

**Healthy Georgia Initiative Health Systems Mini-Grants**

**Request for Applications (RFA)**

**Please complete this cover page. This document provides the Georgia Department of Public Health with an overview of your health system and the population served.**

Which grant is your organization applying for*?*

🞎 NQF 0018: Undiagnosed Hypertension Grant ($10,000) 🞎 NQF 0059: Diabetes Grant ($10,000)

Name of Health System/Hospital \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Manager/Practice Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Manager Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health System Leader or Champion (see page 7 in this RFA) – provide the name and email address of the person who will manage the Health Systems grant if awarded:

Champion Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Champion Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Average Annual Patient Census: \_\_\_\_\_\_\_\_\_

If a Hospital System, Total Population Residing in Catchment Area: \_\_\_\_\_\_\_\_\_\_

Number of Providers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of Staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Healthy Georgia Initiative Health Systems Mini-Grants**

**Purpose**

The Department of Public Health (DPH) with the support of funding from the Centers for Disease Control and Prevention (CDC) is issuing this Request for Applications to increase chronic disease initiatives regarding the management and control of hypertension and its risk factors; and to expand the implementation of quality improvement practices around cardiovascular health. DPH seeks to improve the reporting of blood pressure and diabetes measures by healthcare providers in accordance with National Quality Forum (NQF) measures 18 (Hypertension) and 59 (Diabetes) and increase the utilization of electronic health records in health systems. In addition, DPH aims to increase the institutionalization and monitoring of standardized quality measures for providers and health systems.

**Background**

The Georgia Department of Public Health (DPH) is the state agency with ultimate responsibility for the health of communities and Georgia’s population. At the state level, DPH manages more than 100 programs to protect and promote the public’s health. At the local level, DPH functions via [18 health districts and 159 county health departments](http://www.health.state.ga.us/regional/index.asp). DPH works to improve the quality of Georgians’ lives by promoting healthy lifestyles, creating environments that support health, and preventing chronic disease, disability, and premature death.

Hypertension is one of the leading causes of death in the State of Georgia. Hypertension is defined as having a systolic blood pressure of 140 or above or a diastolic blood pressure of 90 or above. One in five adults is diagnosed with hypertension, and one in three adults die from health complications related to cardiovascular diseases each year. Each year 136,000 years of potential life lost occur in Georgia due to cardiovascular diseases. Heart disease, stroke, cancer and diabetes are among the most prevalent, costly and preventable chronic diseases in Georgia. From 2009-2013 Georgia’s leading causes of death were chronic diseases of the heart with 79,083 deaths, followed by cancer with 77,740 deaths, then stroke with 18,055 deaths. With the prevalence of residents diagnosed with hypertension and diabetes an emphasis needs to be placed on systems of care and their prevention, diagnosis and treatment programs.

Hospital discharge rates and chronic disease mortality rates in Georgia concerning heart disease, stroke and diabetes are disproportionately high among the population. In some health districts mortality rates are above 200 per 100,000 for heart disease and above 40 for stroke. Hospital discharge rates for these chronic diseases in Savannah, Valdosta and Augusta were among the highest, with Savannah and Valdosta ranking among the top three in the state. Ultimately, these poor health conditions are an economic burden on the health system costing the state an estimated $6.1 billion in 2012. Quality improvement provides a solution to improving the quality of care and lowering costs of serving Georgia adults with hypertension and diabetes.

**Funding Opportunity Overview**

The Healthy Georgia Initiative at DPH will provide technical assistance and oversight for these programs. DPH will partner with health systems to implement and conduct the scope of work outlined below. The selected health systems will collaborate with provider practices to focus on the control of undiagnosed hypertension using self-management plans in their patient population.

Health systems may apply for either Component I or Component II below:

1. NQF 0018: Undiagnosed Hypertension Grant: The health system will partner with 4 provider practices to do the following:

1) Identify patients with undiagnosed hypertension:

Search an electronic medical record or clinical data system to identify patients not diagnosed with hypertension with two or more elevated blood pressures, and recall those patients using telephonic, written or email reminders to be rescreened for hypertension, and provide a report containing: a) an aggregate number of patients identified for recall based on the search of the records system; b) the percentage of those patients who return to be rescreened; and c) the total number of recalled patients diagnosed with hypertension, if available.

2) Use a Plan-Do-Study-Act (PDSA) approach to test at least three (3) changes in practice, policy, patient management, and/or patient education in an existing panel of patients to improve control over hypertension. Tests of change may include, but are not limited, to the following:

• Standardizing practice across all providers within a clinical setting to a single recognized algorithm or guideline for the control of hypertension (e.g., JNC guidelines);

• Adding provider reminders in an electronic medical records system to schedule referrals or follow-up appointments with patients with single elevated blood pressures;

• Providing patients with written or electronic blood pressure tracking tools to record blood pressures taken between appointments and in clinical settings, such as fire departments;

• Providing patients with home blood pressure monitors to facilitate self-monitoring of blood pressure between appointments;

• Standardizing patient education provided regarding hypertension and the risks of hypertension and medication adherence.

1. NQF 0059: Diabetes Grant: The health system will partner with 4 provider practices to do the following:

1) Identify patients with diabetes:

Search an electronic medical record or clinical data system to identify patients not diagnosed with diabetes having an A1C of 6.5% or higher, and recall those patients using telephonic, written or email reminders to be rescreened for diabetes, and provide a report containing: a) an aggregate number of patients identified for recall based on the search of the records system; b) the percentage of those patients who return to be rescreened; and c) the total number of recalled patients diagnosed with diabetes, if available.

2) Use a Plan-Do-Study-Act (PDSA) approach to test at least three (3) changes in practice, policy, patient management, and/or patient education in an existing panel of patients to improve control over diabetes. Tests of change may include, but are not limited, to the following:

• Standardizing practice across all providers within a clinical setting to a single recognized algorithm or guideline for the control of diabetes (e.g., ADA guidelines);

• Adding provider reminders in an electronic medical records system to schedule referrals or follow-up appointments with patients with a single A1C of 6.5% or higher;

• Providing patients with written or electronic blood glucose tracking tools to record blood glucose measurements taken between appointments and in clinical settings;

• Providing patients with a point of care test to facilitate self-monitoring of blood glucose between appointments;

• Standardizing patient education provided regarding diabetes and the risks of diabetes and medication adherence. (e.g., Diabetes Self-Management Education and Support Programs)

**Eligibility**

Any Georgia health system is eligible to apply. Health systems applying for funding through this grant opportunity must implement evidenced-based strategies and activities that advance policies and improve the health of Georgians through systems of care that support the adoption of healthy behaviors.

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| Health System Definition |
| For purposes of this grant Health Systems are defined as health care delivery organizations including: Health maintenance organizations (HMOs); Federally Qualified Health Centers (FQHCs); Rural Health Centers (RHCs); Health Plans; Health Center Controlled Networks (HCCNs); Independent Physician Associations (IPAs); Accountable Care Organizations (ACOs); Care Management Organizations (CMOs); a hospital system with large primary care systems; and other clinical groups operating within the state. In instances where the state government or local government is responsible for providing clinical care, these settings could be included. |

**Deliverables**

1. Complete a comprehensive health systems assessment questionnaire, which will be provided to the Health System by the Department 60 days from receipt of the assessment.
2. Send at least one person, ideally two, to attend the Hypertension and Diabetes Symposiums in Atlanta, Georgia on June 23, 2016 and June 24, 2016 (tentative dates) and participate in ongoing follow-up technical assistance to carry out quality improvement activities related to either component I or component II below.
3. The Health System will provide a detailed report to DPH on the 15th business day during the first and last month of the award period on the following:

Component I: NQF 0018: Undiagnosed Hypertension Grant

1. Provide a report containing:
   1. an aggregate number of patients identified for recall based on the search of the records system;
   2. the percentage of those patients who return to be rescreened; and
   3. the total number of rescreened patients diagnosed with hypertension, if available;
2. Using a reporting template provided by the DPH, a brief description of each test of change and dates each change was implemented and suspended, if applicable;
3. The total number of practices that have EHRs appropriate for treating patients with high blood pressure;
4. The total number of practices in the system that have EHRs appropriate for treating patients with diabetes;
5. The total number of practices in the system that report on NQF measure 18;
6. The total number of practices in the system that report on NQF measure 59;
7. The total number of patients enrolled in each practice;
8. The total number of patients with high blood pressure in adherence to medication regimens;
9. The total number of patients with diabetes in adherence to medication regimens;
10. The total number of patients with high blood pressure that have a self-management plan;
11. The total number of patients with known high blood pressure who have achieved blood pressure control;
12. The total number of patients with diabetes having an A1C greater than 6.5;
13. The total number of practices in the system with policies or systems to encourage a multi-disciplinary team approach to blood pressure control;
14. The total number of patients that are in health care systems that have policies or systems to encourage a multi-disciplinary approach to blood pressure control;
15. The total number of practices in the system with policies or systems to encourage a multi-disciplinary team approach to A1C control;
16. The total number of patients that are in health care systems that have policies or systems to encourage a multi-disciplinary approach to A1C control;

OR

Component II: NQF 0059: Diabetes Grant

1. Provide a report containing:
   1. an aggregate number of patients identified for recall based on the search of the records system;
   2. the percentage of those patients who return to be rescreened; and
   3. the total number of rescreened patients diagnosed with diabetes, if available;
2. Using a reporting template provided by the DPH, a brief description of each test of change and dates each change was implemented and suspended, if applicable;
3. The total number of practices in the system that have EHRs appropriate for treating patients with high blood pressure;
4. The total number of practices in the system that have EHRs appropriate for treating patients with diabetes;
5. The total number of practices in the system that report on NQF measure 18;
6. The total number of practices in the system that report on NQF measure 59;
7. The total number of patients enrolled in each practice;
8. The total number of patients with high blood pressure in adherence to medication regimens;
9. The total number of patients with diabetes in adherence to medication regimens;
10. The total number of patients with high blood pressure that have a self-management plan;
11. The total number of patients with known high blood pressure who have achieved blood pressure control;
12. The total number of patients with diabetes having an A1C greater than 6.5;
13. The total number of practices in the system with policies or systems to encourage a multi-disciplinary team approach to blood pressure control;
14. The total number of patients that are in health care systems that have policies or systems to encourage a multi-disciplinary approach to blood pressure control;
15. The total number of practices in the system with policies or systems to encourage a multi-disciplinary team approach to A1C control;
16. The total number of patients that are in health care systems that have policies or systems to encourage a multi-disciplinary approach to A1C control;

**Award Information**

**Funding Agency**: Funding for this project is provided by the Georgia Department of Public Health under funding from the Centers for Disease Control Cooperative Agreement Number 6 NU58DP004801-03-03.

**Funding:** Mini-grants will be awarded in the amount of $10,000 each for Component I and/or Component II. Grant funding will be provided to the selected health systems upon receipt of all DPH required financial forms. These forms include a State of Georgia Vendor Management form as well as other documentation required by DPH Financial Services (see Financial Overview section). Grantees are required to participate in an initial technical assistance call along with their Health System financial representative if awarded. Health systems must agree to be the primary fiscal agent for funds awarded through this grant opportunity.

The funds may be used for:

* Giving or receiving technical assistance on quality improvement practices
* Billing specialist, including contracting with an outside agency to provide training on PDSAs
* Cost associated with travel, participant transportation or increasing provider referrals
* Administrative work to complete program deliverables
* Supplies for DSME programs such as instructors’ kits
* Educational materials for hypertension and diabetes patients
* Salaries and other costs of a person to assist programs with data collection quality and reporting National Quality Forum and Physician Quality Reporting System measures
* Costs associated with meetings or trainings to provide education on reimbursement requirements from different sources, or on quality improvement
* Marketing strategies for programs and initiatives related to the grant work

The funds may **not** be used for:

* No direct services: no salaries, stipends, or other funding for individuals to teach undiagnosed hypertension or diabetes methodology
* Equipment
* No participant incentives such as t-shirts, water bottles, etc.
* Food or beverages
* Capital construction

**Number of Awards**: The exact number of awardees will depend upon the number of applications received.

***Application Due Date****:* Friday, April 29, 2016

***Anticipated Award Date***: Friday, May 13, 2016

***Performance Period***: May 23, 2016 – September 16, 2016 *tentative*

**How to Apply**

Applications should be submitted by 5:00PM on April 29, 2016.

Applications should be submitted to [chronic.disease@dph.ga.gov](mailto:chronic.disease@dph.ga.gov)

Applications will be reviewed and awarded based on the detail, descriptiveness and completion of the elements in the application, listed below. Applications should not exceed three single-spaced pages (excluding the cover page and budget template). Applications should follow the outline as described below in the “Funding Requirements”.

**Funding Requirements:**

1. **Request for Applications Cover Page**

Submit a completed Request for Applications Cover Page.

1. **Proposal**

**Provide a concise proposal of the health system’s plan to implement the health system improvement initiatives**. The proposal should not exceed three single-spaced pages (excluding the cover page and budget template) and should be in 12-point font. The proposal should include the identification of a Health System Leader or Champion. This individual is responsible for guiding the completion of the hypertension initiatives, and development of the monthly and final reports. Applicants should describe this person’s qualifications for serving as the Health System Leader or Champion. The proposal must also contain your plan on reporting the following de-identified information to DPH: (1) The number of practices in the system that have EHRs appropriate for treating patients with high blood pressure; (2) The number of practices in the system that have EHRs appropriate for treating patients with diabetes; (3) The number of practices in the system that report on NQF measure 18;( 4) The number of practices in the system that report on NQF measure 59; (5) The number of patients enrolled in each practice; (6) The number of patients with high blood pressure in adherence to medication regimens; (7) The number of patients with diabetes in adherence to medication regimens; (8) The number of patients with high blood pressure that have a self-management plan;( 9) The number of patients with known high blood pressure who have achieved blood pressure control (calculated using the definition of NQF 18); (10) The number of patients with diabetes having an A1C greater than 6; and (11) a brief description of each test of change and date each change was implemented and suspended, if applicable. In addition, a timeline detailing your health system’s plan to complete the Georgia Health Systems Assessment within the defined time period must be provided. Please also include if your Health System reports on Uniform Data System (UDS) or if you are ONC certified.

1. **Financial Overview**
   1. **W-9 Form**

Complete the W-9 Taxpayer Identification Form and submit it with the proposal.



* 1. **Vendor Management Form**

Complete the Vendor Management Form and submit it with the proposal.



* 1. **Budget**

Submit a detailed budget and budget justification providing a descriptive and complete narrative on how funds will be expensed.

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| **Health Systems**  **Mini-Grants Budget Template** | | |
| **Name of Health System: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| 🞎 **NQF 0018**: Undiagnosed Hypertension Grant ($10,000) 🞎 **NQF 0059**: Diabetes Grant ($10,000) | | |
| **Item** | **Amount** | **Justification** |
| * SALARIES and WAGES | | |
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| * CONSULTING COSTS | | |
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| * OTHER | | |
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| **TOTAL** |  |  |

Additional information related to the application and/or technical assistance regarding this request for application may be obtained by contacting:

Brittany D. Taylor, MPH

Cardiovascular Health Program Manager

Attn: Healthy Georgia Initiative Health Systems Mini-Grants

Georgia Department of Public Health

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