NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

Request for Application (RFA)
Chronic Disease Management Navigation and Education Initiative

Purpose

The Nebraska Department of Health and Human Services, Chronic Disease Prevention Program invites proposals to expand Chronic Disease Management through Navigation and Education across Nebraska's communities. This initiative is funded through the Rural Health Transformation Project, 4.4A. It aims to connect people in need with resources to promote healthy living and strengthen coordination among patients and health systems.

Program Scope

Funded projects will expand **community-based education, care navigation, and self-management support** for individuals living with chronic conditions such as diabetes, cardiovascular disease, asthma, and other long-term health challenges. Projects should improve health outcomes by helping individuals **understand their conditions, navigate complex health systems, and access timely, community responsive resources**. Through structured education, one-on-one navigation support, and partnerships with healthcare providers and community organizations, participants gain the knowledge and skills needed to manage their conditions, reduce preventable complications, and improve quality of life.

Workplans should include, but are not limited to:

- Chronic disease education delivered through workshops, group sessions, and individualized learning tailored to participant needs
- Care navigation and referral support, helping participants connect to primary care, specialty services, medications, and community resources
- Health system navigation, including assistance with appointments, care plans, insurance literacy, and follow-up care

Eligible Applicants

- Rural Clinics
- Federally Qualified Health Centers (FQHCs)
- Certified Community Behavioral Health Clinics (CCBHCs)
- Local Health Departments (LHDs)
- Critical Access Hospitals (CAHs)
- Rural Emergency Hospitals (REHs)
- Rural Hospitals (non-CAH)
- Tribal Health Facility
- This list is not exhaustive. Please, if interested, apply!

Funding Amounts

Awards will be made based on applicant type, project scope, and demonstrated need. Single applications should not exceed $400,000 per proposed budget. Applicants must verify and/or justify that their proposed workplan does not overlap existing efforts. Our goal is to expand program reach, not duplicate efforts.

Administrative and Indirect Cost Limitations

- Administrative and indirect costs charged to this grant may not exceed **7.5% of the total award amount**.
- Personnel time spent performing **direct programmatic activities** outlined in the grant scope (e.g., patient care, RPM monitoring, CHW engagement, clinical oversight, training delivery) is considered **allowable direct costs** and is **not classified as administrative**.
- Time spent exclusively on **administrative functions** (e.g., general grant management, reporting, invoicing, or organizational overhead) must be classified as administrative and will count toward the 7.5% administrative/indirect cost cap.

Period of Performance

Should your application be selected, you will be notified via email with a Notice of Award, and your grant agreement will be processed immediately through our procurement system. Work can begin following receipt of an Intent of Award notification. All awarded funds must be spent by October 30, 2026, and final invoice is due no later than November 30, 2026. Optional renewals for the following years will be determined by the DHHS Program Manager and will be communicated prior to October 2026.

Expected Outcomes

Funded projects are expected to demonstrate improvements in:

- Chronic disease control
- Patient engagement and self-management
- Reductions in hospital readmissions and emergency department utilization
- Care coordination across clinical and community settings

Applications must include baseline data and targets for the following metrics:

Outcome metric	Data source	Baseline	Target & timeframe
Number of participants enrolled in chronic disease management program (overall and by chronic condition)	Data reported quarterly by partners	Applicant must provide	Target: Applicant must provide Timeframe: From receipt of Intent to Award through October 30, 2026
Number of participants assisted with healthcare or chronic disease navigation	Data reported quarterly by partners	Applicant must provide	Target: Applicant must provide Timeframe: From receipt of Intent to Award through October 30, 2026

Award Scoring

Selected applications will include the following:

- The required workplan and budget
    - Workplan must include sustainability components
    - Budget not to exceed $400,000
    - Administrative/Indirect costs will not exceed ≤ 7.5%

- Activities must align with scope of the federal funding
- Non-duplication justification must be included
- Performance management metric targets, including number of individuals impacted

Scoring Criteria

The following must be addressed in all applications. See **appendix A** for examples.

1. Alignment with RFA Purpose & Target Population (15 pts)
2. Project Design, Sustainability & Workplan Quality (20 pts)
3. Impact on Expected Outcomes (20 pts)
4. Care Navigation & System Integration (15 pts)
5. Non-Duplication & Program Expansion (10 pts)
6. Organization & Collaboration Capacity (10 pts)
7. 7. Budget & Cost Effectiveness (10 pts)
8. Optional Bonus (Up to 5 pts – Only if base score ≥ 75)
    a. Innovation / Tribal engagement / Data integration strength

Overall Recommendation

☐ Highly Recommend (90–105)
☐ Recommend (80–89)
☐ Consider if Funds Remain (70–79)
☐ Do Not Recommend (<70)

Submission Instructions

Please submit your draft workplan and budget to Brianna.Cochran@nebraska.gov by March 17, 2026. Please use the provided workplan and budget template for your application. If you have questions or would like technical assistance with your application, please contact Brianna.

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Appendix A

1. Alignment with RFA Purpose & Target Population (15 pts)

Strong Example 1

Project directly aligns with the RFA's purpose to expand chronic disease education and navigation services in rural Nebraska. Serves adults diagnosed with diabetes, hypertension, cardiovascular disease, and asthma in three medically underserved counties where over 28% of adults report at least one chronic condition. Target population includes low-income, uninsured, underinsured, and Medicare/Medicaid beneficiaries who face barriers to accessing coordinated care.

Strong Example 2

Initiative focuses on individuals with poorly controlled Type 2 diabetes (A1C > 8.0), frequent emergency department utilizers, and patients lacking a primary care provider. Program prioritizes rural, frontier, and Tribal populations with limited transportation access and high social vulnerability index (SVI) scores.

Strong Example 3

Aim to reduce disparities in chronic disease outcomes among Hispanic and Native populations by providing culturally responsive education, bilingual navigation, and collaboration with community health workers.

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2. Project Design, Sustainability & Workplan Quality (20 pts)

Strong Example 1

The project includes:

- Monthly chronic disease self-management workshops (6-week cycles)
- Individual care navigation sessions
- Medication adherence counseling
- Insurance literacy education

Workplan includes measurable milestones, quarterly review meetings, and clearly assigned staff responsibilities.

Strong Example 2

Sustainability will be achieved through:

- Integration of community health workers into permanent clinic staffing
- Formalized referral agreements with hospital partners

Strong Example 3

A phased implementation approach ensures scalability:

- Phase 1: Staff training and referral pathway development
- Phase 2: Participant enrollment and service delivery
- Phase 3: Data tracking, quality improvement, and sustainability transition planning

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3. Impact on Expected Outcomes (20 pts)

Strong Example 1

Baseline: 42% of enrolled diabetic patients have controlled A1C (<8.0).
Target: Increase to 60% by September 30, 2026.

Strong Example 2

Baseline: 18% 30-day hospital readmission rate for cardiovascular patients.
Target: Reduce to 12% within the grant period.

Strong Example 3

Baseline: 0 formal navigation program participants.
Target: Enroll 300 individuals; provide navigation services to 250 participants by 9/30/2026.
Use EHR data, hospital discharge reports, and quarterly partner data submissions to measure progress.

4. Care Navigation & System Integration (15 pts)

Strong Example 1

Care navigators will:

- Assist with appointment scheduling and follow-up
- Conduct medication reconciliation
- Provide transportation referrals
- Support insurance enrollment

Strong Example 2

Integrate navigation notes directly into the EHR and implement closed-loop referral tracking to ensure follow-through with specialty care and community services.

Strong Example 3

Formal MOUs are established with:

- Local hospital discharge planners
- Behavioral health providers
- Community pharmacies
- Food access and transportation organizations

This ensures seamless coordination between clinical and community settings.

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5. Non-Duplication & Program Expansion (10 pts)

Strong Example 1

While a clinic may provide routine primary care, you may not currently offer structured chronic disease self-management education or dedicated care navigation. This funding will expand services rather than duplicate existing care.

Strong Example 2

Current case management services are limited to post-discharge follow-up calls. This project expands to proactive, ongoing chronic disease management and education.

Strong Example 3

Conduct an environmental scan of local programs and identify gaps in bilingual navigation services and rural outreach. The initiative fills those identified gaps.

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6. Organization & Collaboration Capacity (10 pts)

Strong Example 1

An organization serves 5,200 unique patients annually and operates three rural clinics. It has an established quality improvement team and data reporting infrastructure.

Strong Example 2

Key staff include:

- Licensed RN Care Coordinator (10 years chronic care experience)
- Certified Diabetes Care and Education Specialist (CDCES)
- Community Health Worker Supervisor
- Data Analyst

Strong Example 3

Have active partnerships with:

- Regional hospital system
- Local public health department
- Behavioral health provider

- Tribal health representatives

Quarterly coalition meetings ensure cross-sector coordination.

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7. Budget & Cost Effectiveness (10 pts)

Strong Example 1

Total Request: $395,000

Administrative/Indirect Costs: 7.3% (within 7.5% cap)

Strong Example 2

80% of funds support direct program services including:

- Care navigator salaries
- Education materials
- RPM devices
- Data tracking software

Strong Example 3

Cost per participant served: $1,316 (based on 300 participants).

Long-term cost savings anticipated through reduced ED utilization and hospital admissions.

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8. Optional Bonus – Innovation / Tribal Engagement / Data Integration (Up to 5 pts)

Innovation Example

Support patient navigation via group education on use and reporting of glucometers and blood pressure cuffs, allowing accurate data sharing and proactive outreach.

Tribal Engagement Example

The program includes formal collaboration with Tribal health leadership, culturally tailored curriculum adaptation, and CHWs recruited from Tribal communities.

Data Integration Example

We will integrate EHR data with hospital admission-discharge-transfer (ADT) feeds to enable immediate outreach within 48 hours of discharge.