State of Arkansas
ARKANSAS DEPARTMENT OF HEALTH
4815 West Markham St
Little Rock, Arkansas 72205

# APPLICATION PACKET
# DH-21-0014

***Purpose of Sub-Grant:***
The Arkansas Department of Health (ADH) issues this Notice of Funds Availability (NOFA) on behalf of the Chronic Disease Prevention and Control Branch to obtain applications for funding primary care practices to participate in the Arkansas Clinical Transformation program. This program offers quality improvement and clinic redesign training to primary care practice teams to improve the management of patients with chronic diseases.

**NOTE: Word version of Application Packet available upon request.**

# APPLICATION SIGNATURE PAGE

*Type or print the following information.*

| APPLICANT'S INFORMATION | | | | | |
|---|---|---|---|---|---|
| Company: | | | | | |
| Address: | | | | | |
| City: | | State: | | Zip Code: | |
| Business Designation: | ☐ Individual<br>☐ Partnership | ☐ Sole Proprietorship<br>☐ Corporation | | ☐ Public Service Corp<br>☐ Nonprofit<br>☐ Intergovernmental | |
| Minority and Women-Owned Designation*: | ☐ Not Applicable<br>☐ African American | ☐ American Indian<br>☐ Hispanic American | ☐ Asian American<br>☐ Pacific Islander American | ☐ Service Disabled Veteran<br>☐ Women-Owned | |
| | AR Certification #: ______________________ | | * See *Minority and Women-Owned Business Policy* | | |

| APPLICANT CONTACT INFORMATION<br>*Provide contact information to be used for bid solicitation related matters.* | | | |
|---|---|---|---|
| Contact Person: | | Title: | |
| Phone: | | Alternate Phone: | |
| Email: | | | |

| ILLEGAL IMMIGRANT CONFIRMATION |
|---|
| By signing and submitting a response to this s*olicitation*, the applicant agrees and certifies that they do not employ or contract with illegal immigrants. If selected, the recipient certifies that they will not employ or contract with illegal immigrants during the aggregate term of a contract. |

| ISRAEL BOYCOTT RESTRICTION CONFIRMATION |
|---|
| By signing and submitting a response to this solicitation, the applicant agrees and certifies that they do not boycott Israel, and if selected, will not boycott Israel during the aggregate term of the contract. |
| Geographical Coverage Area: Indicate geographical coverage area as either statewide or by individual counties, alphabetically.<br>______________________________________________<br>______________________________________________<br>______________________________________________<br>______________________________________________ |

***An official authorized to bind the prospective recipient to a resultant contract shall sign below.***

By signing and submitting a response to this Notice of Funds Availability (NOFA), the applicant agrees to comply with all requirements, and that any exception that conflicts with a requirement of this RFA will cause the application to be disqualified.

**Authorized Signature:**______________________________ **Title:** ______________________
*Use Ink Only*

**Printed/Typed Name:**______________________________ **Date:** ______________________

# Agreement and Compliance

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal sub-grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, sub-grant, loan, or cooperative agreement.

2. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this Federal contract, sub-grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, “Disclosure of Lobbying Activities,” attached hereto, in accordance with its instructions. This disclosure form must be filed with the Arkansas Department of Health (ADH) at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affects the accuracy of the information contained in any disclosure form previously filed. An event that materially affects the accuracy of the information reported includes:

   a. A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action; or,

   b. A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or,

   c. A change in the officer(s), employee(s), or member(s) contracted to influence or attempt to influence a covered federal action.

3. The undersigned shall require that the language of this certification be included in the award documents for all sub awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

By signature below, vendor agrees to and **shall** fully comply with all Requirements as shown in this section.

**Authorized Signature:** ______________________________________
*Use Ink Only*

**Printed/Typed Name:**________________________________________**Date:** ______________________________

**INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES**

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, State and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks “Subawardee,” then enter the full name, address, city, State and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 (e.g., Request for Proposal (RFP) number; Invitations for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Included prefixes, e.g., “RFP-DE-90-001.”

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, State and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

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According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB control Number. The valid OMB control number for this information collection is OMB No. 0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503

Approved by OMB
0348-0046

# Disclosure of Lobbying Activities

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

<table>
<tr><td>1. Type of Federal Action:<br>a. contract<br>____ b. grant<br>c. cooperative agreement<br>d. loan<br>e. loan guarantee<br>f. loan insurance</td><td>2. Status of Federal Action:<br>a. bid/offer/application<br>_____ b. initial award<br>c. post-award</td><td>3. Report Type:<br>a. initial filing<br>_____ b. material change<br><br>For material change only:<br>Year _______ quarter _______<br>Date of last report __________</td></tr>
<tr><td colspan="2">4. Name and Address of Reporting Entity:<br>____ Prime _____ Subawardee<br>Tier______, if Known:<br><br>Congressional District, if known:</td><td>5. If Reporting Entity in No. 4 is Subawardee,<br>Enter Name and Address of Prime:<br><br>Congressional District, if known:</td></tr>
<tr><td colspan="2">6. Federal Department/Agency:</td><td>7. Federal Program Name/Description:<br><br>CFDA Number, if applicable: ___________</td></tr>
<tr><td colspan="2">8. Federal Action Number, if known:</td><td>9. Award Amount, if known:<br>$</td></tr>
<tr><td colspan="2">10. a. Name and Address of Lobbying Registrant<br>(if individual, last name, first name, MI):</td><td>b. Individuals Performing Services (including address if different from No. 10a)<br>(last name, first name, MI):</td></tr>
<tr><td colspan="2">11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.</td><td>Signature: ______________________________<br><br>Print Name: _____<br><br>Title: _____<br><br>Telephone No.: ___________ Date: _______</td></tr>
<tr><td colspan="2">Federal Use Only</td><td>Authorized for Local Reproduction<br>Standard Form - LLL (Rev. 7-97)</td></tr>
</table>

# PROPOSED SUBCONTRACTORS FORM

- ***Do not*** *include additional information relating to subcontractors on this form or as an attachment to this form.*

**PROSPECTIVE CONTRACTOR PROPOSES TO USE THE FOLLOWING SUBCONTRACTOR(S) TO PROVIDE SERVICES.**

*Type or Print the following information*

| Subcontractor’s Company Name | Street Address | City, State, ZIP |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

☐ **PROSPECTIVE CONTRACTOR DOES NOT PROPOSE TO USE SUBCONTRACTORS TO PERFORM SERVICES.**

# RESTRICTION OF BOYCOTT OF ISRAEL CERTIFICATION

Pursuant to Arkansas Code Annotated § 25-1-503, a public entity **shall not** enter into a contract valued at $1,000 or greater with a company unless the contract includes a written certification that the person or company is not currently engaged in, and agrees for the duration of the contract not to engage in, a boycott of Israel.

By signing below, the Contractor agrees and certifies that they do not currently boycott Israel and will not boycott Israel during any time in which they are entering into, or while in contract, with any public entity as defined in § 25-1-503* If at any time after signing this certification the contractor decides to engage in a boycott of Israel, the contractor must notify the contracting public entity in writing.

If a company does boycott Israel, see Arkansas Code Annotated § 25-1-503.

| Name of public entity | Arkansas Department of Health NOFA DH-21-0014 |
|---|---|
| AASIS Vendor Number | |
| Contractor/Vendor name | |

Contractor Signature:____________________________________ Date: ____________________

Signature must be hand written, in ink

"Public Entity" means the State of Arkansas, or a political subdivision of the state, including all boards, commissions, agencies, institutions, authorities, and bodies politic and corporate of the state, created by or in accordance with state law or regulations, and does include colleges, universities, a statewide public employee retirement system, and institutions in Arkansas as well as units of local and municipal government.

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## APPENDIX A

**Arkansas Department of Health DH-21-0014**
**Arkansas Clinical Transformation (ACT) Program**
**Notice of Funds Availability 2021-2023: Application Page**

| | |
|---|---|
| 1. Practice Name: ____________<br>Address: ____________<br>City/State/Zip Code: ____________<br>Phone: ____________<br>County: ____________<br>Tax ID: ____________ | For Internal Use by ACT Staff Only<br><br>Application No.<br><br>Funding Year(s): |

2. Practice Team Leader: ____________
Address: ____________
City/State/Zip Code: ____________
Phone: ____________
Contact Email Address: ____________
Financial Manager: ____________
Address: ____________
City/State/Zip Code: ____________
Phone: ____________
Contact Email Address: ____________

3. Type of Applicant (Select One):
   - Private Practice
   - Hospital-Based Clinic
   - Federally Qualified Health Center/Community Health Center
   - Arkansas Area Health Education Center

4. Budget Amount Requested: FY22 $ ____________
Budget Amount Requested: FY23 $ ____________

5. Certification of the Authorized Official

To the best of my knowledge and belief, all information contained in this application is true and correct, and the governing body has authorized submission. I understand that if the application is found to contain significant misinformation or deviates significantly from the ACT application process, this application will be automatically eliminated from further consideration for funding.

Signature: ____________ Title: ____________ Date: ____________

**APPENDIX B**

# CLINIC ASSESSMENT

## A. Organizational Capacity

1. Is your clinic based in Arkansas?
   **Yes No**

2. Does your clinic have other organizational affiliations?
   **Yes No**

   **If Yes, name the organization(s).**

3. If awarded funding, will your clinic team show accountability by regularly attending ACT Learning Sessions, implement necessary quality improvement (QI) strategies, ensure performance measurement and monitoring, and report relevant de-identified data to ADH?
   **Yes No**

4. If awarded funding, will your clinic team responsibly use funds as indicated and show evidence of accountability to the ADH for the funding as stipulated in this NOFA?
   **Yes No**

5. What is the current number of adult patients (18+ years) in your provider patient panel(s)?

## B. Methodology

1. How does your clinic ensure best practices for the delivery of chronic disease patient care?

2. a) Name the electronic health record (EHR) system used at your clinic.

   b) Does your clinic have the capability to collect and report EHR data for the ACT program?
   **Yes No**

3. How will your clinic team ensure ACT program deliverables for Learning Session attendance, implementation of QI strategies, performance measurement, and reporting of relevant de-identified data for the ACT program?

4. What mechanisms will be used to ensure accountability to ADH for ACT program funding?

5. Will your clinic ensure team participation and commitment for both the Intensive and Enhanced phases of the ACT program?
   **Yes** **No**

## C. <u>Data and Performance</u>

Please enter de-identified and aggregated numerators, denominators, and percentages for the following core clinical measures from your EHR for the total number of adult patients seen by your clinic's provider(s) from January 1, 2020-December 31, 2020.

| Measure Name (ID) | Numerator | Denominator | Percentage |
|---|---|---|---|
| Hypertension: Controlling High Blood Pressure BP < 140/90 mmHg (NQF: 0018, Quality ID: 236) | | | |
| Hypercholesterolemia: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (NQF: 0018, Quality ID: 438) | | | |
| Diabetes Mellitus: Hemoglobin A1c Poor Control (NQF: 0059, Quality ID: 1) | | | |

## APPENDIX C

## Sample Budget

| Activity and Completion Criteria | Required Activities | Amount Requested |
|---|---|---|
| Identify clinic population of focus for quality improvement (QI) strategies, collect appropriate measures to establish baseline data and monthly data submissions. (Additional information will be provided in the ACT Program Guide prior to Learning Session 1.)<br><br>**Measures of Completion:**<br>• Patient registries in place<br>• Baseline measures by Learning Session 1 and improvements in monthly trends<br>• Monthly narratives reflective of clinic changes<br><br>**Itemized Estimated Reimbursement for Activity Completion:**<br>Total reimbursable hours = 80 hours<br>• Develop EMR patient registries for hypertension and diabetes through EHR queries (15%) = 12 hours<br>• EHR adaptation for CPOE, alerts, structured and additional fields, use of interfaces, etc. (10%) = 8 hours<br>• Staff QI training time (30%) = 24 hours<br>• Clinical QI through clinic workflows and policies, PDSAs, checklists, etc. (15%) = 12 hours | • Develop EMR patient registries for hypertension and diabetes through EMR queries<br>• EMR adaptation for CPOE, alerts, structured and additional fields, use of interfaces etc.<br>• Staff QI training time<br>• Clinical QI through clinic workflows and policies, PDSAs, checklists etc.<br>• Monthly data review, collection in provided tool and reporting to show improved performance for CVD, diabetes, and preventive screening measures<br>• Monthly narrative reporting to show changes in strategies for clinic transformation | Data Entry and Abstraction and Narrative reporting = Clinic/IT Staff $35.00/hour x 80 total hours = $2,800.00<br><br>**Total = $2,800.00** |
| Electronic Health Records (EHR) Modifications<br><br>To add dashboard electronic quality measures to meet ACT performance measures and data reporting requirements | | **Total = $3,000.00** |
| Attendance and participation in all Learning Sessions<br><br>**Measure of Completion:**<br>Three or more members on-site during each Learning Session | • Mileage ($0.42 per mile)<br>• Lodging ($108.00 per night)<br>• Meals (only those not provided; current per diem rates are $13.00 breakfast, $14.00 lunch, $23.00 dinner) | 400 miles x $0.42/mile = $168.00 x 4 employees = $672.00 x 5 trips = **3,360.00**<br><br>Hotel = $108.00 x 5 nights = $540.00 x 4 employees = **$2,160.00**<br><br>Meals = $23.00 dinner x 2 meals per trip x 5 trips = $230.00 x 4 employees = **$920.00**<br><br>**Total = $6,440.00** |
| Staff replacement time while teams are attending Learning Sessions, team calls and webinars<br><br>**Measures of Completion:**<br>• Report of staff replacement hours<br>• Webinar participation and attendance<br>• Copy contract/invoice with fees paid to replace staff<br><br>**Itemized Estimated Reimbursement for Activity Completion**<br>Staff reimbursement =<br>• 5 Learning Sessions @ 8 hours each = 40 hours<br>• 5 Webinars/Conference Calls @ 1 hour each = 5 hours | • Staff replacement time<br>• Extra shifts<br><br>**Note:** Lost productivity is not reimbursable through this program. | Employee 1: Office Manager = $35.00/hour x 45 hours = $1,575.00<br><br>Employee 2: LPN = $30.00/hour x 45 hours = $1,350.00<br><br>Employee 3: Team Leader = $45.00/hour x 45 hours = $2,025.00<br><br>**Total = $4,950.00** |
| **Total Amount Requested** | | **$17,190.00** |

## APPENDIX D

### Physician Office Assessment of Readiness to Change Clinic Practices

| Current Clinic Practices | Yes | No | Comment |
|---|---|---|---|
| 1. Does your practice have one or more committed physicians who would like to change practice processes for improvement? | | | |
| 2. Does each provider in your practice have?<br>a) An assigned panel of patients?<br>b) A shared panel of patients? | | | |
| 3. Does your practice have an EMR/EHR that supports disease registries for hyper-tension, cardiovascular disease, diabetes, and chronic disease preventive screening? | | | |
| 4. Does your practice report population data for DM/CVD/Adult Prevention? | | | |
| 5. Does your practice have at least one medical assistant for every two providers? If No, what is your current ratio of medical assistants to providers? | | | |
| 6. Does your practice determine the risk status of every patient? | | | |
| 7. Does your clinic team assure timely follow-up of high-risk patients? | | | |
| 8. Does your practice integrate Quality Improvement into the practice including data review and use of improvement strategies? | | | |
| 9. Does your practice support patients in lifestyle improvement using behavioral strategies such as patient goal setting? | | | |
| 10. Does your clinic team reference and use chronic disease and prevention guidelines/ recommendations for patient care at every visit? | | | |
| 11. Does your practice have a managed care contract in place for data improvement? If No, how do you work to improve clinic data? | | | |

**Physician Office Assessment of Readiness to Change Clinic Processes (Continued)**

| | | | |
|---|---|---|---|
| 12. Do your providers assign work to various team members for coordinated clinic processes and increased efficiency and effectiveness? | | | |
| 13. Does your practice identify the sickest, highest-risk patients and have mechanisms in place to reduce ER visits and/or hospitalizations? | | | |
| 14. Does your practice have NCQA - PCMH recognition? If yes, what year? | | | |
| 15. Does your clinic team/physician receive information from the hospital/ER when a patient has been admitted or discharged? | | | |
| 16. Does your practice use HEDIS measures to assess performance? If yes, what average percentile does your practice aim to achieve? | | | |
| 17. Which of the capabilities listed in questions 1-14 do you see as areas for improvement in your current clinic practice? | | | |
| 18. We would like to help your clinic team improve your current clinic practices to be most effective. Please list other areas of clinic process changes not listed above that you would like to see in your current practice. | | | |