FUNDED

A GRANTS OFFICE PUBLICATION

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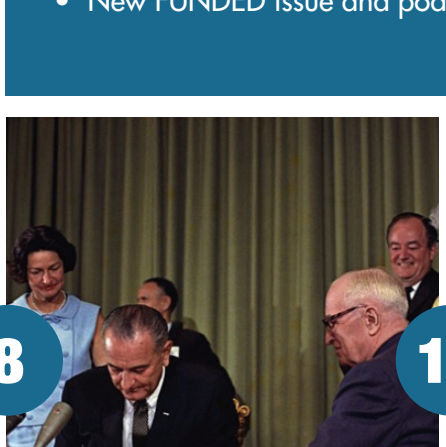

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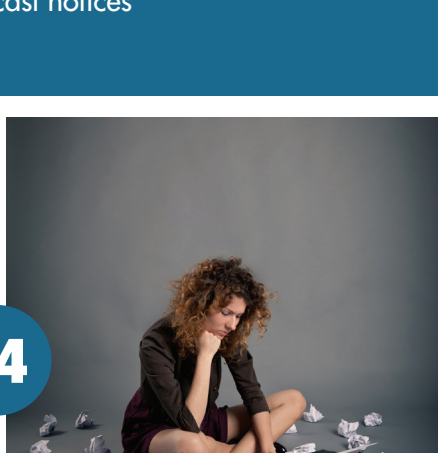

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ON THE COVER

The widespread adoption of electronic health records in the healthcare environment is just one example of how healthcare innovation is being driven by public policy. Financial incentives for providers who adopted the technology early and penalties for those that lagged behind are probably the two most obvious levers the federal government has used, but competitive grants to encourage the better management and cross-provider sharing of patient data also played a significant role in defining and enabling health information technology across the provider landscape.

FROM THE EDITOR

Dear Readers,

This month's issue of FUNDED takes a look at several ways funding encourages innovation, and a couple of ways it punishes intransigence. Chris LaPage takes us on a deep dive into the evolving healthcare landscape and the impact of emerging priorities and government policies on funding. Everyone from healthcare providers and payors to the general public are being asked to do more with less, and the call for innovation has never been more urgent.

Of course, funding is both a follower and a driver of these trends. The Affordable Care Act (ACA), with its built-in incentives and penalties, takes a carrot and stick approach to facilitating the evolution of healthcare across the country, and the impact of its many interventions is still unclear.

More than just healthcare funding, too, is what we can learn from ACA experience about the potential of well-funded public policy to impact any established domain to meet the needs of a changing population, or just to better align with the political philosophies of those who have been elected to lead.

And speaking of leading, the best-administered Homeland Security Grant in the country, the Assistance to Firefighters Grant Program, is open, and although the application period is short, it provides a significant opportunity for fire departments, that are often one of the last in line for larger statewide homeland security funding, to acquire and upgrade their equipment, training, and vehicles, and perhaps do a little innovating of their own.

Matt Hawkes also provides some insight into the Corporation for National and Community Service's Social Innovation Fund, including an analysis of CNCS's own brand of encouraging innovation by partnering with local and regional foundation grantmakers.

We're always happy to receive your feedback to help us improve future issues, so feel free to e-mail me at mpaddock@grantsoffice.com with your reactions and suggestions.

I hope you enjoy this issue of FUNDED as much as we've enjoyed bringing it to you!

Sincerely,

Michael Paddock
Editor and Publisher, *FUNDED*

ASSISTANCE TO FIREFIGHTERS GRANTS (AFG)

SUMMARY: The purpose of AFG is to enhance through financial assistance the safety of the public and firefighters regarding fire and fire-related hazards. The objective of the AFG is to award grants directly to fire departments and EMS organizations that are unaffiliated with a hospital to enhance their ability to protect the health and safety of the public, as well as that of first-responder personnel.

In 2013 there are three types of eligible applications:

1. Operations and safety - The five fundable activities included in this program are: (a) firefighter training, (b) firefighter equipment, (c) firefighter personal protective equipment (PPE), (d) firefighter wellness and fitness, (e) modifications to fire stations and facilities.

2. Vehicles - Due to inherent differences among urban, suburban, and rural firefighting needs, AFG has different priorities in the Firefighting Vehicles program area for departments that serve different types of communities. When requesting more than one vehicle, you will be asked to fill out a separate line item and answer all the questions including a NEW narrative for each vehicle. For example, if you are requesting to replace three ambulances, you must fill out the age and vehicle identification number (VIN) of each vehicle being replaced. You cannot use the same VIN in each line item. AFG provides grants for new, used, and refurbished vehicles. Funds may be used to refurbish a vehicle the department currently owns, but it will be eligible only if the vehicle was designed originally for firefighting. Refurbished vehicles must meet current NFPA 1912 standards.

3. Any eligible fire department or a non-affiliated EMS organization may act as a “host” applicant and apply for large-scale projects on behalf of itself and any number of other local AFG eligible organizations that will be participating partners in the award. Joint/Regional projects should achieve greater cost effectiveness and regional efficiency and resilience. If an applicant wishes to submit a Joint/Regional application, they should select the “Regional” radio button when filling out the application. For the purpose of this document and the AFG Application, the term “Regional” will serve the same meaning as “Joint/Regional.”

A full list of eligible expenditures for each project type is available in this programs guidance.

DEADLINE: The deadline to submit an application is December 6, 2013.

ELIGIBILITY: Only fire departments and nonaffiliated EMS organizations are eligible to apply for funding. Organizations must operate in one of the 50 States, the District of Columbia, the Commonwealth of the Northern Mariana Islands, Virgin Islands, Guam, American Samoa, or Puerto Rico.

AWARD AMOUNTS: The estimated available funding is $285,828,075. This program has a 12 month period of performance from the date funds are awarded. In general, an eligible applicant seeking a grant to carry out an activity shall agree to make available non-federal funds to carry out such activity in an amount equal to and not less than 15 percent of the grant awarded, except for entities serving small communities:

1. When serving a jurisdiction more than 20,000 residents, but not more than 1,000,000 residents, the applicant shall agree to make available non-federal funds in an amount equal to and not less than 10 percent of the grant awarded.

2. When serving a jurisdiction of 20,000 residents or fewer, the applicant shall agree to make available non-federal funds in an amount equal to and not less than 5 percent of the grant awarded

FOR MORE INFORMATION SEE: http://www.fema.gov/welcome-assistance-firefighters-grant-program

CNCS SOCIAL INNOVATION FUND: TAKING IT LOCAL

by Matthew Hawkes

"Innovation" has been a popular tagline among government programs and has increasingly become shorthand for programs seeking public-private partnerships that can effectively cut costs. Cost-cutting, of course, is a major goal for policy makers, but there is an element in economic downturns which seems to sharpen funders' focus on initiatives that do more for less. The Social Innovation Fund (SIF), administered by the Corporation for National and Community Service (CNCS) is the flagship program for public-private partnerships in the non-profit sector, leveraging local resources and knowledge to solve social problems.

The SIF is intended to help nonprofits expand and replicate effective community based initiatives. The keystone of the program is the funding of the intermediary foundations that are deemed by the SIF to be experienced grant makers and therefore presumably are well positioned to indentify the most high-impact nonprofit community organizations as grantees. These intermediaries must match federal dollars on a 1:1 basis when they receive the funding and their subgrantees are also required to match the funds they receive from other non-federal sources, thus generating $3 in program support for every $1 in federal funding. Community organizations are competitively selected for subgrants by SIF intermediaries based on rigorous evaluation of evidence for compelling impact, and intermediaries are in turn evaluated based on their selection of grantees. This process is certainly consistent with the SIF mission statement: "By fostering private and public collaborations that identify, evaluate, and expand promising nonprofits, the SIF increases access to effective programs that enable people and communities in need to overcome their most pressing challenges in the program priority areas of economic opportunity, youth development, and health."

The fund follows the trend of funding evidence-based approaches that is taking hold in many government programs. It also encourages the use of program data and performance measures to get the most out of limited tax payer dollars. This may prove to be impactful, particularly in the context of SIP as it pushes intermediary foundations to develop the criteria and practices that select for non profits that have the best measurable and compelling impact on their communities.

This also provides a rare competitive incentive for foundations to be the best funder by having supported the most effective non-profit grantees. A push for the use of data to evaluate the most effective initiatives will also help non-profit applicants to better replicate the best known practices. To help everyone better identify and replicate effective programs, CNCS maintains a clearinghouse for information on best practices resulting from initiatives that have been supported by past grantees.

Though the SIF is in its third year, the jury is still out on whether this evidence-based funding and is expanding promising non-profits, with the smaller non-profits being particularly vulnerable to being overlooked. Smaller non-profits, which may have great ideas for innovation, may lack the resources to gather and analyze data, raise additional funds for cost sharing and compete with larger mainstream non-profits that are already on the go-to list for foundations to show off to SIF administrators.

Despite the pitfalls, using regional intermediary foundations for re-granting certainly creates a mechanism that is more responsive (than non-local administrators) to local social problems that non-profits are trying to address. The clear emphasis for evidence-based initiatives, and published examples in the clearing house can also guide non-profits to adopt practices which have been proven to work, and indeed perhaps inform non-profits on how to more effectively take on social issues.

Now in its third year, the Corporation for National and Community Service's Social Innovation Fund (SIF) has awarded grants to 20 intermediary grantmakers, which have selected 221 nonprofit subgrantees working in 37 states and the District of Columbia. (CNCS document, *Where are Social Innovation Fund Subgrants Going?)*

GIVE THANKS: AFG IS OPEN!

By Michael Paddock

In the midst of major fluctuations in homeland security funding over the past three years, compounded by sequester cuts, shutdown delays, and budget uncertainty, the Assistance to Firefighters Grant (AFG) Program provides a reminder that some federal grants are still working well.

AFG grants, or a version thereof, have been supporting the nation's firefighters since 1974, and the 2013 round of the program opened for applications on November 4, 2013, with a deadline of December 6, 2013. This year's program will provide $288,828,075 to fire departments and non-affiliated EMS agencies for a broad range of essential operations, training, vehicles, and regional preparedness needs.

Consistency is one of the four characteristics of the AFG program that make it one of the best administered homeland security grants in the country (transparency in the award-making process, a competitive focus on the most needed and impactful projects, and readily available technical assistance are the other three).

That said, there are a few administrative changes to the program for 2013 that applicants should be aware of.

APPLICATION TIME FRAME

Rather than an early spring or summer deadline, as in past years, the **2013 AFG grants are due December 6.** Technically this timing is also unusual because it falls **after** the beginning of the 2014 federal fiscal year, but following as it does on the heels of the third-longest government shutdown in US history, some delay was probably unavoidable.

MICRO GRANTS

Applicants this year have the option of voluntarily limiting their AFG request to less than $25,000, making their proposal a "micro grant" request. Micro grants may be given additional consideration for an award, but the guidance doesn't specify with any certainly whether such consideration will be provided nor what they mean by "consideration."

Based on all this hedging, the best advice is probably to develop your project as usual. Then, if your unmodified request would be $30,000 or less, it would be worth the potential competitive advantage to try to get the federal share under $25,000 and check the "Micro Grants" box. If the federal share in your first budget draft works out to more than $30,000, you may risk undermining the potential impact of the project by cutting it too deeply in order to meet the micro grant threshold.

NEW EMS CATEGORY

Although for many years, AFG has funded nonprofit, non-affiliated EMS agencies, EMS was certainly a secondary focus for the funding. This year, AFG made a point of adding an EMS category for "Community Paramedics" (EMT-Ps with Primary Care Certification). This addition will most notably affect training aspects of many EMS grants. Keep in mind that despite this extra attention, EMS awards are only likely to amount to 3.5% of the total AFG program funding.

LIMITS ON AWARDS

Although the statute that currently authorizes the AFG program, the National Defense Authorization Act for Fiscal Year 2013, contemplates AFG awards as high as $9 million for projects servicing the largest populations, the original AFG authorizing statute, the Federal Fire Prevention and Control Act of 1974, actually limits any single applicant from receiving more than 1% of the total appropriated funding in a given year, which in this case is $3,209,200.

This limit applies regardless of how many successful applications they submit. For example, if a large urban fire department were to submit two winning applications for $3,209,200 (each), say, under the operations and safety and vehicle acquisition categories, the department could only actually receive **one** award. Exceptions are possible in cases of extraordinary need, but these are unlikely to be granted.

See the official guidance for many more details on the program's application requirements and allowable activities, and as soon as you possibly can, **make sure your System for Award Management (SAM) registration is up to date!**

HEALTHCARE: THE NEW NORMAL

by Chris LaPage

Healthcare is a business, yet it typically trails most business-related trends by several decades. For instance, while most other businesses began the transformation to electronic record-keeping in the late 1980s and 1990s, the movement in healthcare has primarily happened over the past five years. Considering that healthcare is a life-critical system as opposed to a mission-critical business, any change must be approached with caution. However, occasionally government regulations and the political arena force rapid change and evolution in the healthcare business model. Taking the example of electronic health records (EHRs), it was the combination of government incentives (to adopt) and future penalties (failing to adopt) built into the 2009 American Recovery & Reinvestment Act (ARRA) that finally provided the impetus for providers to make the jump to EHRs.

President Lyndon Johnson signs the Medicare Bill on July 30, 1965, with President Harry S. Truman, Lady Bird Johnson, Vice President Hubert Humphrey, and Bess Truman looking on.

Expanding the availability of healthcare beyond those already covered by Medicare and Medicaid was a primary focus of the 2010 Patient Protection and Affordable Care Act (ACA), but billions of dollars authorized by the ACA have also been spent to improve healthcare quality and reduce costs, changing the healthcare landscape along the way. (White House Photo courtesy of Lyndon B. Johnson Presidential Library, U.S. National Archives)

Healthcare providers must stay on top of these regulations and understand the trends in healthcare in order to remain financially solvent. One of the major game changers for healthcare providers came in the form of the 2010 Patient Protection and Affordable Care Act (ACA), which is sometimes referred to as Obamacare. In many ways, the ACA creates a new normal in healthcare through a mix of regulations, incentives, penalties and other mechanisms that will solidify certain trends in the industry. The primary funder for health services is the Department of Health & Human Services, which is the same entity that is regulating this “new normal” in healthcare. Thus, beyond merely staying in business, a thorough understanding of the evolving healthcare

landscape will serve providers well as they seek grant funding to make up for decreased reimbursement and increased risk sharing.

Emerging trends in healthcare more broadly are also having an impact on federal grant funding.

THIN MARGINS ➡ THINNER MARGINS

The trend toward thinning margins is not a new development with the ACA. Hospitals and healthcare providers have been dealing with the mantra that they have to do more with less since the explosion of managed care and capitation payment plans. When it comes to Medicaid patients, often times the reimbursement schedule is determined by state governments (with little or no input from providers or consideration of actual service costs), offering as little as $30 for a primary care visit to a private physician in New York State, for example. On average, commercial insurers would reimburse the same type of visit at $100.

> **"AS MUCH AS THE GENERAL PUBLIC HATES TO HEAR IT, HEALTH CARE PROVIDERS COMPETE FOR PATIENTS. UNLIKE TRADITIONAL BUSINESSES, THE PATIENTS ARE NOT TRUE CONSUMERS IN THE SENSE THAT THEY PAY FOR 100% OF THE COST OF THEIR SERVICES AND MAKE CHOICES ACCORDINGLY. THUS, SUCH COMPETITION RESULTS IN DUPLICATION OF ADMINISTRATIVE STRUCTURES, SERVICES AND TECHNOLOGY WHILE FAILING TO PROVIDE A COROLLARY DECREASE IN PRICE, OR COST OF HEALTHCARE SERVICES."**

Healthcare costs continue to accelerate, easily outpacing general inflation. At the same time, regulatory pressures are driving reimbursement rates downward. One of the less talked about long-term consequences of the new health insurance exchange marketplaces that are now operational is their effect on provider margins. The marketplace will exert intense pressure on commercial payors to drive down their plan prices in response to increased competition. By-and-large, insurers are for-profit conglomerates that answer to shareholders who will not stand for decreased profit margins. These insurers are going to pass that loss on to providers as they negotiate future reimbursement contracts.

Expect to see thin margins become even thinner over the next several years, requiring providers to be creative and innovate in order to survive. Likewise, as the subsequent demand from providers to take advantage of grant funding to fill these funding gaps increases, it is innovation and creativity that will separate those that are successful from those that struggle or fail. On one hand you have a provider that requests a grant to overcome an operating deficit related to decreased reimbursement for provided services. Such a request pales in comparison to a provider that is proposing an innovative telehealth solution that decreases overhead and provider travel time (loss time) to deal with the lower reimbursement levels. A funder will be much more likely to fund the one-time upfront costs (and some ongoing maintenance) of a telehealth project rather than providing a blank check to cover operating deficits that a provider is experiencing.

Multiple Providers ➡ Provider Networks & Consolidation

These regulatory and environmental pressures will also manifest themselves in the form of continued provider consolidation in the healthcare sector. One of the easiest ways for providers to deal with thinning margins is to engage in mergers and acquisitions. As much as the general public hates to hear it, health care providers compete for patients. Unlike traditional businesses, the patients are not true consumers in the sense that they pay for 100% of the cost of their services and make choices accordingly. Thus, such competition results in duplication of administrative structures, services and technology while failing to provide a corollary decrease in price, or cost of healthcare services. In order to decrease these inefficiencies and ensure they capture a larger share of the patients in their catchment area, providers must look to consolidate to survive. In addition, provider consolidation and networking increases their

group purchasing power when it comes to negotiating favorable reimbursement rates with commercial insurers and purchasing supplies and large capital equipment.

Thus, there are a many benefits to provider consolidation in terms of remaining financially viable. The good news is that providers that are willing to go down that path – whether through formal consolidation or creating large informal healthcare networks – are putting themselves in position to capitalize on grant funding. Cooperation and partnerships amongst providers has always been a selling point to funders when it comes to securing grants. In many cases, the formation of an informal or formal provider network is a prerequisite to meet the eligibility requirements of the grant program. In fact, the Health Resources and Services Administration (HRSA) currently has an open solicitation for the Rural Health Network Development (RHND) Grant Program. The program provides up to $900,000 over three years to rural health networks (formal arrangement with network board and bylaws), which can be used to connect network participants, purchase technology, or implement a variety of network activities. **[You can find more information on this funding opportunity on page 12 of this publication]**

Inpatient ➡ Outpatient ➡ Home-Based Care

In the interest of reducing healthcare costs, there is a concerted effort amongst government and commercial payors to incentivize the provision of care in ambulatory and home-based environments and penalize institutionalized care. There is no question that the bulk of healthcare costs are driven by costly inpatient stays in acute care hospitals and skilled nursing facilities. With that in mind, the ACA dished out billions in funding for demonstration projects (e.g. Money Follows the Person) that incentivized states to transform their Medicaid long-term care reimbursement mechanisms to move patients out of nursing homes and into community-based settings. Likewise, the Center for Medicare and Medicaid Services (CMS) was appropriated billions of dollars through the ACA to test and evaluate new delivery and payment models in the healthcare system. Many of these new delivery mechanisms involve innovative projects that allow for the provision of care in ambulatory and home-based settings.

Providers do not have much leverage in combating this particular trend, because the implications go beyond the cost savings of ambulatory over inpatient settings. The truth is that hospitals and nursing homes, while being equipped to deal with the most complex patients and healthcare problems, are also hotbeds for nasty antibiotic-resistant bacteria and other infectious diseases. Thus, providing care in alternative settings and moving patients out of institutional settings quickly also improves health outcomes in the form of a decrease in hospital acquired infections.

When it comes to grants, this regulatory shift is mirrored in the priorities of funders. Many federal funders will not even consider projects that are exclusive to inpatient settings. They are much more interested in funding projects that address wellness, prevention, and chronic disease management in ambulatory settings. This includes the movement towards mobile health (mHealth) and the involvement of smart phones, tablets and other technology in assisting patients with managing their care by adhering to treatment plans and increasing informal communication between providers and patients. There is still some potential to find funding for inpatient initiatives, but at the very least providers must be able to connect it to transitions in care settings (primarily ambulatory/home-based).

> **"RATHER THAN TRYING TO OFFSET PENALTIES, A HOSPITAL CAN IMPLEMENT A QUALITY CONTROL PROGRAM THAT AIMS TO REDUCE HOSPITAL READMISSIONS. BY REDUCING READMISSIONS, SUCH A PROJECT WILL BE IMPROVING HEALTH CARE QUALITY WHILE REDUCING COSTS. A PROJECT THAT IS PRESENTED IN THESE TERMS IS SOMETHING THAT BOTH FEDERAL AND FOUNDATION GRANTMAKERS WOULD FIND COMPELLING."**

Fee-for-Service ➡ Payor & Provider Share Risk ➡ Transparency & Pay for Performance

No discussion of the "new normal" in healthcare can be complete without addressing the movement away from traditional fee-for-service reimbursement mechanisms. The days are numbered whereby providers are

reimbursed for every patient encounter, test conducted, and procedure performed. As with ambulatory services, CMS is investing billions in alternative payment methodologies. Some of the common arrangements being tested through grant programs and demonstration projects include accountable care organizations (ACOs), shared provider-payor savings and bundled payments. Though the details of each of these respective payment models could be discussed ad nauseam, at the end of the day they all are being explored because they shift responsibility and risk from payors to providers. Under shared savings arrangements, any cost efficiencies are split between providers and payors. With ACOs, a network of providers receives an overarching fee per enrollee by the payor and assumes all risk if the costs of a particular patient's care exceeds the reimbursement. With bundled payments, services are grouped together (e.g. – pre-surgical appt, tests, surgery, and post-surgical follow-up) and a single payment is made to providers regardless of the number of encounters, tests, procedures, or hospital inpatient days actually racked up by the patient.

In addition to shifting risk, the ACA and associated regulations are taking transparency in health care to the next level. Healthcare providers are being forced to track all financial and health outcomes data as well as make it available to the public. Medicare has already begun penalizing for poor performance through its Hospitals Readmissions Reduction Program. Essentially, CMS has put the onus on providers to prevent hospital readmissions by assessing a penalty when patients are readmitted to a hospital within 30 days of a previous discharge. In many ways, this type of penalty should be viewed as the start of pay-for-performance. Obviously, medical professionals do not believe it is fair for them to assume the majority of financial risk in treating patients when so much of health outcomes are contingent on lifestyle choices and other factors outside of their control. However, the emergence of pay-for-performance may be inevitable, and the pressure payors are currently exerting on providers may grow dramatically as patients catch on to this new dawn of transparency. With the growth of high deductible health plans and efforts of payors to shift financial responsibility for care to patients, the latter group is considering costs and provider quality metrics more than ever when making treatment decisions. As this data becomes even more readily available at the patient's fingertips, this trend will undoubtedly continue. Soon, both patients and payors will be demanding more accountability from providers, making pay-for-performance a logical next step.

When it comes to providers assuming risk and pay-for-performance, the impact on grant funding is already evident. Many hospitals are desperately seeking out grant funding to assist them with the Medicare readmission penalties. The issue is that while providers can provide adequate explanations as to why readmissions are not their fault, this is not a need that can easily be sold to funders. In that respect, it comes down to how providers are framing their problems and needs to funders. Rather than trying to offset penalties, a hospital can implement a quality control program that aims to reduce hospital readmissions. By reducing readmissions, such a project will be improving health care quality while reducing costs. A project that is presented in these terms is something that both federal and foundation grantmakers would find compelling. When it comes to federal funding, one would be wise to always consider the design and implementation of new payment models when requesting funds for innovations in service delivery. In this case, it comes down to knowing the trend and funder's priorities (e.g. new payment models, provider risk, transparency) as well as how to frame your request (e.g. avoiding penalties versus improving quality and reducing costs through decreased hospital readmissions).

Conclusion (3-Part Aim ➡ The "New Normal" ➡ Grant-friendly)

With so many trends and new regulations to consider, it can be tough for providers to navigate the "new normal" in healthcare, particularly when it comes to their grant-seeking efforts. As the primary grant funder in the sector, one must consider the priorities of the Department of Health & Human Services and the trends they are forcing through regulations and reimbursement policies. Knowing these priorities and trends is crucial to a provider in determining which projects may be fundable through grants and how to frame their needs. When you are attempting to read between the lines as it relates to various grant programs, the 3-part aim established by CMS's Innovation Center should provide the guiding principles: better health (status), better health care (delivery) and reduced costs. If you look back on any of these trends that establish the "new normal" in healthcare, these three goals are at the heart of all these initiatives. If you can make the connection between a particular project or initiative and the 3-part aim, you can make a solid case for grant funding.

RURAL HEALTH NETWORK DEVELOPMENT (RHND) PROGRAM

SUMMARY: The RHND Program supports established health oriented networks with a history of collaboration to develop and maintain collaborative relationships to integrate systems of care administratively, clinically and financially. Networks must consist of at least three health care providers that are separately owned entities. Each member of the network must sign a memorandum of agreement or similar formal collaborative agreement. Applicants to the Rural Health Network Development Program will be required to select at least one activity from a prescribed topical area from one legislative charge outlined by the authorizing legislation.

Legislative Charge: Achieve Efficiencies

Topical Area: Integrated health networks will focus on integrating health care services and/or health care delivery of services to achieve efficiencies and improve rural health care services. Networks will focus on integrating their individual systems of care to achieve the following goals:

- Implement a common system finance that will reduce costs;
- Improve quality and delivery of health care services; and
- Improve medical oversight

Grantees will be required to choose one of the activities from the following areas:

- Integrating behavioral health in primary care settings;
- Integrating primary care in behavioral health care settings;
- Integrating oral health in primary care settings;
- Integrating primary care in oral health settings; and
- Integrating emergency medical services (EMS) in hospital settings.

Legislative Charge: Expand access to, coordinate and improve the quality of essential health care services

Topical Area: Integrated health networks will collaborate to expand access to and improve the quality of essential health care services by focusing on projects and/or network activities directly related to the evolving health care environment. Grantees will be required to choose at least one activity from the following areas:

- Improving performance on quality measures for hospitals, skilled nursing facilities, home health agencies, and/or ambulatory surgical facilities;
- Networks will work to improve the quality and safety of health care by improving care transitions from hospital to other settings and reducing hospital readmissions;
- Improving coordination of services;
- Consumer Assistance Programs/Patient Navigation for facilitating enrollment in health insurance marketplace;

- Collaboration of Essential Community Providers (ECPs) for leveraging competitive negotiations and contracts with Qualified Health Plans (QHPs);
- Implementing innovative alternative payment and delivery models;
- Creating initiatives to increase attention to quality health care for Medicare beneficiaries in Critical Access Hospitals (MBQIP) or other similar measures for non-Critical Access Hospitals (Hospital-Compare); and
- Implementing programs to increase primary care workforce in rural areas.

Legislative Charge: Strengthen the rural health care system as a whole

Topical Area #1: Networks will improve population health by implementing promising practice, evidence-informed and/or evidence-based approaches to address health disparities in their communities.

Topical Area #2: Integrated Health Networks will collaborate to achieve population health goals through the use of technology. Types of Telehealth services may include:

- Remote monitoring;
- Interactive Telehealth services;
- Store and forward Telehealth;
- Imaging services; and
- Specialist and primary care consultation.

Types of HIT/MU activities may include:

- E-prescribing and incorporating lab results into Health Information Exchange;
- Electronic transmission of patient care summaries across multiple settings;
- Patient access to self-management tools; and
- Patient access to comprehensive patient data through patient-centered HIE.

DEADLINE: The deadline to submit an application is November 22, 2013.

ELIGIBILITY: Applicants for the Rural Network Development Program must meet the ownership and geographic requirements stated below. (Note: If an incorporated network does not apply on behalf of its members, the award will be made to only one member of the network that will be the grantee of record and only that organization needs to meet the eligibility criteria.):

- The lead applicant organization must be a public or private non-profit entity located in a rural area or in a rural census tract of an urban county, and all services must be provided in a rural county or census tract. The applicant's EIN number should verify it is a rural entity. To ascertain rural eligibility, please refer to: http://datawarehouse.hrsa.gov/RuralAdvisor/ and enter the applicant organization's state and county. A network serving rural communities but whose applicant organization is not in a designated rural area will not be considered for funding under this announcement.
- In addition to the several States, only the Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the Virgin Islands, American Samoa, Guam, the U.S. Virgin Islands, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau may apply. If applicants are located outside the 50 states, they still have to meet the rural eligibility requirements.

Current and former grantees of any ORHP community-based grant programs are eligible to apply if the proposed project is a new proposal (entirely new project) or an expansion or enhancement of the previous grant. The project should not supplant an existing program.

AWARD AMOUNTS: Approximately $4,500,000 is expected to be available annually to fund approximately 15 grantees. Applicants may apply for a ceiling amount of up to $300,000 per year. The project period is 3 years. Cost sharing is not required.

FOR MORE INFORMATION SEE: https://grants3.hrsa.gov/2010/Web2External/Interface/FundingCycle/ExternalView.aspx?&fCycleID=7df81c8f-b635-4a8a-8cec-fe9a59b4d067&txtAction=View+Details&submitAction=Go&ViewMode=EU

DEVELOP A FOUNDATION PROPOSAL (WITH LITTLE DIRECTION)

by Michael Paddock

Federal funders are notorious for prescribing every detail of applicants' proposals, down to the font and margin sizes. Guidance documents for these programs leave grantwriters wondering whether they will ever have an opportunity to describe the program they want to propose after they've spent all their time complying with the formatting requirements the funder has established.

But little or no guidance from funders can also cause some distress among would-be applicants because of their ambiguity and lack of structure, especially for grantwriters who have become expert at following grant guidelines to the letter.

Generally, it's the small, local foundations that require no specific format. I say generally, because self-structured proposals may also be required for bigger, national funding sources, like congressional earmarks and unspent past years' funding from the Department of Homeland Security, just to name a couple of examples.

Because they may only make a few dozen grants each year, smaller foundations' decision makers (often part-time volunteers) rightfully spend their time evaluating projects, rather than coming up with elaborate proposal requirements. The downside, of course, is that you, as a potential recipient of their funding, have no real direction on how to engage with them.

Here are a few tips to help you develop a proposal you can feel confident in submitting.

UNDERSTAND THE FUNDER

Even though a funder may not have a defined format for proposals, you can bet they have expectations of the proposals they will fund, and no matter what grantmaker you're planing to apply to, the first step should always be to understand the funding source to which you will be applying. In the absence of a specific set of requirements or a clearly defined format to use to guide your proposal, the funders themselves can provide all the insight you need into how you should structure your proposal.

If the funder is interested in nonspecific local support, start with a detailed description of the need you are addressing and why it is important locally.

If the funder has supported other similar initiatives, relate your project to these others and explain how it builds on their success.

If the funder has narrowly defined interests, you can afford to be more technical and specific in explaining how your project will be impactful.

If the funder articulates specific goals anywhere (on the Web or in a newspaper or TV interview, for example), describe how your project will support those goals.

If the funder has a long history in the community, talk about your own agency's work in the community and the other community organizations you collaborate with.

A phone call or meeting with representatives of the funder can also provide valuable insights into what types of projects they are interested in.

JUST START WRITING

You might notice that the tips above are just ideas or points of emphasis, rather than formatting guidelines. Don't spend too much time self-consciously contemplating how your proposal should flow from beginning to end before you start typing. The sooner you get some text in place of the blank page, the sooner you can get down to the business of working through your proposal.

Start by getting your most relevant thoughts on paper, then you can shift them around until they start to resemble a coherent narrative. Of course, you may approach the

writing in whatever way makes sense to you, and you'll have the freedom to do so in a self-structured narrative.

If you really need an outline to work from, here are some common topics most funders will be looking for:

1. **EXECUTIVE SUMMARY OR COVER LETTER (WRITE THIS LAST)**
   The executive summary provides a handy reference for the funders reviewing the proposal, but it may be the only thing they read, so be sure your summary hits all the high points of your project. In addition to the summary of the project you're proposing, you'll also want to include project contact information, the amount you're requesting, the total project cost, and what (if any) organizations you're collaborating with. This can all be included in a cover letter as well, making it less formal but equally informative.

2. **THE NEED FOR THE PROJECT**
   Much has been written about articulating the need for a project. It's best to use data from recognizable sources and use this part to begin to align the project with what you've learned about the funders preferences and priorities.

3. **PROJECT GOALS**
   Be sure to keep your goals measurable and consistent with the need you've identified, by using the same metrics you used in your needs section. You can also make your goals more credible by providing evidence connecting your project to similar outcomes in other settings.

4. **WORK PLAN**
   Depending on the nature of your project, the work plan may include a list of tasks and assignments or a more general description of what the project team will do. Be a specific as you can about how you will recruit participants, how you will prepare for the project, how you will evaluate your progress toward your goals, how you will continuously improve the project along the way, and who will be responsible for each activity.

5. **DETAILED BUDGET**
   Just as they don't spend a lot of time on detailed proposal guidelines, local foundation funders usually don't develop a lot of contractual documentation for grantees before they give them a grant. Therefore, your proposal budget is likely to be the only forecast they will get of what you will be spending on your project. A detailed and realistic budget also communicates your understanding of what your project will require and an acknowledgement that the project's funders deserve to know how their money will be spent.

6. **THE FUTURE OF THE PROJECT**
   Some discussion of plans for the future of the project provides funders with an understanding of where you're planning to take it. Everyone knows that the future is unpredictable, so the primary purpose of this part of the proposal should be to let potential funders know your current thinking about the potential future of the project.

Lastly, don't forget to tweak the narrative as you go, to make sure it flows and reads well. After all, you may not have that many opportunities in grantwriting to just write whatever you want write in whatever way you want to write it!

Writing without guidance can feel a little distressing, particularly for experienced grantwriters who have become accustomed to following funder' specific requirements to the letter. But with a little shift in your approach, a self-structured proposal can give you the freedom to articulate your project in a way that you feel completely conveys its importance.

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