NC Department of Health and Human Services

Office of Rural Health
SFY 2026
Community Health Grant

Request for Application
Webinar

November 2024

Programs at ORH

Placement and HPSA Services

Recruit providers and designates health professional shortage areas

NC Rural Health Centers

Supports state designated rural health centers that serve the entire community

NC Community Health Grants

Supports the primary care safety net system with increasing access to health care for vulnerable populations

NC Farmworker Health Program

Supports medical, dental and educational services for members of the North Carolina agricultural labor force and their families

Rural Health Information Technology Program

Supports equitable access to the health information (HIE), NCCARE360 platform, telehealth and other technological and digital equity goals

NC Rural Hospital Program

Funds operational improvement projects for the benefit of all critical access hospitals and eligible small rural hospitals

NC Medication Assistance Program

Provides free and low-cost medications donated by pharmaceutical manufacturers to patients who cannot afford them

NC Statewide Telepsychiatry Program

Supports psychiatric evaluation of patients through videoconferencing technology in emergency departments

NC Analytics & Innovations

Support data analytics, shortage designations, and pioneering efforts to improve health

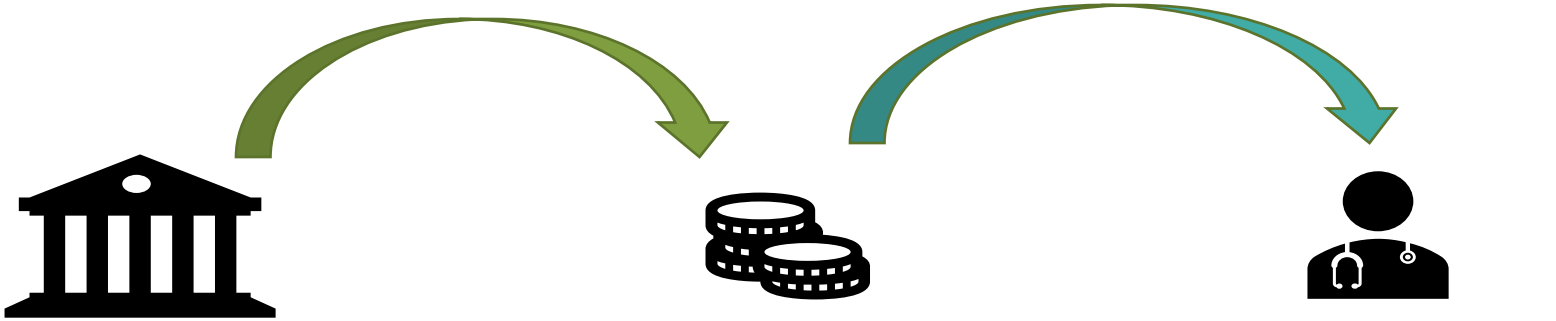
Community Health Worker Program

Support North Carolinians by connecting them to medical and social support resources.

Overview

- **Community Health Grant RFA**
  - **Purpose**
  - **Program Reach**
  - **Eligibility**
  - **Reimbursement**
  - **Deadlines**
- **Application Process and Scoring**
- **Performance Measures**

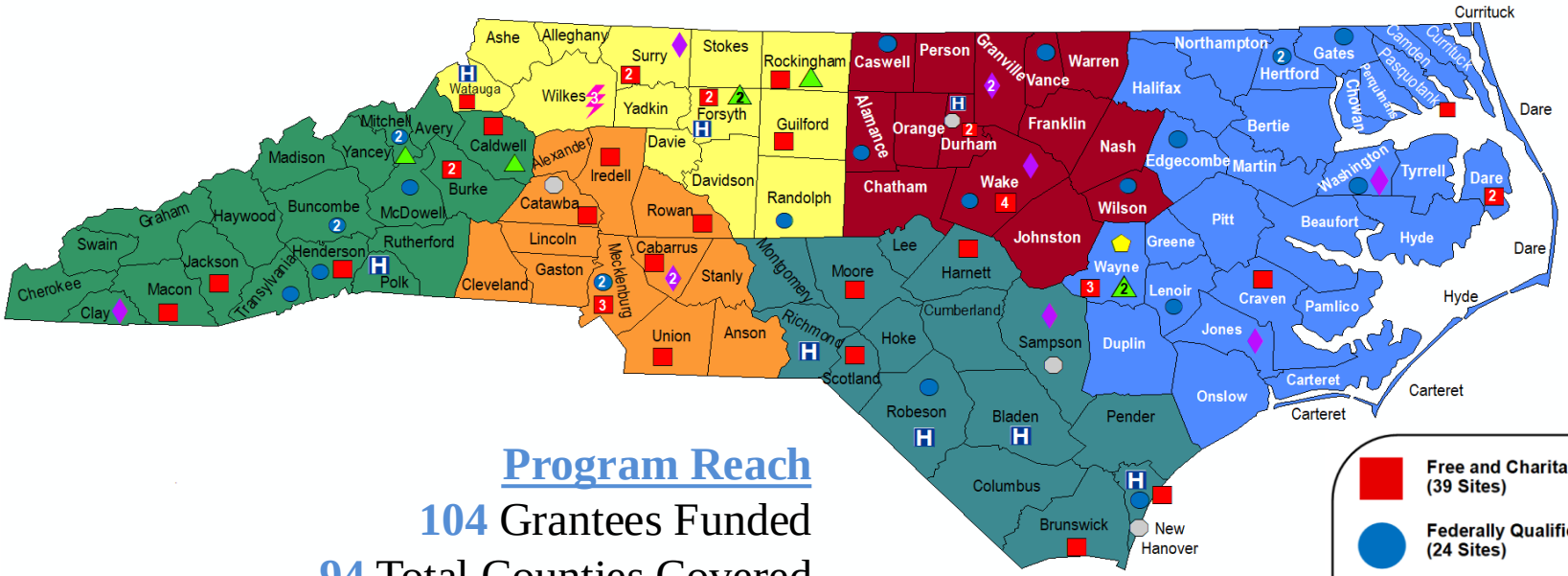
Community Health Grant RFA



Purpose

Strengthening the safety net through increased levels of collaboration and integration of services and organizations to more effectively meet the needs of our state's most vulnerable population is an important purpose of this grant.

Community Health Grant Program
Program Reach



Program Reach

104 Grantees Funded

94 Total Counties Covered

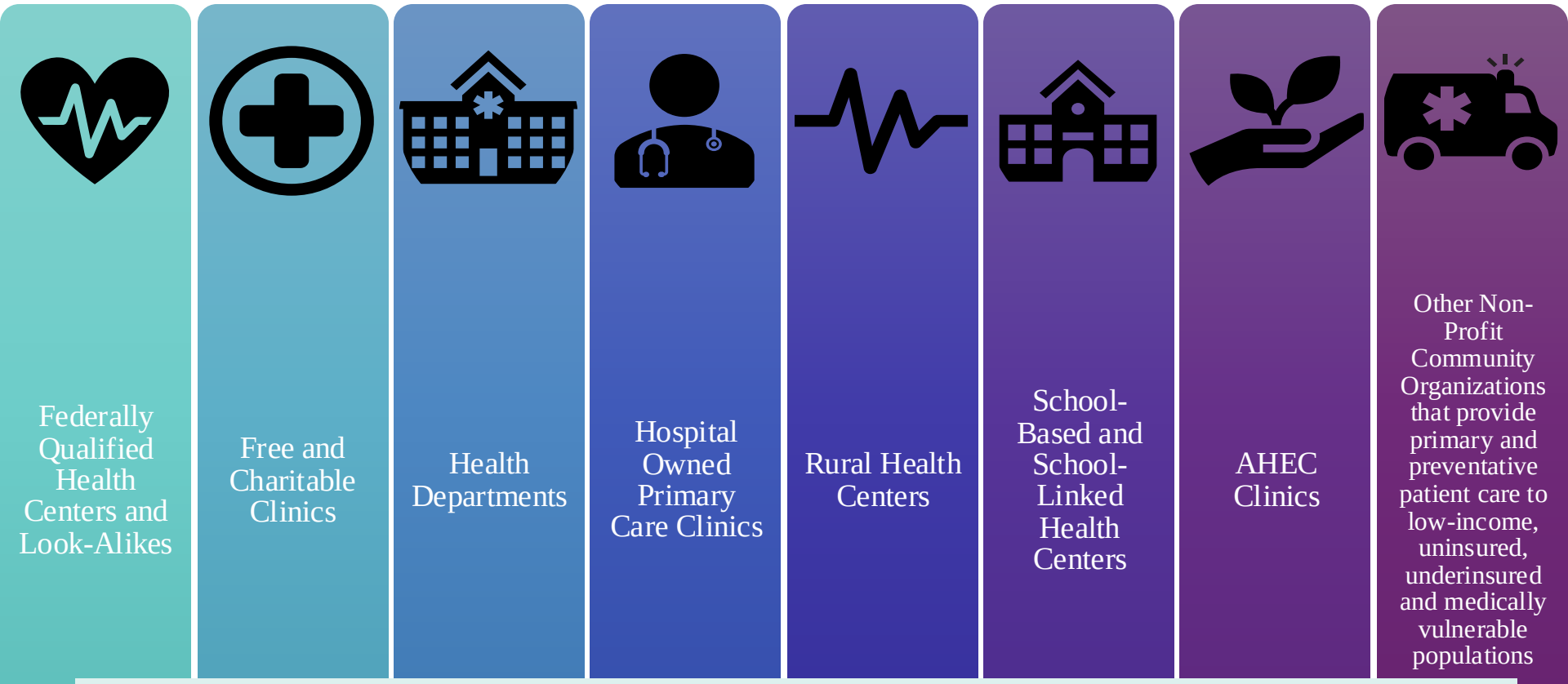
64 Rural Counties Covered

- Free and Charitable Clinic (39 Sites)
- Federally Qualified Health Center (24 Sites)
- Health Department (12 Sites)
- Other (Non-Profit, AHEC Clinic) (5 Sites)
- Hospital/Hospital-owned Primary Care Clinics (8 Sites)
- School Based Health Center (7 Sites)
- Health Department/Federally Qualified Health Center (3 Sites)
- Rural Health Center (1 Site)

Community Health Program supports the primary care Safety Net system to increase access for vulnerable populations.

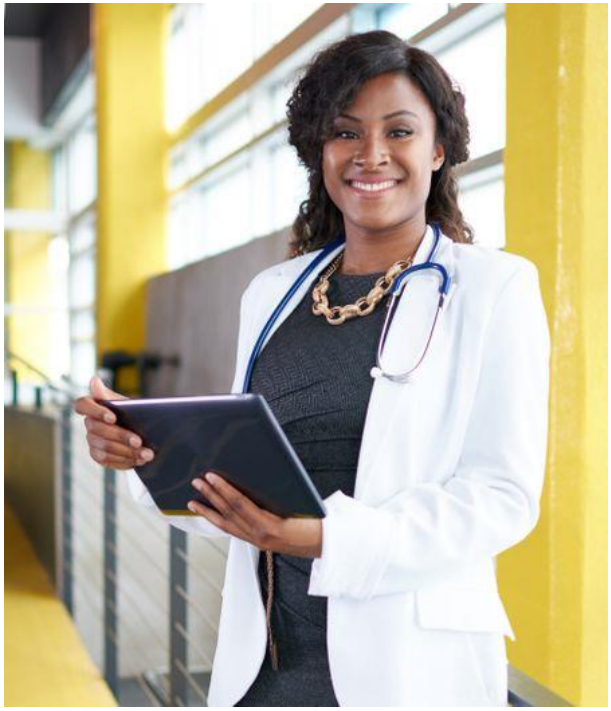
Session Law 2021-180: 2021 State Budget Special Provisions: S105-CCSMLxr-3 v5.pdf

Who's Eligible?



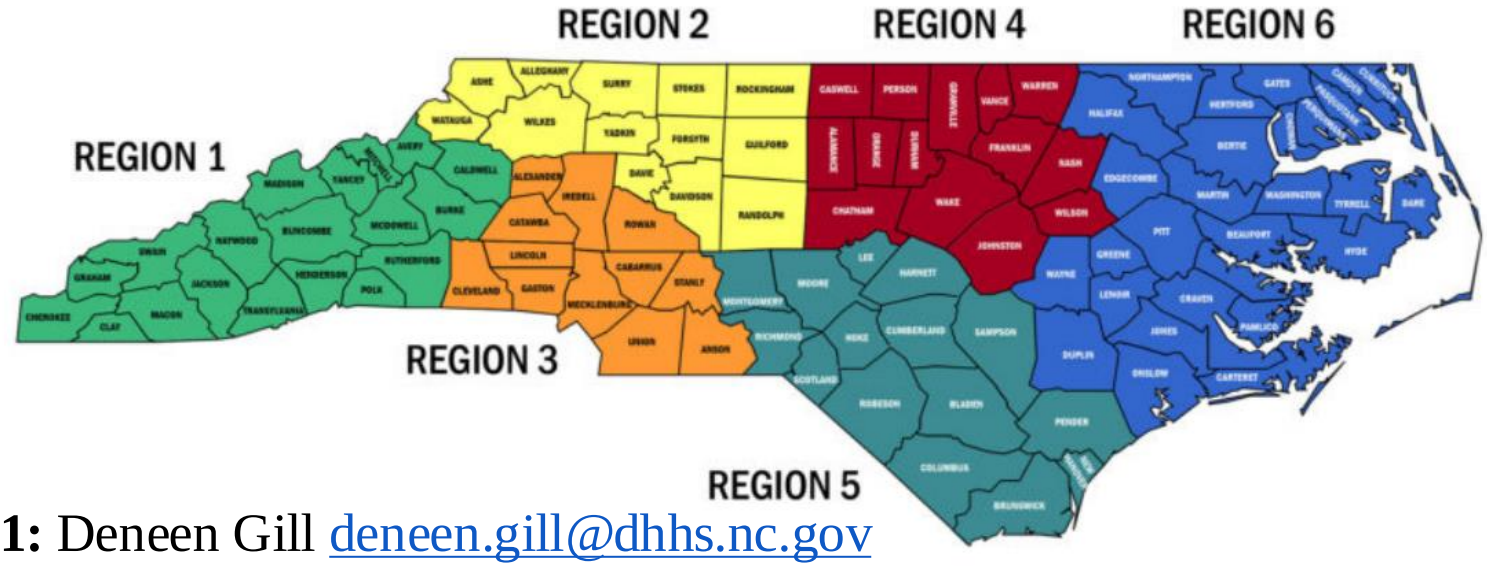
All primary care safety net organizations that currently provide direct primary and preventive care and serve as a medical home are eligible to apply.

Eligibility cont'd



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

Community Health Grant Monitors



Region 1: Deneen Gill deneen.gill@dhhs.nc.gov
Region 2: Trenesse Michael trenesse.michael@dhhs.nc.gov
Region 3: Bianca Revis bianca.revis@dhhs.nc.gov
Region 4: Nina Baccanari nina.baccanari@dhhs.nc.gov
Region 5: Sharema Williams sharema.williams@dhhs.nc.gov
Region 6: Liliana Andrade liliana.andrade@dhhs.nc.gov
Financial Reviewer: Angelia Lightfoot angelia.Lightfoot@dhhs.nc.gov
Financial Reviewer: Kayla N. Taylor kayla.n.taylor@dhhs.nc.gov
Program Manager: Nicole Fields-Pierre nicole.fields-pierre@dhhs.nc.gov

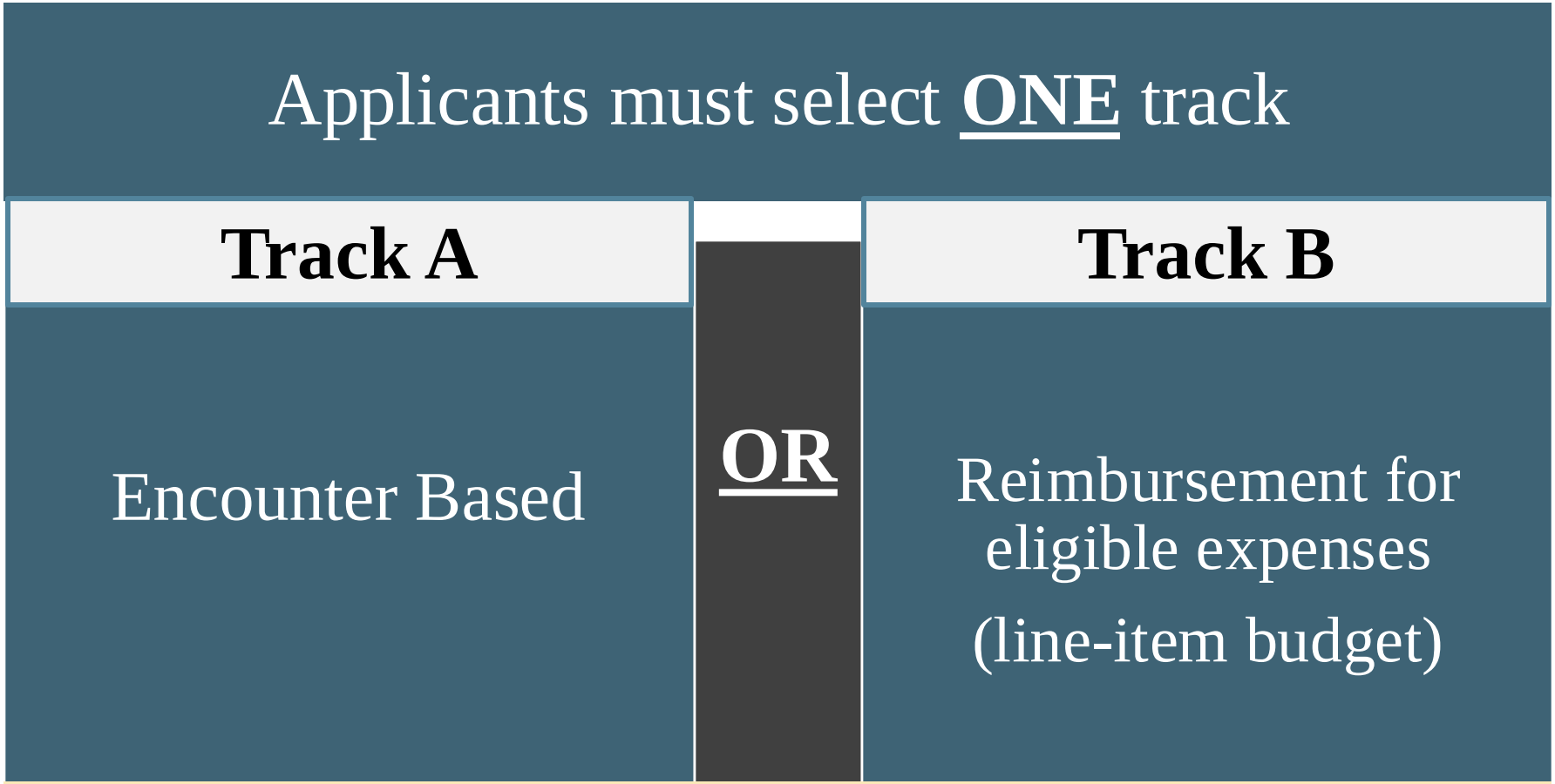
Reimbursement - Number of Awards

We anticipate that approximately 33 applicants will receive new funding.

<u>Please note:</u> This is not continuation funding. Applicants seeking Continuing Year 2 or Year 3 should follow the Continuation Application process in which you will receive specific instructions from your grant monitor.

Reimbursement cont'd

Primary care safety net organizations who currently care for underserved and medically indigent patients in the state are eligible to apply for this funding to pay for patient care through



CHG Funds Telehealth Use Cases for Healthcare Providers

- Healthcare providers can use Community Health Grant (CHG) funds to purchase ***Tablets, Mobile Wi-Fi Hotspots, and Cameras*** to support telehealth services at their practice.

- Healthcare providers can use CHG funds to support an FTE position such as a ***Community Health Worker or Telehealth Coordinator*** that helps incorporate telehealth services into existing clinical workflows.

- Healthcare providers can use CHG funds to ***purchase or lease telehealth equipment*** such as scales, blood pressure cuffs, pulse oximeters, etc., that can be used for remote patient monitoring. This equipment in conjunction with patient education can assist patients with chronic disease management.

Reimbursement cont'd

REMINDER - 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.

Deadlines

One grant application per organization will be reviewed. Under session law, grantees must serve as a medical home and provide direct primary and preventive care services.

Application Deadline	**December 19, 2024**
Instructions and Budget Template	SFY26 CHG RFA and Budget Template
Anticipated Notice of Awards	**Spring 2025**
Request Unique Application Link	**Request application link by December 20, 2024**
Maximum Award	**$150,000**
Contract Period	**July 1, 2025 - June 30, 2026**

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

Two-Step Application Process

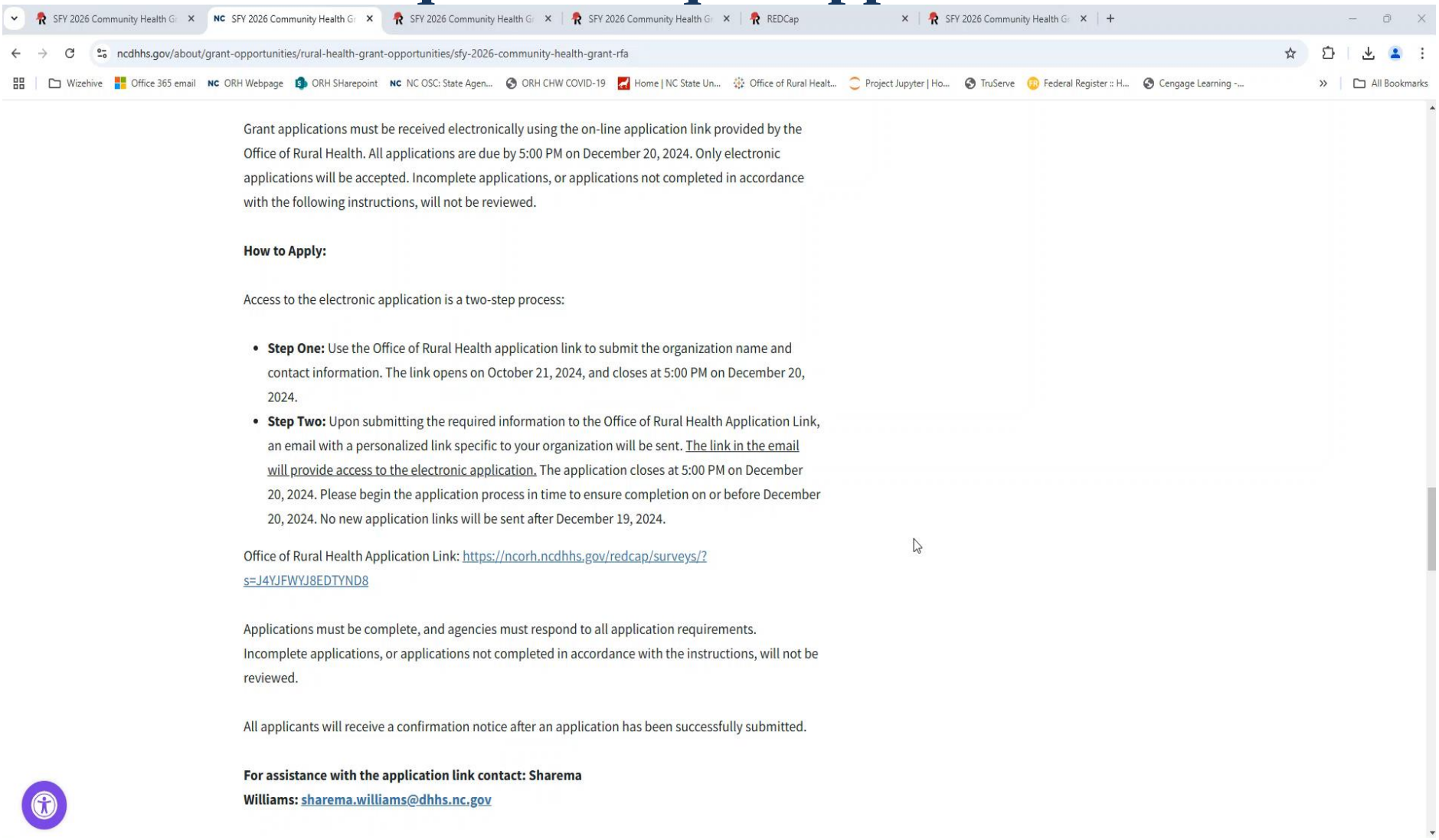
Request Unique Application Link

- Submit your organization name and contact information by December 19, 2024.
- https://ncorh.ncdhhs.gov/redcap/surveys/?s=FMM3PJCM84W88X7J

Application Deadline

- Submit application electronically using the link unique to your email address and organization **by 5:00 p.m. on December 20, 2024**.

How to Request Unique Application Link



Grant applications must be received electronically using the on-line application link provided by the Office of Rural Health. All applications are due by 5:00 PM on December 20, 2024. Only electronic applications will be accepted. Incomplete applications, or applications not completed in accordance with the following instructions, will not be reviewed.

How to Apply:

Access to the electronic application is a two-step process:

- **Step One:** Use the Office of Rural Health application link to submit the organization name and contact information. The link opens on October 21, 2024, and closes at 5:00 PM on December 20, 2024.
- **Step Two:** Upon submitting the required information to the Office of Rural Health Application Link, an email with a personalized link specific to your organization will be sent. The link in the email will provide access to the electronic application. The application closes at 5:00 PM on December 20, 2024. Please begin the application process in time to ensure completion on or before December 20, 2024. No new application links will be sent after December 19, 2024.

Office of Rural Health Application Link: https://ncorh.ncdhhs.gov/redcap/surveys/?s=J4YJFWYJ8EDTYND8

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 application link contact: Sharema Williams: sharema.williams@dhhs.nc.gov

Application Scoring

Application Areas to be Completed	Points
▪ Overview of Organization	5 Points
▪ Budget ▪ Track A ▪ Track B ▪ Provider Documents	15 Points
▪ Community Need and Patient Population	20 Points
▪ Project Description and Improved Access to Care	20 Points
▪ Collaboration and Community Engagement	20 Points
▪ Project Evaluation and Return on Investment	20 Points
	Total Points 100

Overview of Organization

5 Points

- A set of questions regarding hours your clinic is open, patient services, capacity, etc.

- Brief description of your organization and past year achievements

Budget – Track A
Reimbursement per encounter

10 Points

Upload document that demonstrates the organization's capacity to document patient encounter eligibility for the Primary Care Medical Access Program. Your documentation should include:
Organization Name,
Address,
Time Period,
Number of Uninsured/Underinsured Patients, and,
Number of Unduplicated Encounters

Include accurate calculations
# of encounters x $100 per encounter = $ [Total Amount of Grant Award]

REMINDER
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.**

Budget – Track B
Reimbursement for eligible expenses

10 Points

Proposed budget should align with the project

Include accurate calculations

Avoid line items for small amounts (makes it difficult for meaningful 15% adjustments)

Budget Template Guidance for Track B

Track B Budget Template is located on RFA website, along with the application

Please be sure to use current version of SFY26 Track B Budget Template

Template has specific instructions, including:

- Things not to include in your salary costs, such as bonuses of any kind.
- Fringe cannot exceed 30% of total line item for salary allocated to the grant.
- Fringe only includes employer paid benefits.
- Four tabs to complete
  - Personnel
  - Line-Item Budget
  - Budget Narrative
  - Subcontractors Budget, if applicable (New)

Budget - Provider Documents

5 Points

The following documents will be required from each applicant:

Governmental:

- **State Certifications** (*be sure to check a box for (3)(b)*)

Non-Governmental:

- **State Certifications** (*be sure to check a box for (3)(b)*)
- **Conflict of Interest Acknowledgement and Policy**
- **Conflict of Interest Verification**
- **IRS Tax Exemption**
- **State Grant Certification - No Overdue Tax Debts** (*Notarized*)

If your organization receives funding from **NC Farmworker Health Program, Rural Hospital Flexibility Program, Small Rural Hospital Improvement Program (SHIP),** you will also need to complete the **Federal Certifications**.

Community Need and Patient Population

20 Points

Describe the population served by this grant proposal and provide citations/references of data sources.

Describe how this project will align with the most recent Community Needs Assessment.

Patient Insurance Status in your Organization Table = Meaningful access to care for the uninsured or medically indigent population.

Describe how the organization plans to achieve the patient population goals with emphasis on care to uninsured and medically indigent patients.

Project Description and Improved Access to Care

20 Points

Describe the purpose of the grant request and how the grant funds will be used.

Include activities, timelines to implement grant activities, and anticipated outcomes.

Directly align with the community need and patient population described in the Community Need and Patient Population Section.

Describe the organization's arrangements for after-hours care.

Collaboration and Community Engagement

20 Points

Describe how the organization currently, or will, collaborate with community hospitals or other safety net organizations and provide a specific example.

Describe the 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.

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, does the proposal describe plans to increase services to underserved populations?

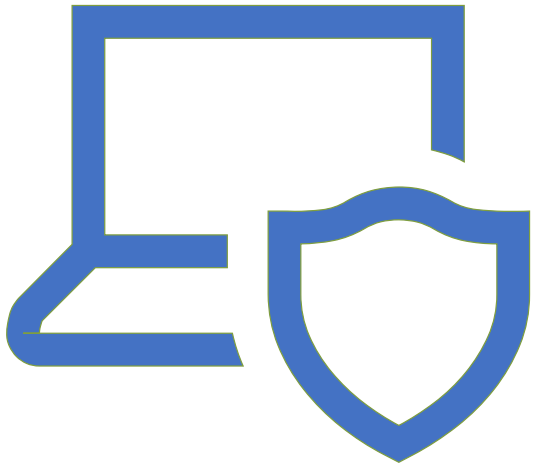
Project Evaluation and Return on Investment

20 Points

Include the organization's overall budget and explain why the project is a good use of State funds.

Include all required Program Performance Measure (PM) data.

Describe how the organization will use the mandatory PMs to improve patient health outcomes and identify potential factors that could negatively affect the PM targets and describe how these factors might be mitigated.



Performance Measures

Note:

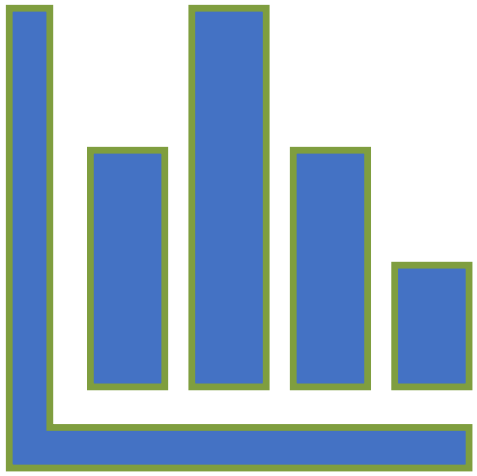
Our performance measures are based on measures in the Uniform Data System, a standardized reporting system that federally qualified health centers use to submit data.

Performance Measures

New SFY26

Applicants are asked to identify which patient population is being utilized when reporting patient insurance status, patient race/ethnicity tables, and quarterly performance data. For each, you will select one of the following options:

- **Sub-Population**: The reported data is 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. NOTE: grantees using the encounter-based reimbursement track (Track A) would only report from the pool of patients seen for those encounters.
- **One-Site Population**: The reported data includes only those patients seen at a specific site location.
- **Multi-Site Population**: The reported data includes patients from more than one site location within the health care organization.



Performance measures, cont'd.

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

Data Source: where will you obtain the information you report for your performance measures?

Collection Process and Calculation: what method will you use to collect the information?

Collection Frequency: how often will you collect the information? (We provide the answer to this!)

Data Limitations: what may prevent you from obtaining data for your performance measures?

Quarterly Performance Data Reporting

Quarters 1 and 3

- Patient Encounters
- Patients Served

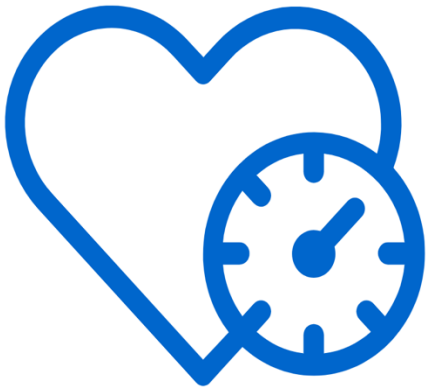
Quarters 2 and 4

- Patient Encounters
- Patients Served

- Diabetes
- Hypertension
- BMI
- Tobacco Cessation

- Behavioral Health
- School Based Health Center
- Maternal
- Dental

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. • Only include patients with an active diagnosis of Type 1 or Type 2 diabetes, even if their medical visits during the year were unrelated to the diagnosis. • Include patients in the numerator whose most recent HbA1c level is greater than 9.0%, for whom the most recent HbA1c result is missing, or for whom no HbA1c tests were performed or documented during the reporting period. • This measure is calculated using the numerator and denominator defined by UDS. This service cannot be conducted via telehealth.



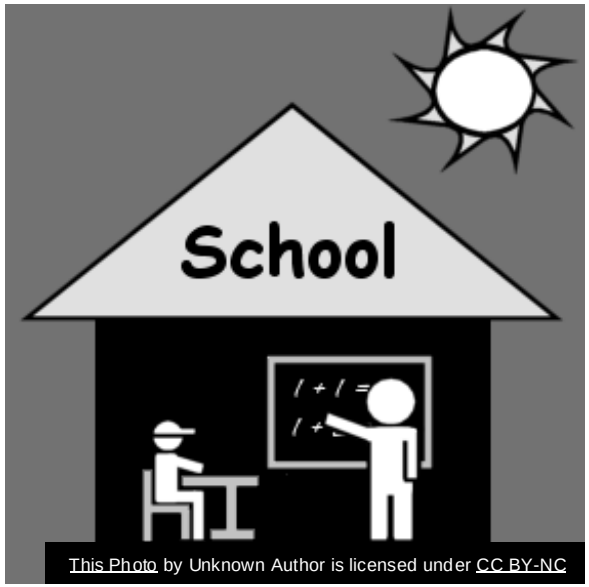
Measure Description	**Hypertension: Controlling High Blood Pressure** Percentage of patients 18-85 years old who had a diagnosis of hypertension (HTN) starting before and continuing into, or starting the first six months of the measurement period, and whose most recent Blood Pressure (BP) was adequately 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. • Include patients who have an active diagnosis of hypertension even if their medical visits during the year were unrelated to the diagnosis.

Measure Description	**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 medical record at the health center or in outside medical 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 if the 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. • Telehealth or telephone-only visits are excluded 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 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 reporting period ***and who*** received tobacco cessation intervention during the reporting period or in the 6 months prior to the reporting period if identified as a tobacco user
Guidance	• If patients use any type of tobacco, (i.e., smokes or uses smokeless tobacco), tobacco cessation intervention is expected (counseling and/or pharmacotherapy). • 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: 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 O 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 2024 UDS manual, pages 105-106.

Behavioral Health 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. 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: O Additional interventions designed to treat depression, such as behavioral health evaluation, psychotherapy, or additional treatment. O Referral to a provider for further evaluation for depression. O 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 compliant follow-up plan on the date of the visit is still required. • Screening may occur outside of a countable visit. • Documentation of a follow-up plan “on the date of the visit” can refer to any countable visit, NOT only a medical visit. • A suicide risk assessment DOES NOT qualify for the numerator as a follow-up plan. • DO NOT count patients who are re-screened as meeting the numerator criteria as a follow-up plan to a positive screen. • DO NOT count a PHQ-9 screening that follows a positive PHQ-2 screening during the measurement period as meeting the numerator criteria for a follow-up plan to a positive depression screening. • For more information review the 2024 UDS manual, pages 113-115.



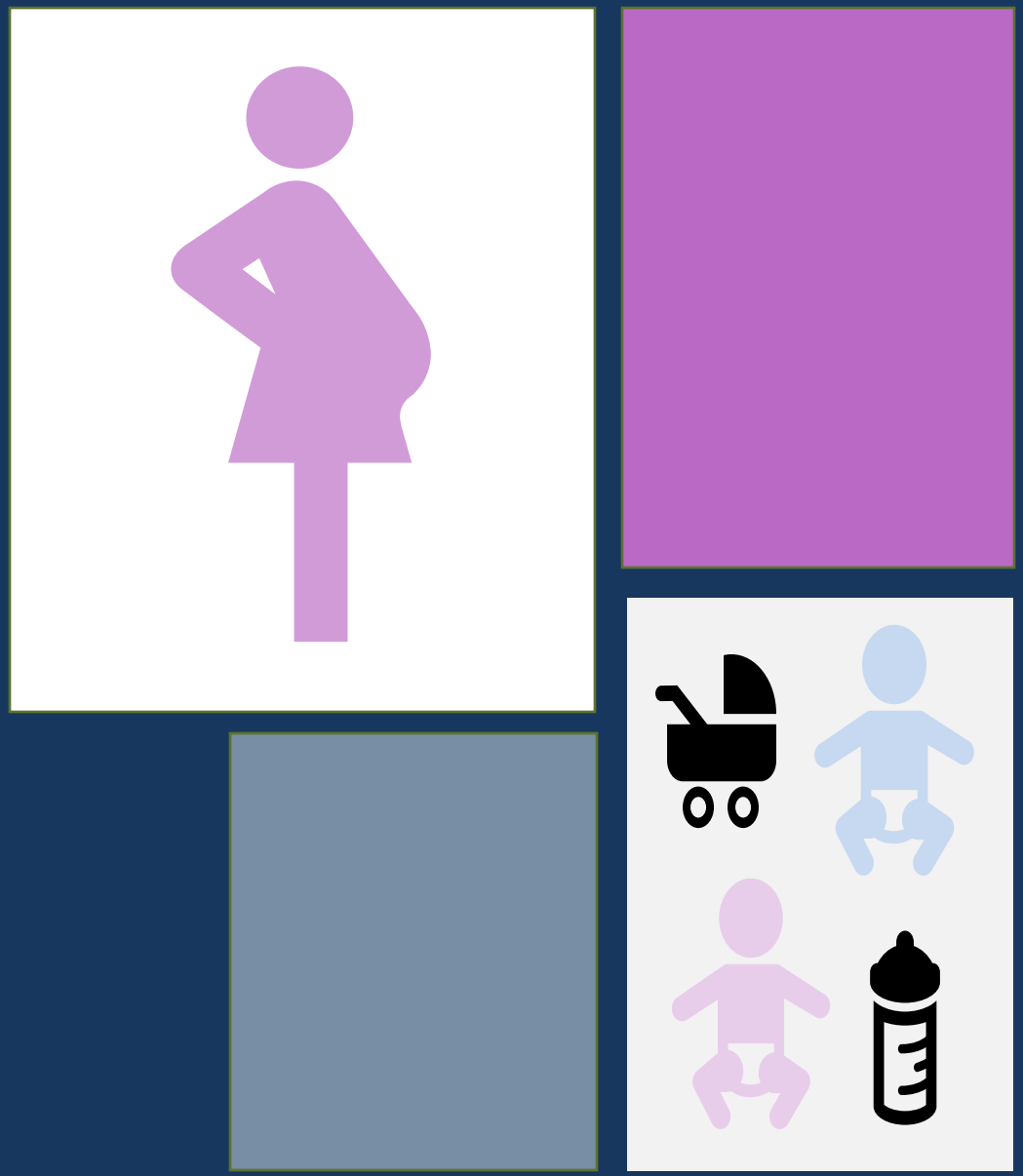
Performance Measures

School Based Health Center Applicants

Weight Assessment and Counseling for Nutrition and Physical Activity

Tobacco Use and Help with Quitting Among Adolescents

Screening for Clinical Depression and Follow-Up Plan



Performance Measures

Maternal Care Applicants

Percentage of prenatal care patients who entered prenatal care during their first trimester.

Performance Measures

Dental Clinic Applicants

Number of Encounters

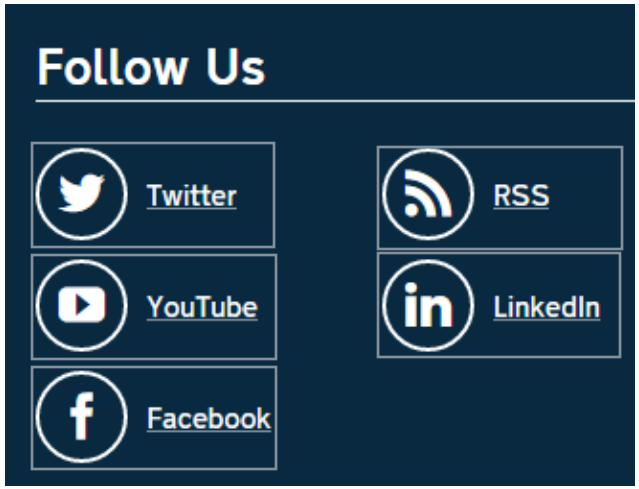
Number of Unduplicated Patients Served

Funding Agency Contact/Inquiry Information:
Nicole Fields-Pierre at nicole.fields-pierre@dhhs.nc.gov

For assistance with the application link:
Sharema Williams, sharema.williams@dhhs.nc.gov

North Carolina Department of Health and Human Services
https://www.ncdhhs.gov/

North Carolina Office of Rural Health
https://www.ncdhhs.gov/divisions/orh



Questions?
Please place all questions in the chat. We will be creating a FAQ document that will be added to the SFY26 CHG RFA webpage.