Fiscal Year 2020 National Health Center Training and Technical Assistance Partners (NTTAP) Cooperative Agreements Notice of Funding Opportunity: Sample Project Work Plan

You must complete the Project Work Plan (PWP) in the HRSA Electronic Handbooks (EHBs). The PWP outlines your proposed training and technical assistance (T/TA) activities for the first 12 months. You must propose activities that will lead to Objective Target attainment by the end of the 3-year project period (June 30, 2023). Guidance for completing each field in the Project Work Plan form is available in the Appendix A of the NTTAP NOFO on the NTTAP Technical Assistance webpage. Reference Appendix B in the NTTAP NOFO for numerator and denominator definitions when developing your baseline data. Use this sample PWP for reference only.

For objectives where you provide baseline data, utilize data that are valid, reliable, and whenever possible, derived from current national-level data sources related to health centers and/or NTTAP population or development areas. For further guidance, reference the Data Tip Sheet on the NTTAP Technical Assistance webpage. If baselines are not yet available, you may enter "0" for the numerator and state in the comments field when baseline data will be available.

NTTAP Type: Special Population - People Experiencing Homelessness
Objective 2: Diabetes Control
Objective Description: Reduce the percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c greater than 9.0 percent during the measurement period
***Baseline Data Source:** In 2018 Uniform Data System (UDS) Table 7: Health Outcomes and Disparities, 2,385,969 *total health center patients* (8.40%) had diabetes mellitus, and 783,354 or 32.83% of those patients had hbA1c levels greater than 9%. According to UDS Table 6A reported by Health Care for the Homeless (HCH) award recipients, 92,202 or 9.12% of patients experiencing homelessness had diabetes mellitus in 2018. Since people experiencing homelessness often have difficulty adhering to treatment plans due to inconsistent access to healthy food, diabetes medications, and medical care, we expect that diabetic patients experiencing homelessness have higher rates of uncontrolled diabetes (hbA1c levels over 9%) than the total health center patient population. Based on a survey of HCH health centers regarding their diabetic patients, we estimate the actual baseline for uncontrolled diabetes in this patient population is closer to 45%.
Numerator: 783,354 (prepopulated)
Denominator: 2,385,969 (prepopulated)
Baseline Percentage: 32.83% (prepopulated)
***Objective Target:** 30.83%
***Objective Impact Narrative:** Through T/TA on innovative education and self-management methods for diabetic patients experiencing homelessness, including T/TA for utilizing remote monitoring devices when appropriate, we will support health centers in decreasing the percentage of patients with hbA1c levels over 9% to 30.83% by the end of the project period. We will collaborate with other NTTAPs focusing on people experiencing homelessness in developing, coordinating, and disseminating diabetes prevention and control T/TA to maximize impact.
***Formal T/TA Session Target - Learning Collaborative:** 24

[Cumulative number of formal T/TA sessions for a learning collaborative audience throughout the 3-year project period]
***Formal T/TA Session Target - National Audience:** 16 [Cumulative number of formal T/TA sessions for a national audience throughout the 3-year project period]
***Participation Target:** 1,000 [Cumulative number of health center representatives who will participate in all formal T/TA sessions throughout the 3-year project period]
***Participant Satisfaction Target:** 4.5 [Estimated average satisfaction score using a 5-point scale for all T/TA participants throughout the 3-year project period]
***Participant Behavior Change Target:** 4 [Estimated average T/TA behavior change score using a 5-point scale for all T/TA participants throughout the 3-year project period]
Key Factors
***Key Factor Type:** Contributing
***Key Factor Description:** Health centers have access to state-of-the-art diabetes testing methods at discounted prices and extensive knowledge about serving patients experiencing homelessness. We can build upon past learning collaborative experience with Healthcare for the Homeless (HCH) health centers around remote monitoring of diabetic patients to quickly expand and accelerate activities in this area.
***Key Factor Type:** Restricting
***Key Factor Description:** Barriers that impact patients experiencing homelessness in managing diabetes include inconsistent access to healthy foods, proper storage of medications that control hbA1c levels, and a lack of transportation to access medical and other services, resulting in difficulty adhering to treatment plans that support diabetes management.
Activities
***Activity Name: Diabetes Education and Self-Care Collaborative**
***Activity Audience:** Learning Collaborative
***Activity Description:** We will form a 25-member learning collaborative comprised mostly (75%) of health centers receiving HCH funding. In the first year the learning collaborative will develop goals and procedures, and identify and plan the implementation of innovative diabetes education and self-care methods for diabetic patients experiencing homelessness. We will hold at least two project planning-focused T/TA sessions, one implementation-focused T/TA session, and one evaluation-focused T/TA session via teleconference in the first twelve months for approximately 3 staff participants per learning collaborative member (e.g., health center or PCA). Results will inform national T/TA activities in this area.
***Person or Group Responsible:** P. Rao, Program Lead
***Targeted Start Date:** August 16, 2020
***Targeted End Date:** June 30, 2021
***Expected Outcome:** We will establish the learning collaborative, identify and select promising diabetes education and self-management methods, and begin planning their implementation. The learning collaborative will also establish a continuous quality improvement framework to evaluate a core package of services for diabetic patients experiencing homelessness that reduce barriers to care, rates of uncontrolled diabetes, and rates of diabetes in general.
Comments: n/a

Fields noted with * are required.