

## Rural Healthcare Exchange Program “Peer-to-Peer Mentoring in Rural Idaho”



IDAHO DEPARTMENT OF HEALTH & WELFARE  
DIVISION OF PUBLIC HEALTH



**What is the Rural Healthcare Exchange Program?** This program, offered by Bureau of Rural Health & Primary Care, provides opportunities for health organizations serving rural and underserved areas of Idaho to learn from their peers. The Rural Healthcare Exchange Program provides travel support for individuals or small groups to meet with similar entities from other areas of the state and share information, ideas, and successful approaches to improving quality and access to healthcare services.

**Who is eligible?** The program is open to staff serving Idaho Critical Access Hospitals, Rural Health Clinics, Federally Qualified Health Centers, and Free Medical Clinics. Eligible applicants also include Idaho’s rural non-profit EMS agencies, rural health grant writers and foundation staff, and network representatives serving rural Idaho health organizations. The program does *not* include visits with consultants, conference travel, or support for regularly scheduled meetings or training events.

**How does it work?** The applicant speaks with a prospective peer mentor to discuss the proposed exchange activity. Applicants may visit a peer mentor in another community or invite the mentor to visit their organization. After an agreement is reached, the applicant submits the Rural Healthcare Exchange Program application to the Bureau of Rural Health & Primary Care.

**When arranging the exchange, if travel costs exceed 5% of the estimated approved amount, contact the Bureau of Rural Health & Primary Care prior to incurring the expense to ensure there is funding available.**

**When can the exchange be scheduled?** The period of activity for this opportunity is **July 1, 2019 – May 31, 2020**. The Bureau of Rural Health & Primary Care will contact the applicant within 5-7 business days with an approval or denial of the application. Applicants and exchanges meeting the criteria defined in the attached instructions will be approved on a “**first-come, first-serve**” basis. **Exchanges must be completed by May 31, 2020.**

**What happens after receiving the approval?** Applicants proceed with their proposed exchange based on the approved application. Following the exchange visit, the applicant submits an invoice, receipts, and a completed outcome report to the Bureau of Rural Health & Primary Care for reimbursement.

**Questions?** For additional questions or information, please contact:

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**Rural Healthcare Exchange Program- APPLICATION**  
***“Peer-to-Peer Mentoring in Rural Idaho”***

**1) Applicant:** \_\_\_\_\_ Date: \_\_\_\_\_  
Organization: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Contact Name: \_\_\_\_\_  
Email: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Name of person(s) involved in exchange: \_\_\_\_\_

**2) Location of exchange:**  
Check one:  
 I/We want to visit the following community/organization: \_\_\_\_\_  
 I/We want to bring \_\_\_\_\_ to our community/organization.

**3) Exchange request:**  
a. Describe the exchange mentoring activity for which funding is requested: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
b. Anticipated date(s) of exchange (*no later than 05/31/20*): \_\_\_\_\_  
c. Intended outcome: \_\_\_\_\_  
\_\_\_\_\_  
d. Total estimated funding request: \$ \_\_\_\_\_  
*Details on allowable expenses can be found on the instruction page. If costs exceed 5% of the approved application amount, contact the Bureau of Rural Health & Primary Care prior to incurring the expense.*

**Mileage:**  
Travel from: \_\_\_\_\_ Travel to: \_\_\_\_\_  
Total mileage cost: \$ \_\_\_\_\_ (calculated at # miles x \$0.58/mile)

**Lodging:**  
# of nights: \_\_\_\_\_ # staff: \_\_\_\_\_ at: \_\_\_\_\_ per night (maximum 3 nights/person; limited to length of exchange). Total Lodging: \$ \_\_\_\_\_

**Airfare:**  
Airfare: \$ \_\_\_\_\_ (limited to advance purchase, coach class)

*Organizations receiving travel support are required to complete the attached outcome report upon exchange completion; receipts for lodging and airfare are required for reimbursement.*

## Instructions for Completing Rural Healthcare Exchange Program Application

1. **Eligible Applicants:** Critical Access Hospitals, certified Rural Health Clinics, Federally Qualified Health Centers, Free Medical Clinics, network representatives serving rural health entities, rural health grant writers and foundation staff, rural non-profit EMS agencies, and other non-profit healthcare entities serving rural and underserved areas of Idaho.
  - The mentoring exchange may involve more than one person from the same organization, if they are essential to implementing the project. *Please note: funds cannot be requested to cover consultant fees, conference expenses, or regularly scheduled meetings.*
2. **Location of Exchange:** The exchange visit may occur at the applicant's organization or the applicant may travel to the location of the peer mentor. This decision is based upon the agreed upon location of the applicant and mentor. For example, the applicant may invite a peer with expertise in quality improvement to meet with a team at their facility or an applicant may travel to another location to view and evaluate an automated medication dispensing system.
3. **Exchange Request:** Itemize and total the funding estimate for the proposed exchanged based on the following:
  - Round-trip ground mileage between your organization and the mentor location at \$0.58 per mile; receipts not necessary for reimbursement; state mileage chart used for mileage verification.
  - Lodging limited to reasonable accommodations at the government per diem rate and only those nights necessary to meet the needs of the proposed exchange; maximum three nights per person for two-day exchange; receipt required for reimbursement.
  - Airfare limited to two-week advance purchase, coach class, round trip travel; receipt required for reimbursement.
  - ***When arranging the exchange, if travel costs will exceed 5% of the approved amount, contact the Bureau of Rural Health & Primary Care prior to incurring the cost to ensure there are funds available.***

### Approval and Reimbursement Information

- A. Applications may be emailed, faxed, or mailed to the Bureau of Rural Health & Primary Care; applicants will receive confirmation and an approval or denial of the proposed exchange within 5-7 business days of receipt of the application.
- B. All travel must be completed by May 31, 2020 and invoices received by June 1, 2020.
- C. The attached outcome report must be submitted with your reimbursement request; reimbursement will be denied if the outcome report and applicable receipts (airfare and lodging) are not included.
- D. A sample invoice can be provided, upon request, to assist with your reimbursement request.
- E. Mentoring exchanges are limited to **two people per organization**.
- F. **Funding is allocated on "first-come, first-serve" basis for applicants meeting the criteria. The mentoring program ends when available funds are exhausted.**

**Rural Healthcare Exchange Program- OUTCOME REPORT & INVOICE**  
***“Peer-to-Peer Mentoring in Rural Idaho”***  
***Due upon exchange completion and required for reimbursement***

**1) Applicant:** \_\_\_\_\_ Date: \_\_\_\_\_  
Organization: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Organization Tax ID#: \_\_\_\_\_  
Contact Name: \_\_\_\_\_  
Email: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Name of person(s) involved in exchange: \_\_\_\_\_  
\_\_\_\_\_ License Plate # \_\_\_\_\_

**2) Location of exchange:** \_\_\_\_\_

**3) Exchange project:**

a. Description of the completed exchange project: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

b. What key issues or information did you learn from this visit? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

c. How will that information be used? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

d. Please add your comments or suggestions to improve the peer-to-peer mentoring program or application process: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**4) Reimbursement request: \$** \_\_\_\_\_

*Please submit your invoice and receipts with this report.*



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