

**Clinic Application Checklist**

**“****Nebraska Heart Disease and Stroke Clinical Quality Improvement”**

*Note: This document is for applicant use only and is not to be submitted with application materials.*

Date full application package submitted:Click or tap to enter a date.

Required Application Documents:

 [ ]  Completed Clinic Application

[ ]  Completed Pre-Award Questionnaire

* Decisions will be no later than May 16th, 2025. If you would like a copy of the scan and plan tool before official notice of application acceptance please e-mail sara.lawless@nebraska.gov.

**Clinic Application**

**“Nebraska Heart Disease and Stroke Clinical Quality Improvement””**

1. **Applicant Information**

Clinic Name: Click or tap here to enter text.

Health System Name (if applying as part of a health system): Click or tap here to enter text.

Clinic Mailing Address: Street Address

 City, State, Zip Code

Please indicate if the Clinic or overarching Health System is a nonprofit or for-profit entity:

 [ ]  Nonprofit [ ]  For-profit

If part of a for-profit Health System, does this Clinic and/or Health System have a nonprofit sector through which funds could be distributed?

 [ ] Yes [ ]  No [ ]  N/A – it is a nonprofit entity

If yes, please provide the title of the nonprofit sector this grant would run through:

Click or tap here to enter text.

1. **Grant Team**

Clinic Lead Contact Name: Click or tap here to enter text.

Clinic Lead Contact Role/Job Title: Click or tap here to enter text.

Clinic Lead Contact Email Address: Click or tap here to enter text.

Clinic Lead Phone Number: Click or tap here to enter text.

In addition to the clinic lead contact listed above, list the name, role/job title, and email of each staff member who, if selected for this opportunity, will be serving on the team dedicated to this grant. Please include at least 1 provider who is invested in championing your clinic’s Self-Monitored Blood Pressure Program.

|  |  |  |
| --- | --- | --- |
| **Name** | **Role/Job Title** | **Email Address** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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1. **Required Subaward Information**

**Grantee Signor Name:**

**Grantee Signor E-mail:**

**Grantee Signor Phone Number:**

**Organization UEI:**

**Did you attach a W-9 form?**

1. **Electronic Health Record (EHR) System and Capabilities**

EHR System: Click or tap here to enter text.

Describe the EHR’s capabilities as related to the proposed interventions for this grant work. Inability to document these items does NOT disqualify you from this project.

Check yes if it is known that the EHR *can* document:

Check if Clinic/Site currently uses the EHR to document:

|  |  |
| --- | --- |
| [ ]  | [ ]  Blood pressure measurements |
| [ ]  | [ ]  Hypertension diagnoses |
| [ ]  | [ ]  SDOH Screening |
|  |  |

1. **Overall Control Rates**

Hypertension Control Rate (% of adult patients with HTN who have achieved BP control from the Action Planning tab of the Scan and Plan Tool): Click or tap here to enter text.

*Note: To be considered for this grant opportunity, a clinic must have a hypertension control rate (for their total population age 18+) that is not yet meeting the national goal of 80% as set by the Million Hearts Initiative. Priority for this grant opportunity will be given to clinics/sites that fall below the HEDIS average for Medicaid patients of 60.9% (2022 HEDIS data: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/). Further priority will be given to clinics/cites which demonstrate need for interventions for both hypertension and social determinants of health screenings.*

**The Chronic Disease Prevention and Control Program (CDPCP) encourages applicants who cannot pull data to determine hypertension rate to apply with a brief explanation of the barriers to this data collection. Grant activities can include building capacity to pull this data. These applications will still be considered for funding. The CDPCP may provide additional assistance to the awardee to assist with acquiring data from the clinic’s EHR. If this applies to your clinic, please describe the challenges to collecting this data:**

Click or tap here to enter text.

Clinic Participation Commitment

**“Nebraska Heart Disease and Stroke Clinical Quality Improvement”**

By signing below, our Clinic acknowledges understanding of the goals and expectations of the funding opportunity outlined by the Chronic Disease Prevention & Control Program (CDPCP) at the Nebraska Department of Health and Human Services (DHHS) and commits to full participation in the entirety of the initiative as defined by the agreement for the funding opportunity, “Nebraska Heart Disease and Stroke Clinical Quality Improvement.”

**Clinic Name:** Click or tap here to enter text.

**Clinic Address:** Street Address

City, State, Zip Code

**Health System Name (if applying as part of a health system):** Click or tap here to enter text.

**Clinic Lead Contact**

Name: Click here to enter text.

Role/Job Title: Click or tap here to enter text.

Email Address: Click here to enter text.

Signature:

Date: Click here to enter date.

**System-level or Lead Administrator Contact**

Name: Click here to enter text.

Role/Job Title: Click or tap here to enter text.

Email: Click here to enter text.

Signature:

Date: Click here to enter date.