc-b9d0-449a-85c3-ecc26cd7ed19%22%2c%22Oid%22%3a%22221f56c0-5811-4df1-bcca-9de268774ace%22%7d) Meeting ID: 266 522 869 350 9 Passcode: uD33FH9D **Dial in by phone** +1 984-204-1487,,508852337# United States, Raleigh [Find a local number](https://dialin.teams.microsoft.com/c102d528-0544-4660-b869-294e85047e28?id=508852337) Phone conference ID: 508 852 337# **Join on a video conferencing device** Tenant key: ncgov@m.webex.com Video ID: 118 758 430 8 [More info](https://www.webex.com/msteams?confid=1187584308&tenantkey=ncgov&domain=m.webex.com) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **To obtain further information:** Funding Agency Contact/Inquiry Information:  **Nicole Fields-Pierre:** **nicole.fields-pierre@dhhs.nc.gov****For assistance with the application link:** **Sharema Williams:** **sharema.williams@dhhs.nc.gov** |
| **RFA Description** | The purpose of grants awarded under this program is to assure access to primary and preventive care for vulnerable, underserved and medically indigent patients in the state, with emphasis on providing primary and preventative medical services to **uninsured or medically indigent patients**. Primary care\* is defined as that care provided by physicians specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern. There are providers of health care other than physicians who render some primary care services. Such providers may include nurse practitioners, physician assistants, and some other healthcare providers.  \*American Association of Family Practice: <https://www.aafp.org> Uninsured\* is defined as not having coverage under private health insurance, Medicare, Medicaid, a state-sponsored or other government-sponsored plan or program. \*Center for Disease Control and Prevention: <https://www.cdc.gov> Underinsured\* is defined as having coverage, but because of high premiums or out-of-pocket cost patients are unable to meet their share of costs and may skip necessary care. \*Centers for Medicare & Medicaid Services: <https://www.cms.gov> Encounters\* are defined as documented face-to-face contact between a beneficiary and a provider. \*Centers for Medicare & Medicaid Services: <https://www.cms.gov>Grants will be awarded on a competitive basis to safety net organizations that:1. Provide primary and preventative medical services to uninsured or medically indigent patients **and**
2. Serve as a medical home to these vulnerable populations, in order to accomplish any of the following purposes:
	1. Increase access to primary care and preventative health services for these vulnerable populations in existing primary care locations.
	2. Establish primary care and preventative health services in counties where no such services exist to assist these vulnerable populations.
	3. Create new services, sustain existing service levels, or augment existing services provided to these vulnerable populations, including primary care and preventative health services, dental, pharmacy, and behavioral health services when integrated into the medical home.
	4. Increase primary care capacity to serve these vulnerable populations, including enhancing or replacing facilities, equipment, or technologies necessary to participate in the exchange of data and tools to monitor and improve the quality of care provided.
 |
| **Eligibility** | All primary care safety net organizations that currently provide direct primary and preventive health care and serve as a medical home are eligible to apply. This includes: * Federally Qualified Health Centers and Look-Alikes (FQHCs),
* Free and Charitable Clinics,
* Health Departments,
* Non-Profit, Hospital-Owned Primary Care Clinics,
* State-Designated Rural Health Centers,
* School-Based and School-Linked Health Centers,
* AHEC Clinics,
* Other Non-Profit Community Organizations that provide direct primary and preventive patient care to low-income, uninsured, underinsured and medically vulnerable populations.

Eligibility Criteria **cannot** be satisfied by referral services to another organization that provides the primary and preventative health care services. Eligible organizations that currently provide direct primary and preventive care *may use these funds to support any of the following:* * Health promotion, health maintenance, health counseling,
* Disease prevention,
* Patient education,
* Diagnosis and treatment of acute and chronic illnesses,
* Integrated care services (dental, pharmacy, behavioral health, care coordination/care management by a primary care entity),
* Women’s health, maternal and child health that supports health care services in a primary care setting,
* Collaborative, community-based, whole person-centered health care delivery models,
* Telehealth patient care,
* Care coordination and navigation, including activities related to Medicaid Expansion
* Community Health Workers.

Eligibility: Each provider that receives Medicaid or state funds will be required to connect or have a plan to connect to the N.C. Health Information Exchange Authority (NC HIEA) now called NC HealthConnex to receive state funds. For further information, please see the HIEA website: <https://hiea.nc.gov>). |
| **Maximum Award Amount and Allowable Costs** | **Maximum Award Amount:** Applicants may request up to $150,000 per year of the grant. Primary care safety net organizations that currently provide primary and preventative health care services and serve as a medical home are eligible to apply for this funding to pay for patient care through encounter-based reimbursement (Track A) or through reimbursement for eligible expenses (Track B). Applicants must select ONE track.**Track A:** Encounter-based reimbursement. Payment per patient encounter for low-income, uninsured and underinsured residents, who do not have health care coverage or access to primary health care services. Visits are reimbursable for medically necessary, on-site, face-to-face provider encounters. Face-to-face encounters may also include telehealth patient encounters with a provider.*NOTE - Per the Free Clinics Federal Tort Claims Act (FTCA) Program Policy Guide, grant funding that applies to reimbursement, payment, or compensation for the delivery of health services to patients falls within the statutory prohibition, while grant funding that is not intended for or applied to this purpose does not. Free clinics who are FTCA recipients that choose a “per encounter’ reimbursement methodology may void their FTCA liability protection.***Track B**: Reimbursement for eligible expenses. Payment may include salary/fringe for clinical staff, medical/office supplies and equipment, and capital expenses, including equipment for telehealth services.*Regardless of track selected, applicant organizations must ensure that Community Health Grant funding does not duplicate or supplant any other funding.* Grant recipients **shall not** use these funds to do any of the following: 1. Enhance or increase compensation or other benefits for personnel, administrators, directors, consultants, or any other persons receiving funds for program administration.
2. Supplant existing funds, including federal funds traditionally received by Federally Qualified Community Health Centers. However, grant funds may be used to supplement existing programs that serve the purposes of:
	1. Providing primary and preventative medical services to uninsured or medically indigent patients and,
	2. Serving as a medical home to these vulnerable populations.
3. Finance or satisfy any existing debt.
 |
| **Other Contractor Requirements for Successful Award Recipients** | As a condition of receiving a grant award, successful applicants must: * Complete the contract process.
* Submit a monthly expense report in a specified format for reimbursement.
* Submit performance measures and reports, established by the Office of Rural Health, throughout the grant term.
* Use an electronic financial software application (EXCEL spreadsheets are not an acceptable format)
* Document collaborations among safety net and social support organizations specifying the distinct roles of each organization and the designated fiscal responsibilities.
* Connect or have a plan to connect to NC HealthConnex (*To meet the state’s mandate, a provider is “****connected****” when its clinical and demographic information is being sent to NC HealthConnex at least twice daily.) For further information, please see the HIEA website*: <https://hiea.nc.gov>).
* Comply with the funder’s policies and procedures for contract development, execution, and management.
* Eligible organizations that have a current CHG award entering Year 2 or Year 3 on July 1, 2025, must have a new project scope or serve a different patient population if submitting an application in response to this RFA.
 |

SFY 2027 Community Health Grants

 **ORGANIZATION INFORMATION and SIGNATURE SHEET**

|  |  |
| --- | --- |
| Organization Name: |  |
| Organization EIN: |   |
| Organization NPI (if applicable): |  |
| Organization UEI (if applicable): |  |
| Mailing Address: |  |
|  City |  |
|  State |  |
|  Zip Code |  |
| Payment Remittance Address: |  |
|  City |  |
|  NC |  |
|  Zip Code |  |
| Organization Fiscal (Month/Year) REQUIRED: |  |
| Organization’s Website Address: |  |
| Organization Type: (check **all** that apply) | * Federally Qualified Health Centers and Look-Alikes (FQHCs)
* Free and Charitable Clinics
* Health Departments
* Non-Profit, Hospital-Owned Primary Care Clinics
* Rural Health Centers
 | * School-Based and School-Linked Health Centers
* AHEC Clinics
* Other Non-Profit Community Organizations that provide direct primary and preventive patient care to low-income, uninsured, underinsured and medically vulnerable populations.
 |

|  |  |
| --- | --- |
| Grant Contact Name: |  |
| *Grant Contact serves as the primary grant contact for the duration of the grant year.* |
| Email: |  |
| Phone Number: |  |
| Finance Contact Name:  |  |
| *Finance Contact is the person responsible for completing Monthly Expense Reports.* |
| Email:  |  |
| Phone Number: |  |
| Grant Signatory Name:  |  |
| *Grant Signatory is the person authorized to sign contracts and other documents on behalf of the organization.* |
| Title: |  |
| Email:  |  |
| Phone Number:  |  |
| Witness Name: |  |
| *Witness person who will witness on electronic contract.* |
| Email: |  |
| Phone Number: |  |

Does your organization currently provide direct primary and preventive care to uninsured and medically indigent patients and serve as a primary care\* medical home?

 🞎 Yes 🞎 No

\**Primary care is defined as that care provided by physicians specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern. There are providers of health care other than physicians who render some primary care services. Such providers may include nurse practitioners, physician assistants and some other health care providers. American Association of Family Practice:* [*http://www.aafp.org*](http://www.aafp.org)

**Summary of Request:** Provide a brief, one to two sentence description of your request. (500-character limit):

***NOTE: The grant signatory’s signature will be the last item requested in the online application.***

SFY 2027 Community Health Grants Application

***Overview of Organization \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 10 Points***

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

1. Provide a brief description of your organization. (1,000-character limit)
2. What has your organization achieved in the past year to advance your mission and improve your organization’s capacity? (1,000-character limit)

1. Does your organization currently provide comprehensive primary care services (e.g., preventive, primary, and/or acute) at the primary care delivery site?
* Yes
* No

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

* 1-10 hours/week
* 11-20 hours/week
* 21-30 hours/week
* 31-40 hours/week
* 41-50 hours/week
* >50 hours/week
1. Describe how your organization serves as a medical home. A medical home can include school-based health centers, public health departments that provide maternal and child health, as well as free and charitable clinics that provide primary and preventive care. Patient Centered Medical Home (PCMH) is encouraged, but not required. (1,000-character limit; character limit is inclusive of space and punctuation)
2. Does your organization provide prenatal care and/or delivery services?
* Yes
* No

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

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

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

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

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

* 1-10 hours/week
* 11-20 hours/week
* 21-30 hours/week
* 31-40 hours/week
* 41-50 hours/week
* >50 hours/week
1. Does your organization provide specialty services (e.g., endocrinology, gastroenterology, neurology, or cardiology)?
* Yes
* No

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

*
* 1-10 hours/week
* 11-20 hours/week
* 21-30 hours/week
* 31-40 hours/week
* 41-50 hours/week
* >50 hours/week
1. Does your organization provide well woman care?
* Yes
* No

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

* 1-10 hours/week
* 11-20 hours/week
* 21-30 hours/week
* 31-40 hours/week
* 41-50 hours/week
* >50 hours/week
1. Does your organization provide primary care for children?
* Yes
* No

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

* 1-10 hours/week
* 11-20 hours/week
* 21-30 hours/week
* 31-40 hours/week
* 41-50 hours/week
* >50 hours/week
1. Does your organization utilize telehealth?
* Yes
* No

 If yes:

* 1. What is the telehealth application your organization is using? (Check all that apply)
* Live (synchronous) videoconferencing: a two-way audiovisual link between a patient and a care provider
* Store-and-forward (asynchronous) videoconferencing: transmission of a recorded health history to a health practitioner, usually a specialist.
* Remote patient monitoring (RPM): the use of connected electronic tools to record personal health and medical data in one location for review by a provider in another location, usually at a different time.
* Mobile health (mHealth): health care and public health information provided through mobile devices. The information may include general educational information, targeted texts, and notifications about disease outbreaks.
	1. List the telehealth vendor(s) your organization is using to provide Telehealth services: \_\_\_\_\_

If no:

1. Is your organization considering using telehealth over the next year?
* Yes
* No
1. Would your organization like an ORH HIT specialist to contact you for telehealth technical assistance?
* Yes
* No
1. Does your organization have an Electronic Health Record?
* Yes
* No
1. If yes, provide the name and version: \_\_\_\_\_\_\_\_
2. Is your organization currently connected to NC HealthConnex (formerly the NC Health Information Exchange)?
* Yes
* No
1. If yes, is data being submitted to NC HealthConnex?
* Yes
* No
1. Does your organization have a need for additional technical assistance regarding NC HealthConnex (ex. Report generation options, other potential opportunities for use of HIE data)?
* Yes
* No
1. If your organization is not currently connected, is your organization actively working with the Health Information Exchange Authority (HIEA) to execute a participation agreement?
* Yes
* No
* Not Applicable, our organization is connected to the HIEA
1. Is your organization currently connected to NCCARE360?
* Yes
* No
1. Does your organization collect data on individual patient’s social risk factors or social determinants of health?
* Yes
* No, but in planning stages to collect this information
* No, not planning to collect this information
1. If yes, what type of tool does your organization use? (Select all that apply)
* Accountable Health Communities Screening Tools <https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf>
* Upstream Risks Screening Tool and Guide <https://www.aamc.org/system/files/c/2/442878-chahandout1.pdf>
* IHELLP (Income, Housing, Education, Legal Status, Literacy, and Personal Safety) <https://www.aap.org/en-us/Documents/IHELLPPocketCard.pdf>
* Recommend Social and Behavioral Domains for EHRs
* Health Leads USA recommended screening tool
* PRAPARE (Protocol for Responding to and Assessing Patient’s Assets, Risks and Experiences)  <http://www.nachc.org/research-and-data/prapare/>
* WE-CARE Survey (Well-child care visit, Evaluation, Community resources, Advocacy, Referral, Education) <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Pages/Screening-Tools.aspx>
* WellRx
* Health Leads Screening Toolkit
* NCDHHS Screening Questions
* THRIVE (Tool for Health and Resilience In Vulnerable Environments)  <https://www.preventioninstitute.org/tools/thrive-tool-health-resilience-vulnerable-environments>
* Hunger VitalSign
* iScreen Social Screening Questionnaire  <http://pediatrics.aappublications.org/content/pediatrics/suppl/2014/10/29/peds.2014-1439.DCSupplemental/peds.2014-1439SupplementaryData.pdf>  <http://pediatrics.aappublications.org/content/134/6/e1611>
* The EveryONE Project (by the American Academy of Family Physicians AAFP)
* <https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/sdoh-guide.pdf>
* Other, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* We do not use a standardized assessment
1. If your organization does not use a standardized assessment to collect this information, please comment on why. (Select all that apply)
* Have not considered/unfamiliar with assessments
* Lack of funding for addressing these unmet social needs of patients
* Lack of training for staff to discuss these issues with patients
* Inability to include in patient intake and clinical workflow
* Not needed
* Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Budget and Provider Documents\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*5 points\_***

**Instructions for Submitting the SFY 2027 CHG Budget Template:** (Up to 5 points)

* Track A Budget:
	+ Enter the number of encounters into the on-line application question.
	+ Upload a report that your organization will use to demonstrate the capacity to document patient encounter eligibility. Documentation must include:
		- Organization Name
		- Address
		- Time Period
		- Number of Uninsured/Underinsured Patients Encounters
		- Number of Unduplicated Encounters
* Track B Budget:
	+ Download the Excel SFY 2027 CHG Budget Template provided in the on-line application
	+ Complete the Excel document tabs
	+ Upload the Excel document to the on-line application

**Please note that points will be deducted for not using the current SFY 2027 CHG Budget Template.**

**Track A:** Encounter-based reimbursement:

Complete the following statement:

**“Number of encounters x $100 per encounter = $ [Total Amount of Grant Award]”**

NOTE - Per the Free Clinics Federal Tort Claims Act (FTCA) Program Policy Guide, grant funding that applies to reimbursement, payment, or compensation for the delivery of health services to patients falls within the statutory prohibition, while grant funding that is not intended for or applied to this purpose does not. Free clinics who are FTCA recipients that choose a “per encounter’ reimbursement methodology may void their FTCA liability protection.

**Track B:** Reimbursement for eligible expenses. Complete the SFY27 CHG Budget Template provided in the on-line application.

Complete: [SFY 27 CHG Budget Template Track B](https://www.ncdhhs.gov/sfy-27-chg-budget-template-track-b/open)

The budget narrative tab in the excel spreadsheet must show the calculations for all budget line items and must clearly justify/explain the need for each budget line item. Calculations should be easy to follow/recreate. Each budgeted line item should explain:

* What is it?
* How many?
* How much?
* For what purpose?

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

**Please use the guidelines below to align each project expense with the proper budget category.**

Indirect costs are not eligible.

|  |  |
| --- | --- |
| **Project Expenses** | **Description** |
| Staffing |
| Employee Salary | Include separate descriptions of each position allocated to the grant, including position title, position duties related to project activities, and percentage of time worked. Include the total annual salary OR hourly rate for each staff person in the project. List only staff members that will work on project activities.  |
| Employee Fringe Benefits | Only include EMPLOYER paid benefits i.e., health, dental and vision insurance, FICA (Social Security & Medicare tax) and 401k employer match. Indicate cost per category per staff person. Fringe cannot exceed 30% of total line item for salary allocated to the grant.  |
| Contracted Staff | Contracted staff are not regular employees at your agency. Include compensation rate and hours per month allocated to the grant. |
| Subcontractors | Subcontractors are vendors, businesses, agencies, or other organizations entering into a Memorandum of Understanding to perform work duties on behalf of your organization. Include a detailed line-item budget. |
| Facility Expenses |
| Rent | Clinic space, office space, program meeting space |
| Utilities  | Gas/Electric/Water expenses |
| Telephone/Internet | Phone/Internet/Wi-Fi expenses |
| Repair & Maintenance | Custodial services or basic repair/maintenance performed by non-organizational staff  |
| General Supplies |
| Office Supplies | Business cards, printer ink, paper, etc. |
| Medical Supplies | Masks, gloves, table paper, etc. |
| Patient Education Materials & Incentives | Training manuals, handouts, one-pagers, information cards. List the specific materials |
| Postage and Delivery | Postage expenses |
| Other Operating Expenses |
| Travel | Include purpose of travel (e.g., travel to visit patients, travel to conferences). Note that travel reimbursement cannot exceed current North Carolina State Government rates as defined by the NC Office of State Budget and Management ([**link**](https://www.osbm.nc.gov/memo-travel-rates-update/download?attachment)).  |
| Staff Development | Conferences and conference registration, training |
| Marketing/Community Awareness | Advertising, publications, PSAs, websites, and web materials. Marketing expenses shall not exceed 10% of the grant total |
| Professional Services | Legal services, IT related technical services, accounting, bookkeeping, payroll, security |
| Dues & Subscriptions | Dues for professional associations/affiliations |
| Equipment |  |
| Types of Equipment | Equipment is divided into Rental, General, Medical and Capital equipment categories. Any single item purchased outright exceeding $500.00 is considered capital equipment. Organizations must provide 2 (two) quotes for individual purchases over $5,000.00. |

**Provider Document Section (**5 points)

Each organization that submits an application is required to complete and submit Annual Certification Documents with the application.   **Applications submitted that do not include the required Annual Certification Documents will be considered incomplete and will not be reviewed.**
To upload the files in the online application, select the ‘Upload file’ hyperlink, select ‘Choose File’, find the file to upload from your computer, select ‘Upload File’. If you need to change the file that is already placed in the upload section, select the ‘Upload new version’ or ‘Remove file’ and repeat the steps listed above.

**Provider Documents to Complete and Upload**

Each organization that signs a contract with the Office of Rural Health must submit annual certification documents. Certification Documents must be signed on or after October 1, 2025. Depending on your organization type, different certification documents are required to be completed. Select the hyperlinks below to download and complete the files.

**Non-Government Entity**
[Conflict of Interest Acknowledgement and Policy](https://www.ncdhhs.gov/media/15081/open)
[Conflict of Interest Verification](https://www.ncdhhs.gov/conflict-interest-verificationdoc/open)
[IRS Tax Exemption Form](https://www.ncdhhs.gov/irs-tax-exemption-form/download?attachment)
[No Overdue Tax Debts](https://www.ncdhhs.gov/state-grant-certification-no-overdue-tax-debts/download?attachment) This form must be notarized.
[State Certification](https://www.ncdhhs.gov/state-certificationsdocx/open) (be sure to check a box for 3(b))

**Government Entity**
[State Certification](https://www.ncdhhs.gov/state-certificationsdocx/open) (be sure to check a box for 3(b))

If your organization receives funding from Office of Rural Health NC Farmworker Health Program, the Office of Rural Health Rural Hospital Flexibility Program (FLEX), or the Office of Rural Health Small Rural Hospital Improvement Program (SHIP), you will also need to complete the [**Federal Certifications**](https://www.ncdhhs.gov/federal-certificationsdoc/open).

**Please note that points will be deducted if you do not follow all applicable instructions listed above.**

**Project Narrative Section**

**Instructions for Submitting Project Narrative Sections:** The Community Need and Patient Population, Project Description and Improved Access to Care, Collaboration and Community Engagement, and the Project Evaluation and Return on Investment sections of the on-line application will be submitted by downloading a Word document supplied in the on-line application. Applicants will enter their responses in the Word document that has been supplied and then upload the single document containing all Project Narrative Sections to the on-line application.

**Please note that points will be deducted if you do not follow all instructions listed above.**

Formatting and Page Maximums: Each section must be formatted as follows: Arial, 12-point font, single or double spaced with 1-inch margins. There will be one-page allotted for citations. Tables provided in the document are excluded from the 12-point font requirement.

* Community Need and Patient Population Section – Three Pages, including Patient Population Table
* Project Description and Improved Access to Care Section - Two Pages
* Collaboration and Community Engagement Section – Three Pages, including Patient Race and Ethnicity Table
* Project Evaluation and Return on Investment Section – One Page (Note: Mandatory Performance Measures will be submitted by direct input into tables/questions provided in the on-line application and should not be included in the Narrative Word Document)

***Community Need and Patient Population \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_20 Points***

**Community Need**

* Describe the population served by this grant proposal. Include the population’s healthcare needs, information on the incidence of poverty in the area served and/or uninsured or medically indigent rates, chronic disease rates, and other pertinent demographic data that support the necessity for grant funding in the targeted community. (Up to 5 points)
* Provide citations/reference sources for the incidence of poverty in the area served and other community demographics and health-status data. (Up to 2.5 points)
* Describe how this project will align with the most recent Community Needs Assessment. (Up to 2.5 points)

**Patient Population**

**METHODOLOGY FOR COUNTING PATIENTS.** Patients are defined as individuals who have at least one visit during the reporting period.  At the onset of each contract, grantees are asked to report on their current (or baseline) number of unduplicated patients.  This baseline number of patients is meant to capture the grantee’s current capacity and will be compared to their twelve-month cumulative count of unduplicated patients.  Each grantee will report a cumulative total of patients at three (3), six (6), nine (9), and twelve (12) months which will represent an unduplicated count of patients (not encounters).

Grantees are asked to identify which patient population is being utilized for the patient insurance and patient race/ethnicity tables their quarterly report includes by selecting one option below:

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

Patient Insurance Status in your Organization Table:Enter the number of unduplicated patients, by category, who are *projected* to be served during the project period at the site(s) where the grant will be utilized. Enter a projected baseline value as of July 1, 2026, in Column A; an *estimated* target value for the total number of patients who will be served by June 30, 2027, in Column B; and the projected net additional patients served in Column C for each insurance type. (5 points)

|  |  |  |  |
| --- | --- | --- | --- |
|  | Column AProjected Baseline Servedas of07/01/2026 | Column BProjected Target Servedas of06/30/2027 | Column CProjected Net Additional PatientsServedColumn B minus Column A |
| 1. No Insurance/Uninsured Patients
 |  |  |  |
| 1. Medicaid
 |  |  |  |
| 1. Children’s Health Insurance Program (CHIP)
 |  |  |  |
| 1. Medicare (including duals)
 |  |  |  |
| 1. Other Public Insurance (e.g., Tricare)
 |  |  |  |
| 1. Private Insurance (e.g., BCBS)
 |  |  |  |
| Total Unduplicated Patients Served (sum of above rows) |  |  |  |

* Describe how your organization plans to achieve the patient population goals with emphasis on care for uninsured and medically indigent patients. (5 points)

***Project Description and Improved Access to Care\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_20 Points***

* Describe the purpose of the grant proposal and how funds will be used. (Up to 5 points)
* Include proposed activities, timelines to implement activities, and anticipated outcomes. (Up to 5 points)
* The project description should directly align with the community need and patient population described in the Community Need and Patient Population Section. (Up to 5 points)
* Describe your organization’s arrangements for after-hours care. (Up to 5 points)

***Collaboration and Community Engagement*  \_\_\_\_\_\_ \_\_\_ *20 Points***

* Describe how your organization currently collaborates with the community or other safety net organizations or will collaborate with partners in the future. Partners can include other safety net organizations, primary care providers, allied health organizations, health departments, or agencies that address social determinants (transportation, food insecurity, personal safety, and/or housing). (Up to 10 points)
	+ Describe, *using a specific example*, how your organization has (or will) build collaborative partnerships with other safety net organizations in the community. The example(s) should include:
		- Name(s) of each partner organization
		- Purpose of the collaboration
		- Outcome of the collaboration
		- Document the collaborative roles among the partners in your example, specifying the distinct function of each organization and the designated fiscal contribution.
		- Describe any unique or innovative community partnerships.
		- Detail any barriers to collaboration.
		- What plans does your organization have to develop future partnerships to address community health needs? Include proposed partners, the purpose of the collaboration, and anticipated outcomes of the partnership. Include any barriers to collaborating with community partners and potential ways to address those barriers.
* Describe your organization’s activities and/or plans to address health equity by creating an environment that is welcoming, respectful, inclusive, and is patient-centered to improve health. (Up to 5 points)
* Provide the number of unduplicated patients served at the sites where grant funds will be utilized in the table below.

Patients by Race and Ethnicity Table: Enter the number of unduplicated patients by Race and Latino Ethnicity that your organization currently serves (a baseline value as of your organization’s most recent 12-month data collection period). Only include patients at the site(s) where the grant will be utilized. Please use row ‘g’ if race is not reported. Use Column C if race is reported but ethnicity is not.

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

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

* In the Patients by Race and Ethnicity Table, is the number of unduplicated patients served reflective of the community? If the current patient population is not reflective of the community, describe plans to increase services to underserved populations. (Up to 5 points)

***Project Evaluation and Return on Investment \_ \_ 20 Points***

* Document your organization’s overall budget and explain why the project is a good use of State funds. (Up to 5 points)
* Complete the mandatory Program Performance Measure Tables. (Up to 5 points)
* Describe how your organization will use the mandatory Performance Measures to improve patient health outcomes. Discuss potential factors that could negatively affect your organization’s ability to reach its performance measure targets and describe how these factors might be mitigated. (Up to 10 points)

**Evaluation Criteria**

Complete these mandatory performance measures required for all applicants. These measures will be reported monthly, quarterly, biannually, or annually as indicated.

**Please ensure that baseline and target metrics are accurate.** If your application is awarded, the metrics included in the application will be used as the baseline and target measures in your contract.

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

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

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

**Community Health Grants: All Applicants**

|  |  |  |
| --- | --- | --- |
| **Evaluation Criteria for Primary and Preventive Care** | **Baseline Values/Measures as of 07/01/2026** | **Target to Be Reached****by 06/30/2027** |
|  | *Projected Value* | *Projected Target* |
| **REQUIRED: Output Measure**Number of **unduplicated patients served**. Patients are individuals who have at least one visit during the reporting period. Note: If the grant funds dental care, organizations will be required to report primary care patients served separated from dental patients served.  |  |  |
| Patient Population**Community Health Grant Program grantees**:  Grantees are asked to identify which patient population their quarterly report includes by selecting one option:* Sub-Population:  The data reported would include data from a specific group of patients supported by the grant.  Examples include School-Based Health Centers, Dental Clinics, Maternal Care patients, and other special projects. Also, those grantees that are on the encounter-based reimbursement track (track A) would only report from the pool of patients seen for those encounters.
* One-Site Population:  The data reported would include only those patients seen at a specific site location.
* Multi-Site Population:  The data reported would include patients from more than one site location within that health care organization.
 |  Select One:* Sub-Population
* One-Site Population
* Multi-Site Population
 |
| Measure Type | Output |
| ORH Required Reporting Frequency  | Quarterly (at 3,6,9 and 12 months) **At the final performance report (12-month report) in addition to number of unduplicated patients served, contractors will also report unduplicated patient information in the following categories: patient age, patient insurance status and patient race/ethnicity.** |
| Data Source |  |
| Collection Process and Calculation |  |
| Data Limitations |  |

|  |  |  |
| --- | --- | --- |
| **Evaluation Criteria for Primary and Preventive Care** | **Baseline Values/Measures as of 07/01/2026** | **Target to Be Reached****by 06/30/2027** |
|  | *Projected Value* | *Projected Target* |
| **REQUIRED: Output Measure**Number of **face-to-face patient encounters (includes clinic visits and virtual visits/telemedicine)**Note: Quarterly reports will ask for clinic visits and virtual visits to be reported separately. If the grant includes dental care and primary care, dental patients will need to be reported separately. For more information review the [2025 UDS manual](https://bphc.hrsa.gov/sites/default/files/bphc/compliance/2025-uds-manual.pdf), pages 65-66. |  |  |
| Measure Type | Output |
| ORH Required Reporting Frequency  | Quarterly (at 3,6,9 and 12 months)  |
| Data Source |  |
| Collection Process and Calculation |  |
| Data Limitations |  |

**Community Health Grants: General Care Applicants**

|  |  |
| --- | --- |
| **Measure Description** | **Diabetes: Hemoglobin A1c Poor Control**Percentage of patients 18-75 years of age with diabetes who had hemoglobin HbA1c > 9.0% during the reporting period |

|  |  |
| --- | --- |
| Guidance | * Note that this is a “negative” measure. For this measure, the *lower* the number of adult diabetics with poorly controlled diabetes, the better the performance on the measure.
* If the HbA1c test result is in the patient health record, the test can be used to determine the numerator criteria.
* Report patients who have an active diagnosis of diabetes even if their medical visits during the year were unrelated to the diagnosis.
* Include patients in the numerator whose most recent HbA1c level is greater than 9.0%, for whom the most recent HbA1c result is missing, or for whom HbA1c tests were performed or documented during the reporting period.
* Even if the treatment of the patient’s diabetes has been referred to a non–health center provider, the health center is expected to have the current lab test results in its records.

This measure is calculated using the numerator and denominator defined below.This service cannot be conducted via telehealth.For more information review the [2025 UDS manual](https://bphc.hrsa.gov/sites/default/files/bphc/compliance/2025-uds-manual.pdf), pages 134-135. |

|  |  |  |
| --- | --- | --- |
| **Measure - Denominator** | Baseline Value as of **07/01/2026** | Target to be reached by **06/30/2027** |
| Denominator: Patients 18-75 years of age with diabetes with a medical visit during the measurement period.Exclusions: Patients who were in hospice care for any part of the measurement period. Patients 66 and older who are living long term in a nursing home any time on or before the reporting period Patients 66 and older with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria: advanced illness with one inpatient visit or two outpatient visits or taking dementia medications during the measurement period or the year prior. Patients who received palliative care during the measurement period. |  |  |
| Measure Type | Outcome |
| ORH Required Reporting Frequency  | Biannually (Reported at six and 12 months) |
| Data Source |  |
| Collection Process and Calculation |  |
| Data Limitations |  |

|  |  |  |
| --- | --- | --- |
| **Measure - Numerator** | Baseline Value as of **07/01/2026** | Target to be reached by **06/30/2027** |
| Numerator: Patients whose most recent HbA1c level performed during the measurement period is greater than 9.0 % or were missing or were not performed during the reporting period. |  |  |
| Measure Type | Quality/Process |
| ORH Required Reporting Frequency  | Biannually (Reported at six and 12 months) |
| Data Source |  |
| Collection Process and Calculation |  |
| Data Limitations |  |

**Community Health Grants: General Care Applicants**

|  |  |
| --- | --- |
| **Measure Description** | **Controlling High Blood Pressure** Percentage of patients 18-85 years old who had a diagnosis of hypertension (HTN) starting before and continuing into, or starting the first six months of the measurement period, ***and*** whose most recent Blood Pressure (BP) was adequately controlled (less than 140/90 mm Hg) during the reporting period. |
| Guidance | * Note that this is a “positive” measure. For this measure, the higher the number of patients with controlled hypertension the better the performance on the measure.
* Only blood pressure readings performed by a provider or remote monitoring device are acceptable for the numerator criteria with this measure.
* Blood pressure readings are acceptable if: taken in person by a clinician, measured remotely by an electronic monitoring device capable of transmitting the blood pressure data to the clinician, or taken by a remote monitoring device and conveyed by the patient to the clinician.
* It is the clinician’s responsibility and discretion to confirm the remote monitoring device used to obtain the blood pressure is considered acceptable and reliable and whether the blood pressure reading is considered accurate before documenting it in the patient’s medical record.
* If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading.
* If no blood pressure is recorded during the reporting period, the patient's blood pressure is assumed "not controlled” and isn’t counted in the numerator.
* DO NOT include blood pressure readings taken during an acute inpatient stay or emergency department visit.
* Include patients who have an active diagnosis of hypertension even if their medical visits during the year were unrelated to the diagnosis.
* Include blood pressure readings taken at any visit type at the health center as long as the result is from the most recent visit.

For more information review the [2025 UDS manual](https://bphc.hrsa.gov/sites/default/files/bphc/compliance/2025-uds-manual.pdf), pages 132-134. |

|  |  |  |
| --- | --- | --- |
| **Measure - Denominator** | Baseline Value as of **07/01/2025** | Target to be reached by **06/30/2026** |
| Denominator: Patients 18 through 85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first 6 months of the measurement period with a medical visit during the measurement periodExclusions: Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Patients with a diagnosis of pregnancy during the measurement period. Patients who were in hospice for any part of the reporting period. Patients 66 and older (by the end of the reporting period) who were living long-term in a nursing home any time on or before the end of the measurement period. Patients 66-80 (by the end of the reporting period) with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria: advanced illness with one inpatient visit or two outpatient visits or taking dementia medications during the measurement period or the year prior. Patients 81 and older with an indication of frailty for any part of the reporting period. Patients who received palliative care during the measurement period. |  |  |
| Measure Type | Outcome |
| ORH Required Reporting Frequency  | Biannually (Reported at six and 12 months) |
| Data Source |  |
| Collection Process and Calculation |  |
| Data Limitations |  |

|  |  |  |
| --- | --- | --- |
| **Measure - Numerator** | Baseline Value as of **07/01/2025** | Target to be reached by **06/30/2026** |
| 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, |  |  |
| Measure Type | Outcome |
| ORH Required Reporting Frequency  | Biannually (Reported at six and 12 months) |
| Data Source |  |
| Collection Process and Calculation |  |
| Data Limitations |  |

**Community Health Grants: General Care Applicants**

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

Do not count as meeting the numerator criteria charts or templates that display only height and weight. The fact that a HIT/EHR can calculate BMI does not replace the presence of the BMI itself. |

|  |  |  |
| --- | --- | --- |
| **Measure - Denominator** | Baseline Value as of **07/01/2025** | Target to be reached by **06/30/2026** |
| Denominator: Patients who were 18 years of age or older with at least one medical visit during the reporting period. Do NOT include patients who only had virtual visits during the year in the denominator.Exclusions Patients who are pregnant at any time during the reporting period. Patients receiving palliative or hospice care at any time during the reporting period. Patients who refuse measurement of height and/or weight. Patients with a documented medical reason for not documenting BMI or for not documenting a follow-up plan. Elderly patients (65 years or older) for whom weight reduction or gain would complicate other underlying health conditions, such as the following examples: Illness or physical disability; Mental illness, dementia, confusion; Nutritional deficiency, such as vitamin or mineral deficiency; Patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient’s health status. |  |  |
| Measure Type | Quality/Process |
| ORH Required Reporting Frequency  | Biannually (Reported at six and 12 months) |
| Data Source |  |
| Collection Process and Calculation |  |
| Data Limitations |  |

|  |  |  |
| --- | --- | --- |
| **Measure - Numerator** | Baseline Value as of **07/01/2025** | Target to be reached by **06/30/2026** |
| Numerator: Patients with a documented BMI during their most recent visit ***or*** during the reporting period, and BMI is within normal parameters **AND** Patients with a documented BMI during the most recent visit or during the reporting period, and when the BMI is outside of normal parameters, a follow-up plan is documented at the visit where the BMI was outside of normal parameters or during the reporting period.\* Normal parameters for age 18 and older, BMI greater than or equal to 18.5 kg/m2 and less than 25 kg/m2  |  |  |
| Measure Type | Quality/Process |
| ORH Required Reporting Frequency  | Biannually (Reported at six and 12 months) |
| Data Source |  |
| Collection Process and Calculation |  |
| Data Limitations |  |

**Community Health Grants: General Care Applicants**

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| --- | --- |
| **Measure Description** | **Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**Percentage of patients aged 12 years and older who were screened for tobacco use one or more times within repoorting period ***and who*** received tobacco cessation intervention duriing the reporting period or in the 6 months prior to the reporting period *if identified as a tobacco user*This measure is calculated using the numerator and denominator defined below.  |
| Guidance | * If patients use any type of tobacco, (i.e., smokes or uses smokeless tobacco), tobacco cessation intervention is expected (counseling and/or pharmacotherapy).
* In order to promote a team-based approach to patient care, the tobacco cessation intervention can be performed by another health care provider; therefore, the tobacco use screening and tobacco cessation intervention DO NOT need to be performed by the same provider.
* If a patient has multiple tobacco use screenings during the 12-month period, use the most recent screening which has a documented status of tobacco user or non-user.
* If tobacco use status of a patient is unknown, the patient does NOT meet the screening component required to be counted in the numerator and has not met the measurement standard. "Unknown" includes patients who were not screened or patients with indefinite answers.
* 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.
* The current evidence is insufficient to recommend electronic cigarettes (e-cigarettes) for tobacco cessation. However, the U.S. Food and Drug Administration definition of tobacco includes e-cigarettes, hookah pens, and other electronic nicotine delivery systems. Therefore, **the measure** **does consider the use of e-cigarettes** **and other electronic nicotine delivery systems to be tobacco use**.
* Report in the numerator records that demonstrate that the patient had been asked about their use of all forms of tobacco during reporting period
* If the cessation intervention is pharmacotherapy, then the prescription must be active (one that has not expired) or ordered during the measurement period.
* Include in the numerator patients with a negative screening *and* those with a positive screening who had cessation intervention if a tobacco user.
* Include patients who receive tobacco cessation intervention by any provider, including those who:
	+ Received tobacco use cessation counseling services, *or*
	+ Received an order for (a prescription or a recommendation to purchase an over-the-counter [OTC] product) a tobacco use cessation medication, *or*
	+ Are on (using) a tobacco use cessation agent.
* DO NOT count as meeting the numerator criteria providing written self-help materials only.

For more information review the [2025 UDS manual](https://bphc.hrsa.gov/sites/default/files/bphc/compliance/2025-uds-manual.pdf), pages 106-107. |

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| --- | --- | --- |
| **Measure - Denominator** | Baseline Value as of **07/01/2026** | Target to be reached by **06/30/2027** |
| Denominator: All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the reporting periodExclusions: Patients who were in hospice care for any part of the measurement period.  |  |  |
| Measure Type | Quality/Process |
| ORH Required Reporting Frequency  | Biannually (Reported at six and 12 months) |
| Data Source |  |
| Collection Process and Calculation |  |
| Data Limitations |  |

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| --- | --- | --- |
| **Measure - Numerator** | Baseline Value as of **07/01/2026** | Target to be reached by **06/30/2027** |
| Numerator: Patients who were screened for tobacco use at least once within the past 12 months and NOT identified as a tobacco userANDPatients who were screened for tobacco use at least once within the past 12 months and received tobacco cessation intervention during the reporting period or during the 6 months prior to the reporting period if identified as a tobacco user INCLUDE in the numerator patients with a negative screening AND those with a positive screening who had cessation intervention if a tobacco user.  |  |  |
| Measure Type | Quality/Process |
| ORH Required Reporting Frequency  | Biannually (Reported at six and 12 months) |
| Data Source |  |
| Collection Process and Calculation |  |
| Data Limitations |  |

**Community Health Grants: Behavioral Health Applicants**

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| **Measure Description** | **Screening for Depression and Follow-Up Plan**Percentage of patients aged 12 years and older screened for depression on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized depression screening tool AND, if positive, a follow-up plan is documented on the date of the visit, or up to two days after the date of, the qualifying visit. |
| Guidance | * Patients who have ever been diagnosed with depression or bipolar disorder prior to the eligible visit will be excluded from the measure.
* The depression screening must be completed on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized depression screening tool and must be reviewed and addressed in the office of the provider on the date of the visit.
* If the screening result is positive, a follow-up plan must be documented on the date of the visit or up to two days after the visit. A follow-up plan could be additional evaluation, referral, treatment, pharmacological intervention, or other interventions.
* Standardized depression screening tools are normalized and validated for the age-appropriate patient population in which they are used, must be documented in the patient health record, and must be used to meet the numerator criteria. Document the screening tool used in the patient health record. Each standardized screening tool provides guidance on whether a particular score is considered positive for depression.
* Use the most recent screening results.
* The follow-up plan must be related to a positive depression screening.
* Follow-up for a positive depression screening must include one or more of the following:
	+ Additional interventions designed to treat depression, such as behavioral health evaluation, psychotherapy, or additional treatment.
	+ Referral to a provider for further evaluation for depression.
	+ Pharmacological interventions, when appropriate.
* Although a Patient Health Questionnaire (PHQ-9) may follow a PHQ-2 as a new screening, if the result is positive, then a CQM-compliant follow-up plan on the date of the visit is still required.
* Screening may occur outside of a countable visit.
* Documentation of a follow-up plan “on the date of the visit” can refer to any countable visit, NOT only a medical visit.
* A suicide risk assessment DOES NOT qualify for the numerator as a follow-up plan.
* DO NOT count patients who are re-screened as meeting the numerator criteria as a follow-up plan to a positive screen.

DO NOT count a PHQ-9 screening that follows a positive PHQ-2 screening during the measurement period as meeting the numerator critieria for a **follow-up plan** to a positive depression screening. This measure is calculated using the numerator and denominators defined below.For more information review the [2025 UDS manual,](https://bphc.hrsa.gov/sites/default/files/bphc/compliance/2025-uds-manual.pdf) pages 114-116. |

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| --- | --- | --- |
| **Measure - Denominator** | Baseline Value as of **07/01/2026** | Target to be reached by **06/30/2027** |
| Denominator: Patients aged 12 years and older with at least one medical visit during reporting period. Exclusions Patients who have been diagnosed with depression or bipolar disorder at any time prior to the visit, regardless of whether the diagnosis is active or not. Patients who refuse to participate. Medical reasons, including: * Patients who are in an urgent or emergent situations where time is of the essence and to delay treatment would jeopardize the patient's health status.
* Patients with documentation of medical reasons for not screening the patient for depression (e.g., cognitive, functional, or motivational limitations) that may impact the accuracy of results.
 |  |  |
| Measure Type | Outcome |
| ORH Required Reporting Frequency  | Biannually (Reported at six and 12 months) |
| Data Source |  |
| Collection Process and Calculation |  |
| Data Limitations |  |

|  |  |  |
| --- | --- | --- |
| **Measure - Numerator** | Baseline Value as of **07/01/2026** | Target to be reached by **06/30/2027** |
| Numerator: Patients who were screened for depression on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized tool, and screened negative for depressionAND Patients who were screened for depression on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized tool, and if screened positive for depression, a follow-up plan is documented on the date of or up to two days after the date of the visit Note: Include in the numerator patients with a negative screening and those with a positive screening who had a follow-up plan documented.  |  |  |
| Measure Type | Outcome |
| ORH Required Reporting Frequency  | Biannually (Reported at six and 12 months) |
| Data Source |  |
| Collection Process and Calculation |  |
| Data Limitations |  |

**Community Health Grants: School Based Health Center Applicants**

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| --- | --- |
| **Measure Description** | **Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents** Percentage of patients 3-18) years of age who had an outpatient medical visit *and* who had evidence of the height, weight, and body mass index (BMI) percentile documentation; documented counseling for nutrition; documented counseling for physical activityThis measure is calculated using the numerator and denominator defined below.\* UDS definition uses 17 years of age as their cutoff, ORH has extended this age to 18 |
| Guidance | * Because BMI norms for youth vary with age and sex, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value~~.~~
* Include medical visits performed by any medical provider (for example, include patients who had a visit with an NP).
* Note: Normal parameters: For age 18 years and older, BMI greater than or equal to 18.5 kg/m2 and less than 25 kg/m2
* DO NOT count as meeting the numerator criteria charts that show only that a well-child visit was scheduled, provided, or billed. The electronic or paper well-child visit template/form must document each of the elements noted above.

For more information review the [2025 UDS manual](https://bphc.hrsa.gov/sites/default/files/bphc/compliance/2025-uds-manual.pdf), pages 103-104. |

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| --- | --- | --- |
| **Measure - Denominator** | Baseline Value as of **07/01/2026** | Target to be reached by **06/30/2027** |
| Denominator: Patients 3-18 years of age with at least one outpatient medical visit during the reporting period.Exclusions: Patients who have a diagnosis of pregnancy during the measurement period. Patients who were in hospice care for any part of the reporting period.  |  |  |
| Measure Type | Quality/Process |
| ORH Required Reporting Frequency  | Biannually (Reported at six and 12 months) |
| Data Source |  |
| Collection Process and Calculation |  |
| Data Limitations |  |

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| --- | --- | --- |
| **Measure - Numerator** | Baseline Value as of **07/01/2026** | Target to be reached by **06/30/2027** |
| Numerator: Children and adolescents who have had:* Their height, weight, and body mass index (BMI) percentile recorded during the reporting period ***and***
* counseling for nutrition during the reporting period ***and***

counseling for physical activity during the reporting period. |  |  |
| Measure Type | Quality/Process |
| ORH Reporting Frequency  | Biannually (Reported at six and 12 months) |
| Data Source |  |
| Collection Process and Calculation |  |
| Data Limitations |  |

**Community Health Grants: School Based Health Center Applicants**

|  |  |
| --- | --- |
| **Measure Description** | **Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**Percentage of patients aged 12 years and older who were screened for tobacco use one or more times during the reporting period ***and*** who received tobacco cessation intervention during the reporting period or in the 6 months prior to the reporting period if identified as a tobacco user*This measure replaces the NQF #2803 “Tobacco Use and Help with Quitting Amoung Adolescents” measure that was previously used by ORH. The NQF is sunsetting the measure and this measure is based off the Tobacco Use measure in the UDS manual. The age has been adjusted to capture younger patients.*For more information review the [2025 UDS manual](https://bphc.hrsa.gov/sites/default/files/bphc/compliance/2025-uds-manual.pdf), pages 106-107. |

|  |  |  |
| --- | --- | --- |
| **Measure - Denominator** | Baseline Value as of **07/01/2026** | Target to be reached by **06/30/2027** |
| Denominator: All patients aged 12 years and older at the start of the reporting period seen for at least two qualifying encounters in the reporting period OR at least one preventive care qualifying encounter during the reporting periodExclusions: Patients who were in hospice care for any part of the reporting period.  |  |  |
| Measure Type | Quality/Process |
| ORH Reporting Frequency  | Biannually (Reported at six and 12 months) |
| Data Source |  |
| Collection Process and Calculation |  |
| Data Limitations |  |

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| --- | --- | --- |
| **Measure - Numerator** | Baseline Value as of **07/01/2026** | Target to be reached by **06/30/2027** |
| Numerator: Patients who were screened for tobacco use at least once during the reporting period and NOT identified as a tobacco userANDPatients who were screened for tobacco use at least once during the reporting period and, if identified as a tobacco user, received tobacco cessation intervention during the reporting period or during the 6 months prior to the reporting period \*Include in the numerator patients with a negative screening and those with a positive screening who had cessation intervention if a tobacco user. |  |  |
| Measure Type | Quality/Process |
| ORH Reporting Frequency  | Biannually (Reported at six and 12 months) |
| Data Source |  |
| Collection Process and Calculation |  |
| Data Limitations |  |

**Community Health Grants: School Based Health Center Applicants**

|  |  |
| --- | --- |
| **Measure Description** | **Screening for Depression and Follow-Up Plan**Percentage of patients aged 12 years and older screened for depression on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized depression screening tool AND, if positive, a follow-up plan is documented on the date of the visit, or up to two days after the date of, the qualifying visit. |
| Guidance | * Patients who have ever been diagnosed with depression or bipolar disorder prior to the eligible visit will be excluded from the measure.
* The depression screening must be completed on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized depression screening tool and must be reviewed and addressed in the office of the provider on the date of the visit.
* If the screening result is positive, a follow-up plan must be documented on the date of the visit or up to two days after the visit. A follow-up plan could be additional evaluation, referral, treatment, pharmacological intervention, or other interventions.
* Standardized depression screening tools are normalized and validated for the age-appropriate patient population in which they are used, must be documented in the patient health record, and must be used to meet the numerator criteria. Document the screening tool used in the patient health record. Each standardized screening tool provides guidance on whether a particular score is considered positive for depression.
* Use the most recent screening results.
* The follow-up plan must be related to a positive depression screening.
* Follow-up for a positive depression screening must include one or more of the following:
	+ Additional interventions designed to treat depression, such as behavioral health evaluation, psychotherapy, or additional treatment.
	+ Referral to a provider for further evaluation for depression.
	+ Pharmacological interventions, when appropriate.
* Although a Patient Health Questionnaire (PHQ-9) may follow a PHQ-2 as a new screening, if the result is positive, then a CQM-compliant follow-up plan on the date of the visit is still required.
* Screening may occur outside of a countable visit.
* Documentation of a follow-up plan “on the date of the visit” can refer to any countable visit, NOT only a medical visit.
* A suicide risk assessment DOES NOT qualify for the numerator as a follow-up plan.
* DO NOT count patients who are re-screened as meeting the numerator criteria as a follow-up plan to a positive screen.

DO NOT count a PHQ-9 screening that follows a positive PHQ-2 screening during the measurement period as meeting the numerator critieria for a **follow-up plan** to a positive depression screeningThis measure is calculated using the numerator and denominators defined below.For more information review the [2025 UDS manual,](https://bphc.hrsa.gov/sites/default/files/bphc/compliance/2025-uds-manual.pdf) pages 114-117. |

|  |  |  |
| --- | --- | --- |
| **Measure - Denominator** | Baseline Value as of **07/01/2026** | Target to be reached by **06/30/2027** |
| Denominator: Patients aged 12 years and older with at least one medical visit during reporting period. Exclusions Patients who have been diagnosed with depression or bipolar disorder at any time prior to the visit, regardless of whether the diagnosis is active or not. Patients who refuse to participate. Medical reasons, including: * Patients who are in an urgent or emergent situations where time is of the essence and to delay treatment would jeopardize the patient's health status.
* Patients with documentation of medical reasons for not screening the patient for depression (e.g., cognitive, functional, or motivational limitations) that may impact the accuracy of results.
 |  |  |
| Measure Type | Outcome |
| ORH Required Reporting Frequency  | Biannually (Reported at six and 12 months) |
| Data Source |  |
| Collection Process and Calculation |  |
| Data Limitations |  |

|  |  |  |
| --- | --- | --- |
| **Measure - Numerator** | Baseline Value as of **07/01/2026** | Target to be reached by **06/30/2027** |
| Numerator: Patients who were screened for depression on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized tool, and screened negative for depressionAND Patients who were screened for depression on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized tool, and if screened positive for depression, a follow-up plan is documented on the date of or up to two days after the date of the visit Note: Include in the numerator patients with a negative screening and those with a positive screening who had a follow-up plan documented.  |  |  |
| Measure Type | Outcome |
| ORH Required Reporting Frequency  | Biannually (Reported at six and 12 months) |
| Data Source |  |
| Collection Process and Calculation |  |
| Data Limitations |  |

**Community Health Grants:** **Maternal Care Applicants**

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| **Measure Description** | **Early Entry into Prenatal Care:** Percentage of prenatal care patients who entered prenatal care during their first trimester.This measure is calculated using the numerator and denominator defined below. |
| Guidance: | * Report patients who were prenatal care patients during the reporting period and whose first visit occurred when they were estimated to be pregnant up through the end of the 13th week after the first day of their last menstrual period.
* Determine the trimester by the trimester of pregnancy that the patient was in when they began prenatal care either at one of the health center’s service delivery locations or with another provider, including a referral provider.
* Report a patient who begins prenatal care with the health center or is referred by the health center to another provider.
* Report a patient who begins prenatal care on their own with another provider and then transfers to the health center
* Patient self-report of trimester of entry is permitted.
* Only report patients who had their first comprehensive prenatal exam with the health center or with the referral provider as having begun prenatal care. Health center visits that include pregnancy and other lab tests, dispensing vitamins, taking a health history, and/or obtaining a nutritional or psychosocial assessment only DO NOT count as the start of prenatal care.
* Report the patient twice as a prenatal care patient in those rare instances when a patient receives prenatal care services for two separate pregnancies in the same calendar year.

For more information review the [2025 UDS manual,](https://bphc.hrsa.gov/sites/default/files/bphc/compliance/2025-uds-manual.pdf) pages 95-96. |

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| --- | --- | --- |
| **Measure - Denominator** | Baseline Value as of **07/01/2026** | Target to be reached by **06/30/2027** |
| Denominator: Patients seen for prenatal care during the reporting period.  |  |  |
| Measure Type | Quality/Process |
| ORH Reporting Frequency  | Biannually (Reported at six and 12 months) |
| Data Source |  |
| Collection Process and Calculation |  |
| Data Limitations |  |

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| --- | --- | --- |
| **Measure - Numerator** | Baseline Value as of **07/01/2026** | Target to be reached by **06/30/2027** |
| Numerator: Number patients who began prenatal care at the health center or with a referral provider, or who began care with another prenatal provider, during their first trimester. |  |  |
| Measure Type | Quality/Process |
| ORH Reporting Frequency  | Biannually (Reported at six and 12 months) |
| Data Source |  |
| Collection Process and Calculation |  |
| Data Limitations |  |

**Appendix A: North Carolina Medicaid Regions**

