

Answers to Questions from Technical Assistance Call March 17, 2020

Q: Given the current situation with COVID-19, does AHRQ plan to extend the due date for the application?

A: AHRQ is closely monitoring the situation and is aware of the challenges it presents. At this time, we are not planning to extend the due date.

Q: Because of the coronavirus pandemic, it has been difficult to engage with public health partners and primary care organizations in the State. Should I still submit an application?

A: AHRQ recognizes these are challenging times to plan for non-COVID research and how difficult it may be to engage with partner organizations, especially in public health and primary care. Only your team can decide whether you should submit an application; however, one approach is to put together the best possible application you can now. Be sure to describe plans for engaging with partners once the acute period of the outbreak has passed. This situation affects all potential applicants and AHRQ will take that into consideration as part of the review and funding process.

Q. If an applicant wants to include a specific approach like academic detailing or practice facilitation, are there AHRQ resources to train people in how to do that?

A. Yes, AHRQ has a number of resources available including a [practice facilitation curriculum](#) and [how to guide, Tools for Change, Evidence for Heart Health \(which includes academic detailing guides from NaRCAD\), TeamSTEPPS](#), and many others.

Q: Regarding eligibility for the grant, it requires States with a rate of CVD events in the highest quartile to apply. Indiana falls in the third quartile; is Indiana eligible to apply for this grant?

A: Any institution that is otherwise eligible, from any State, may apply (see [Part 2 Section 3.1 of the RFA](#)). However, AHRQ is strongly encouraging applications from States with the highest rates of CVD in the U.S. It will be important for applicants to provide strong justification for how they'll be addressing significant CVD burden in their States. Applicants may submit evidence from other data sources (e.g., BRFSS, CDC Atlas, etc.) as part of the justification. Significant CVD disparities are also important to highlight.

Q: Under the objectives, developing a comprehensive...evidence-based approach, it states, "develop a plan to work with a minimum of 50 primary care practices." Can this be spread over the 3 years of the grant, making it a total of 50 at the end of the grant? Or do we have to work with 50 primary care practices every year for the duration of the grant?

A: A minimum of 50 practices should be engaged in the improvement project over the entire period of the grant – not 50 per year or 50 in any 1 year.

Q: The RFA calls for engagement of 50 primary care practices. In a large, populous State like Ohio, is it required to engage practices across the entire State, or is it acceptable to engage practices in one or two diverse regions?

A: Cooperatives must engage primary care practices from across the State in their network. Limiting the scope of the Cooperative or the Network to only a part of the State would not be responsive to the RFA. For the heart health improvement project, recruiting practices from across the State is ideal, but not required.

Q: The RFA specifically calls for engaging practices which care for adults. However, our project idea is tentatively, "improving hypertension diagnosis and control across the lifespan." Could practices which are for both adults and children and adolescents therefore be engaged?

A: The main focus of the heart health improvement project is on adult patients, but practices that care for patients across the lifespan (e.g., family medicine) may be engaged. Furthermore, the heart health improvement project should include efforts to improve other cardiovascular risk factors, and smoking cessation is required. The Cooperative and the Network, however, may support and recruit all types of primary care practices and professionals, and grantees are encouraged to consider conducting other improvement projects as part of this grant and in sustainability planning.

Q: While the RFA emphasizes the "ABCs," are relatively new, diagnostic interventions such as coronary calcium scoring (incorporated in some guidelines) acceptable as a focus?

A: The purpose of the RFA is to disseminate and implement patient-centered outcomes research (PCOR) findings. If applicants can demonstrate that there is PCOR evidence on new, diagnostic interventions, they may include them as part of the evidence they are implementing in the heart health improvement project. However, a narrow focus on **just** new, diagnostic interventions would not be responsive to the RFA, which calls for improving the delivery of ABCS and building internal improvement capacity.

Q: Is it acceptable to focus upon a specific sub-population? For example, African Americans (of all ages) suffer disproportionately from hypertension.

A: The Cooperative and Network are intended to serve primary care practices throughout the State. AHRQ states its interest in priority populations throughout the RFA. Therefore, it is acceptable that the Cooperative and Network might include a focus on supporting and engaging primary care practices that serve priority populations. It would also be acceptable to propose targeting the heart health improvement project to practices that serve priority populations, although this is not required.

Q. Are co or multiple PIs from the same institution permitted?

A. Yes, multiple PDs/PIs from the same institution, and from different institutions, are permitted. The decision to apply for a single or multiple PI should be consistent with and justified by the scientific goals of the project. Please refer to AHRQ's [Multiple Program Director/Principal Investigator Policy](#).

Q. Section II, Eligible Individuals. Please confirm that we may propose multiple PIs if we comply with the Multiple PI/PD Policy and submission details for the Key Person Profile and with AHRQ NOT-HS-16-018.

A. Yes, multiple PDs/ PIs are permitted. The decision to apply for a single or multiple PI should be consistent with and justified by the scientific goals of the project. Please refer to AHRQ's [Multiple Program Director/Principal Investigator Policy](#).

Q. Will AHRQ accept multi-state proposals?

A. No, the goal of the RFA is to establish a State-based cooperative, build a network of primary care practices across the State, and develop an improvement project in a single State.

Q. May our research plan include multiple States for recruitment and implementation?

A. No, the application should establish a Cooperative, build a Network of primary care practices, and develop an improvement project in a single State.

Q. May we submit two applications with similar methodologies but in two distinct States?

A. Applicant organizations may submit more than one application, provided that each application is scientifically distinct. AHRQ will not accept duplicate or highly overlapping applications under review at the same time.

Q. For recruitment, is a physician practice defined by geographic location or Tax Identification Number?

A. A primary care practice is defined by geographic location, not Tax Identification Number. For example, if a practice has multiple sites in different locations that share a Tax Identification Number, a single site would be counted as one of the 50 practices that have to be recruited to participate in the heart health improvement project.

Q. Are electronic health records vendors allowed to be a partner in this RFP?

A. Yes, electronic health record vendors are allowed to partner in applications responding to this RFA.

Q. Could you provide an example of what kind of reimbursement is allowed to reimburse practices related to data collection and measurement?

A. As noted in the RFA, applicants should not plan to provide compensation to primary care practices for participating in the heart health improvement project or other PCOR dissemination and implementation activities. They may include compensation to practices for their efforts related to data collection and measurement activities. These activities might include completion of survey instruments, time for interviews, collecting data reports from EHRs, or other related activities to support the applicant's evaluation.

Q. Under Part 2 section 1, subsection Cooperatives, the statement "Cooperatives are state-level entities..." We interpret that statement to include an organization that collaborates with key state-level stakeholders and community partners to develop a network with statewide scope that supports quality improvement with multiple healthcare entities. Is that accurate?

A. Yes. As stated in the FOA, Cooperatives bring together existing State and local resources to support the development of an external QI support infrastructure that increases the State's capacity to disseminate and implement PCOR evidence to primary care practices across the State. There is no single model for establishing a Cooperative. Applicants will describe their proposed plan to establish a Cooperative and each partnering organization's capacities, including: proposed leadership and governance structure, proposed organizational structure, and whether the Cooperative will be incorporated as an independent entity and how finances will be organized. (See the RFA [Content and Organization of Application Submission](#): PHS 398 Research Plan.)

Q. Under Part 2 section 1, subcategory Developing State-level Capacity to Support Primary Care Practice Improvement, statement "This FOA will fund State-based projects to develop new..." This implies statewide engagement for QI purposes. Is that accurate?

A. Yes, AHRQ is seeking statewide engagement with primary care practices for QI purposes.

Q. Under Part 2 section 1, subsection Objectives, item 2: what are AHRQ's thoughts on the "Network" consisting of a single healthcare system with geographically distributed primary care clinics? These primary care clinics would cover a significant rural and/or under-resourced population.

A. The goal of the FOA is for Cooperatives to over time engage as many primary care practices within the State as possible. A network consisting of a single health system, or even several health systems, would thus not be responsive to the RFA.

Q. If, at baseline measurement, the established network demonstrates strong performance in either of the two clinical quality measures prioritized by AHRQ (controlling high blood pressure and tobacco screening/cessation counseling), do cooperatives have the latitude to adopt

additional measures as long as they are related to improving cardiovascular disease outcomes through the dissemination and implementation of PCOR findings?

A. As noted in the RFA, applicants are encouraged to propose the collection of other clinical and health outcome measures to assess the effectiveness of the implementation approach. Cooperatives may adopt additional measures related to improving cardiovascular disease. However, Cooperatives still must report on the two clinical quality measures identified in the RFA (controlling high blood pressure and tobacco screening/cessation counseling) for the evaluation. Furthermore, Cooperatives may want to consider the reporting burden on practices by adding additional measures.

Q. Can we propose that practices can choose from a list of PCOR evidence to implement, or is there an expectation that practices will implement hypertension and smoking cessation at the same time? I'm concerned that practices may be overwhelmed implementing two or more programs since smoking cessation is very different to implement compared with blood pressure, cholesterol, and aspirin. May lead to change fatigue.

A. AHRQ expects each of the 50 practices participating in the heart health improvement project to implement PCOR evidence related to both hypertension and smoking cessation, but not necessarily at the same time, and applicants can propose how to implement evidence to avoid change fatigue.

Q. What is the expectation for reach across a State? Given limited dollars, it may be challenging to reach an entire State.

A. In general applicants must plan to engage primary care practices from across the State in their network. For the heart health improvement project, recruiting practices from across the State is ideal, but not required.

Q. Is this focused on adults or can this expand to include kids and adults for hypertension or smoking/vaping?

A. The Cooperative may over time focus on many types of activities targeting different types of practices, health conditions, and populations. For the heart health improvement project required under this FOA, the project must focus on adults.

Q. Part 2. Full Text of Announcement; Section I. Funding Opportunity Description; States with High CVD Burden. Per the FOA, a high CVD burden is defined as a State with a rate of CVD events in the highest quartile according to Million Hearts. Is highest quartile defined based on overall rate, overall count, or either?

A. The definition of the highest quartile of CVD events is defined based on the overall rate of CVD events (not overall counts).

Q. Part 2. Full Text of Announcement; Section I. Funding Opportunity Description; States with High CVD Burden. In states where ED data is not available and is estimated, may an applicant submit evidence from its own data source or alternative data sources (i.e. state-level data, BRFSS, CDC Interactive Atlas of Heart Disease and Stroke)?

A. Applicants may submit evidence from other data sources (e.g., BRFSS, CDC Atlas) in support of their justification that their State has a significant CVD burden.

Q. Part 2. Full Text of Announcement; Section I. Funding Opportunity Description; States with High CVD Burden. Do the racial and ethnic disparities for CVD in a State play a role in preferred State applications?

A. Significant CVD disparities may be highlighted in justifying the State has a significant CVD burden.

Q. Part 2. Full Text of Announcement; Section I. Funding Opportunity Description; Cooperatives. Does AHRQ have a preference for whether the cooperative repurposes an existing collaborative infrastructure, or build new in a State where a cooperative doesn't already exist?

A. AHRQ does not have a preference. Applicants must decide how best to establish a Cooperative in their State.

Q. What is the priority in the funding from the two areas of interest stated in the FOA's Purpose Statement?

Purpose

This initiative will fund the dissemination and implementation of PCOR clinical and organizational findings into primary care practices to improve healthcare quality with a focus on cardiovascular care. AHRQ is particularly interested in applications from States with the highest cardiovascular disease (CVD) burden. The initiative will accomplish this goal by catalyzing the development of a sustainable, State-based external primary care quality improvement (QI) support infrastructure to expand the State's current and future capacity to disseminate and implement PCOR evidence into primary care practice.

AHRQ is interested in increasing understanding of how public and private organizations within a State can work together to develop a State's capacity to provide external QI support to primary care practices in order to accelerate the dissemination and implementation of PCOR findings. AHRQ strongly encourages applications from States that currently have limited capacity to provide QI support to primary care practices and that, with funding and support from AHRQ, could overcome existing barriers.

A. The RFA has multiple goals. AHRQ is interested in meeting all of them.

Q. If we are a State that doesn't have a high CVD burden but has a limited infrastructure for PC QI support, is it worth applying?

This FOA will fund State-based projects to develop new or expand limited existing infrastructure for primary care QI support in order to increase the dissemination and implementation of PCOR evidence to improve heart health, with a focus on States with a high burden of CVD

A. Any institution that is otherwise eligible, from any State, may apply (see [Part 2 Section 3.1 of the RFA](#)), AHRQ is strongly encouraging applications from States with the highest rates of CVD in the U.S. Teams from States without a high-burden of CVD should consider carefully the risks and benefits of submitting an application.

Q. For Section 2: Engagement with Primary Care Practices, Professionals, and Stakeholders, please advise on what would be an adequate way to demonstrate such participants are willing to participate in the proposal. A letter of intent (LOI), for example?

A. Letters of support from partners and stakeholders are one way to demonstrate support. Applicants are not expected to recruit practices and produce letters of commitment as part of their application. Applicants should describe the primary care practice outreach and engagement strategy that the Cooperative will use.

Q. Section I, Objectives, #s 2 and 3. In the section titled Improving the Uptake of PCOR Findings: EvidenceNOW, the RFA describes the EvidenceNOW practices as being small- and medium-sized. The objectives section does not describe the size of the practices that we should target for this cooperative agreement. Is there a requirement or preference for practice size?

A. This FOA differs from previous AHRQ FOAs. Cooperatives are encouraged to recruit as many primary care practices from across the entire State to engage with the Network. The application may describe how different types of practices will be supported and prioritized for more intensive support activities. For the heart health improvement project required in response to this FOA, there is no requirement for recruiting practices of a specific size.

Q. Section I, Objectives, #s 2 and 3. Is there a requirement for practice type (e.g., independent, physician-owned, health system practice)?

A. There is no requirement for practice type. AHRQ expects networks formed by Cooperatives to include varied practice types.

Q. Section IV.2, 398 Research Plan, Section 1: The State, the Cooperative and the Project Team. In the third paragraph above Section 2, the range of quality improvement services includes "financial management guidance." Please explain in the context of this cooperative agreement.

A32. "Financial management guidance" is listed as one of a range of services the Cooperative may deliver to a practice. Financial management with regard to practices might include issues relating to coding, billing, revenue generation, etc., especially within the context of implementing PCOR findings.

Q. Section IV.7, Other Submission Requirements and Information. Is IRB approval necessary or applicable to this cooperative agreement? We understand research is an objective but believe the FOA describes a quality improvement initiative that includes evaluation, rather than human subject research.

A. Applicants are expected to submit their projects to Institutional Review Boards, which will determine whether the activities proposed constitute human subjects research or not.