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## 6.1 New York Health IT Strategy

### Attachment 6.1 New York State's Health IT Strategy

To deliver safe, effective, high quality and affordable care in the 21st Century, strategic adoption of an interoperable health information infrastructure is needed to transform health care from today's largely paper-based system to an electronic, interconnected health care system. Accordingly, as one of its principle health care reform initiatives, New York has engaged in the development and implementation of a health information infrastructure called the Statewide Health Information Network for New York (SHIN-NY).

New York's health IT plan is being advanced in the public's interest and with clinical priorities and quality and population health improvement goals leading the way. The plan is currently being updated utilizing a comprehensive, public and private stakeholder-informed statewide process through the public/private collaboration between the New York State Department of Health and the New York eHealth Collaborative.

The following is a link to the plan that is being updated:

[New York State Health IT Strategic Plan](http://nyhealth.gov/funding/rfa/0903160302/health_it_strategic_plan.pdf)

[http://nyhealth.gov/funding/rfa/0903160302/health\\_it\\_strategic\\_plan.pdf](http://nyhealth.gov/funding/rfa/0903160302/health_it_strategic_plan.pdf)

## 6.2 CHITA Services Template

### Attachment 6.2 CHITA Services Template

#### I. Health IT Adoption and Support Services (CHITA Services) Plan

A description of health IT adoption and support services is required that includes all services listed below to promote EHR adoption, ensure adoption and effective use and achieve patient care improvements

Applicants are required to complete the matrix (Attachment 6.11) outlining the EHR adoption and support services needs and a plan to address those needs. This should include intended results with respect to patient care coordination improvements and specific actions for achieving the goals during the grant period. Poor implementations have been identified as one of the prime causes of low adoption of health information technology and this template will help identify the resources necessary to prevent failure.

Below the applicant must list by service how much the service will cost, the quantity of full time equivalents that will be required for that service, the anticipated portion of HEAL funding that will cover that service cost, the anticipated portion of other funding/support that will cover that service cost and where/who the other funding/support is coming from (Other Funding/Support Source). All service cost estimates must be based upon a comprehensive assessment from multiple vendors.

#### II. Service Definitions

Service	Definitions
Readiness Assessment	Services to assess practice readiness for EHR implementations including leadership support, financial commitment, staff capacity and workflow teams, policy considerations, computer literacy of all users, readiness questionnaires and well defined implementation goals.
Workflow Re-design	Analysis and planning for the successful integration of EHRs into practice settings, including office reconfiguration, changes in roles and responsibilities, EHR and IT configuration, setup and transition of legacy data and systems, planning for quality outcomes and reporting
Project Management	End-to-end project management services for EHR and HIE deployments including pre-implementation tasks, system deployment and implementation, post-implementation services. This may include oversight of vendor services and management of interoperability functions.
Vendor Selection	Formalized process and tools used in the EHR vendor selection process,

	including detailed selection criteria (functionality, training, reporting, implementation approach, etc.), vendor certification requirements meeting both federal and state requirements), technical support, maintenance plans, demo plan, references, vendor disaster recovery planning and application hosting.
Adoption Resources/Tools	Processes and tools to help practices achieve higher EHR adoption and continuous process improvement, including templates, flow sheets, workflow toolkits, best practices, data migration processes, etc.
Answer Desk	Resource(s) to respond to calls and email questions from EHR users (Re: EHR functionality, problems and a wide variety of EHR and HIT use issues).
Business Analysis/Project Navigation	Resource(s) to assess project status and support project needs across the EHR value chain, including readiness planning, workflow analysis and execution, goals definition, financial sustainability.
Technology Analysis	Analysis of all aspects of technology required to implement EHRs including IT requirements definition, system requirements, system selection, infrastructure assessments, technology integration, transition planning, hardware configuration, technology support, technology replacement planning and disaster recovery.
Interface Services	Technical resources to advise, certify and provide interfacing services between EHRs and HIE systems and national and local data sources following all federal and state requirements.
IT Implementation and Support	Management services for hardware deployment (infrastructure, network setup, perimeter security, firewalls, wireless networks, etc.) and support (maintenance, upgrades, backups, etc.).
Dictionary Mapping	Guidance and services to map and maintain clinical and administrative dictionaries (ie. services to map lab compendiums to LOINC).
Contract Support	Formalized assistance for the creation, execution and ongoing management of EHR vendor contracts, and other related HIT contracts.
Training	Training resources to ensure successful HIT adoption including basic and enhanced EHR training to maximize use of the system (performance measurement, clinical decision support)
Quality and Process Improvement	Assessing and modifying clinical practices and workflow to achieve improvements in patient care coordination and management.

**Note: See Attachment 6.11 (Budget Forms – “HEAL 17 Budget Worksheet.xls”) and complete CHITA Services tab (Excel file which includes a CHITA Services tab)**

III. Narrative Description of Plan to Address Health IT Adoption and Support Needs (see Sections 3.3.5)

This section must include the following:

- Describe, in detail, the process undertaken to consider cost estimates; and
- Assumptions made as part of estimating costs for services, being sure to address how each component in the table above is going to be delivered and offered as a package with all necessary services (i.e., directly by a CHITA or through a CHITA partnership).

### 6.3 Stakeholder Template

#### Attachment 6.3 Stakeholder Template

(One template should be completed for each diagnosis proposed in the project)

Identify chosen diagnosis for project: \_\_\_\_\_

If the diagnosis above is not one listed in Attachment 6.7 (Diagnosis Choices) include sufficient documentation proving that the mental health or chronic disease diagnosis involves a significant portion of the population in the CCZ. The chosen diagnosis should also align with the PCMH model and include all appropriate stakeholders:

#### NARRATIVE

All project stakeholders must be documented in the tables in the excel file "Attachment 6.3 – Stakeholder Table". Letters of support must appear in section IV of this attachment

## I. Stakeholder Participation Narrative.

This must include a detailed RHIO partnership and governance plan, including but not limited to:

- a. Describe how the PCMH providers are participating in a RHIO and what role the PCMH provider are playing and activities in which they are participating; and
- b. Describe how the PCMH providers are planning on utilizing SHIN-NY services and committing to sharing information with all appropriate providers in the PCMH. RHIOs are a part of the statewide governance structure managed by NYeC and are responsible for implementing the SHIN-NY pursuant to Statewide Policy Guidance.

## II. Patient Centered Medical Home (PCMH) Analysis

In the tables in the Excel file “Attachment 6.3 – Stakeholder Table” describe your Patient Centered Medical Home in terms of the following metrics. Sources for information reported should be included. Sources must be made available to NYSDOH upon request. NYSDOH reserves the right to evaluate responses based on resources available to the Department. Completing the tables attached is required.

## III. Letters of Support

Each letter of support must include the following components:

- Corporate name of the stakeholder:
  - Contact information for the stakeholder (primary contact & backup contact, including project manager or equivalent); and
  - Full commitment to bidirectional sharing of information among the PCMH participants. This includes data for HIE, quality reporting and data for research and evaluation purposes.
- Signature of the stakeholder executive.
- Commitment to project including:
  - Financial contributions (personnel, cash, etc... to be aggregately reported on the Project Funding Form with associated letter of support #);
  - Role in the project;
  - Reason for participation; and
  - Future plans for participation.
- Percentage of population served for each target patient population in the PCMH which is the total number of patients with each of the specified diagnoses covered by the stakeholder divided by the total number of patients with that diagnosis in the PCMH.

The RHIO letter of support must include:

- RHIO name and contact information for the executive director and a back up contact.
- Signature of the RHIO Board Chair and Executive Director.

- Commitment to project including:
  - Description of the role in the project;
  - Providing connections between and among EHRs and other health IT tools and the SHIN-NY technical infrastructure; and
  - How PCMH participants fit into the SHIN-NY governance structure.

If a CHITA is not the lead applicant, then the CHITA letter of support must include:

- CHITA name and contact information for the executive director and a back up contact.
- Signature of the CHITA Director.
- List of all organizations that are a part of the CHITA and providing health IT technical services and/or adoption and support services to the project.
- Commitment to project including:
  - Describe role in the project; and
  - List of all other PCMH projects to which the CHITA is providing services.

If the CHITA is the lead applicant, then letters of support are required from each PCMH participant and include the following:

- Corporate name of the stakeholder:
  - Contact information for the stakeholder (primary contact & backup contact ; including project manager or equivalent); and
  - Full commitment to sharing information among the medical home participants. This includes data for HIE, quality reporting and data for research and evaluation purposes.
- Signature of the stakeholder executive.
- Commitment to project including:
  - Financial contributions (personnel, cash, etc... to be aggregately reported on the Project Funding Form with associated letter of support #);
  - Role in the project;
  - Reason for participation; and
  - Future plans for participation
- Percentage of population served for each target patient population in the CCZ which is the total number of patients with each specified diagnosis covered by the stakeholder divided by the total number of patients with that diagnosis in the CCZ.

Number each letter for reference in Section I of this attachment.

### **Resources for Applicants**

In order to help locate health care providers relevant to the applicant’s CCZ the following resources may be useful:

1. To locate information about home health agencies and hospice programs in New York State: <http://homecare.nyhealth.gov/>
2. To locate information about New York State hospitals: <http://hospitals.nyhealth.gov/>

3. Statewide Patient Centered Medical Home Program For Office-Based Practitioners:  
[http://www.nyhealth.gov/health\\_care/medicaid/program/update/2010/2010-05.htm#sta](http://www.nyhealth.gov/health_care/medicaid/program/update/2010/2010-05.htm#sta)
4. For a directory of health care providers across the state:  
<https://commerce.health.state.ny.us/hcsportal/appmanager/hcs/home>

## 6.4 Model Project Work Plan

### Attachment 6.4 Model Project Work Plan

#### I. Work Plan

Applicants should include a one to two page high level narrative of their work plan (Insert Narrative Here), including an implementation plan and timeline based on incremental phases clearly delineating which stakeholders are participating in the implementation and how the project will be rolled out across the region.

The narrative should be structured in the following way:

- Organizational/Governance Plan (reference Organizational Plan in Application Structure);
- Care Coordination and Management Plan (reference Clinical Plan in Application Structure document);
- Technical and Interoperability Plan (reference 9.9 – Technical Architecture and Implementation Plan);
- CHITA Services Plan (reference 9.2 – Health IT Adoption and Support Services Template); and
- Reimbursement/Sustainability Plan (see Section 4 of the RGA).

Following the narrative, applicants should identify high level milestones, by quarter, for a typical two-year project. This MS Word document should be used.

#### **Insert Narrative Here**

#### **II. Complete Milestones**

##### Year 1

- Quarter 1
  - 
  - 
  - (insert more as appropriate)
- Quarter 2
  - 
  - 
  - (insert more as appropriate)
- Quarter 3
  - 
  - 
  - 
  - (insert more as appropriate)

- Quarter 4
  - 
  - 
  - (insert more as appropriate)

Year 2

- Quarter 1
  - 
  - 
  - (insert more as appropriate)
- Quarter 2
  - 
  - 
  - (insert more as appropriate)
- Quarter 3
  - 
  - 
  - (insert more as appropriate)
- Quarter 4
  - 
  - 
  - (insert more as appropriate)

6.5 Reimbursement and Sustainability Programs and Measures

Attachment 6.5  
Reimbursement and Sustainability Programs and Measures

Projects are encouraged to leverage incentive programs for health information technology to support improvements in patient care and to maximize provider participation and funding support as part of a long term plan for project sustainability. A key to sustainable use of health information technology is using it to capture incentives from quality improvement programs. This attachment provides a list of examples of potential programs that are either currently available or proposed in NYS that can be leveraged to provide further funding to support HEAL 17 projects.

Examples of Available Programs:

- Medicare incentive program for “Meaningful use”
- Medicare incentive program for e-prescribing (utilization based).
- NYS Medicaid and e-prescribing (utilization based).
- Bridges to Excellence P4P (population based).
- NYS Medicaid Medical Home (utilization based).
- Other Health Plan Incentives, such as:
  - Medical Home (utilization based);
  - Pay for Performance (population based);
  - Reimbursement reform (population based); and
  - E-Prescribing (utilization based).

List and describe below any programs (such as the examples listed above) in which stakeholders in your project already participate or plan to participate. Also describe how your project plans to use health information technology to participate successfully in these or other incentive programs.

Program Name	Description of Health IT and Incentive Program	List stakeholders currently participating	List stakeholders planning to participate and when

I. Measures

## 6.6 Regional Health Information Organization (RHIO) Requirements

### Attachment 6.6

#### Regional Health Information Organization (RHIO) Requirements

The proposed project must include a partnership with a state-recognized Regional Health Information Organization (RHIO). The role of RHIOs is to support the implementation of health information exchange and the SHIN-NY through participating in the Statewide Collaboration Process (SCP) and ensuring compliance with Statewide Policy Guidance. Accordingly, the RHIO is required to provide both the project and the state with documentation of their agreed-upon role in the project, and demonstrated compliance with the criteria below. If a project proposes to use an alternative approach to connecting to the SHIN-NY than through the technical support provided by their designated RHIO they must still address all of the elements listed in the chart in appendix 6.6 and describe how this approach will integrate with a unified governance approach. This alternative option for connectivity to the SHIN-NY must also be approved by DOH

#### a. Definition:

A RHIO is a not-for-profit corporation that meets the definition as set forth in the HEAL 5 Request for Grant Applications (<http://www.health.state.ny.us/funding/rfa/0708160258/0708160258.zip>) and agrees in writing to follow the Statewide Policy Guidance ([http://www.health.state.ny.us/technology/statewide\\_policy\\_guidance.htm](http://www.health.state.ny.us/technology/statewide_policy_guidance.htm)) applicable to RHIOs as developed through the Statewide Collaborative Process (SCP) managed by the New York eHealth Collaborative (NYeC).

RHIOs are an integral part of the governance, policy development and implementation activities for health information exchange across NYS. They provide local governance and technical support to connect community-level providers to the Statewide Health Information Network for New York (SHIN-NY). RHIOs also serve as trusted entities to implement information policies that support secure, reliable and efficient exchange of health information in order to improve health care quality, affordability and outcomes.

#### b. Accountability Measures

RHIOs must comply with standards for health information exchange activities in the domains of Organizational, Clinical, Technical, Financial and Privacy and Security.

#### Organizational

- Maintain status as legally established, non-profit entities responsible to a board of directors and committed to operational and financial transparency.

- Provide for open and transparent stakeholder input about the organization, management, and board.
- Maintain an adequate professional staff responsible to the board through an executive to help ensure accountability to the organization’s mission.
- Provide mechanisms for collecting and responding to complaints.
- Develop and maintain updated strategic and operational plans that are aligned with the overall statewide health information technology strategy.
- Have a board composition that reflects the RHIO participants and stakeholders.
- Have participation and data exchange agreements in place that comply with and enforce applicable federal and state laws.

#### Clinical

- Active practicing clinician participation and input at all levels of the governance and implementation process.
- Ensure that clinical and public health priorities and measurable outcomes drive technology implementation.
- Have a clear plan for increasing HIE adoption rates.

#### Technical

- Provide technical services based on common health information exchange protocols and standards (including standards established through federal regulations) to share information among providers and with patients and mobilize information for public health and quality reporting (including meaningful use).

#### Financial

- Develop and maintain financial policies and procedures consistent with state and federal requirements.
- Develop and maintain a business plan that ensures financial sustainability and equitable terms and access to governance and technical services by all health care stakeholders. The RHIO’s plan for equitable access to technical services must include plans to offset user fees or assessments on participants where appropriate. Technical services must include health information exchange capacity to support “meaningful use” and consistency with public good characteristics of health information exchange.

#### Privacy and Security

- Develop and maintain privacy and security policies and procedures consistent with state and federal requirements.

- Develop policies that will protect privacy, strengthen security, ensure affirmative and informed consent, and support the right of New Yorkers to have greater control over and access to their personal health information.

c. Sample Documentation of Accountability Measures

The following are examples of documentation that the RHIO can provide to the project and DOH to “demonstrate compliance” with each of the criteria listed above. However, DOH will have the right to request any and all of the following in the form of documentation or on-site inspection:

Domain	Documentation
Organizational	<ul style="list-style-type: none"> <li>– Governance Plan</li> <li>– Annually submit strategic and operational plans for review by an oversight body</li> <li>– Complete copy of organization policies and procedures</li> <li>– Policies, charters, schedules and minutes for board and committee meetings reflecting a representative structure that is transparent and equitable</li> <li>– Signed/current participation agreements for all board and committee members</li> <li>– Participation agreements and/or MOUs</li> <li>– Executed contracts</li> </ul>
Clinical	<ul style="list-style-type: none"> <li>– Signed/current participation agreements for clinical providers</li> <li>– Committee meeting minutes showing attendance by clinical providers</li> <li>– HIE/EHR/PHR statistic reports</li> <li>– Quality reports</li> <li>– RHIO &amp; Provider Attestations</li> </ul>
Technical	<ul style="list-style-type: none"> <li>– Certifications</li> <li>– Vendor audits</li> <li>– Catalogue of Health Information Exchange services provided</li> <li>– Technical testing demonstrations and outputs</li> <li>– HIE/EHR/PHR statistic reports</li> <li>– Demonstrate successful implementation of the relevant standards and requirements as articulated in the Interim Final Rule on standards and certification criteria for certified EHR technology (<a href="http://edocket.access.gpo.gov/2010/pdf/E9-31216.pdf">http://edocket.access.gpo.gov/2010/pdf/E9-31216.pdf</a>)</li> </ul>
Financial	<ul style="list-style-type: none"> <li>– IRS 990 filing</li> <li>– Independently audited financial statements including balance sheets, income statements and other relevant documents</li> <li>– Sustainable Financing and Business Plan</li> <li>– Financial policies</li> </ul>

	<ul style="list-style-type: none"><li>- Relevant insurances</li><li>- Plan for approval by an oversight body charged with ensuring that costs are distributed equitably among users.</li></ul>
Privacy and Security	<ul style="list-style-type: none"><li>- Consent policies</li><li>- Authentication, Access, Audit, Breach policies</li></ul>

## 6.7 Diagnosis Choices

### Attachment 6.7 Diagnoses Choices\*

#### **Target Patient Population Mental Health or Chronic Disease Diagnostic Choices:**

Project proposals must include one or more of the following Mental Health or chronic disease diagnosis/es to focus the project scope in the proposed care coordination zone. It is implicit that multiple diagnoses will exist (and be prevalent) among the selected patient population. These patients will still benefit from better coordination of care through the PCMH model. These secondary diagnoses are not required to meet criteria identified in the RGA for establishing the PCMH. Alternative diagnoses to those listed below may be proposed but must include documentation with references on how they meet the same criteria as a chronic mental health diagnosis or a chronic disease diagnosis associated with a mental health diagnosis.

#### **Chronic Mental Health Diagnoses**

- Cognitive disorders
- Affective disorders including Depression, Chronic anxiety, Bipolar disorders
- Personality disorders
- Schizophrenia and other Psychotic disorders
- Somatoform, dissociative and related disorders

#### **Chronic Disease Diagnoses**

- Congestive heart failure
- Chronic obstructive pulmonary disease
- Asthma
- Osteoporosis
- Alzheimer's disease
- HIV/AIDS
- End stage renal failure
- Diabetes or other metabolic disease
- Chronic pain disorders ( including Fibromyalgia) and chronic fatigue syndrome
- Autoimmune disease including Celiac disease, inflammatory bowel disease, thyroid disorders, rheumatoid arthritis and others
- Chronic liver disease
- Endocrine disorders such as Cushing's disease
- Chronic neurologic disorders including Alzheimer's disease
- The NYS DOH' provides a website that gives detailed data on the numbers of patients with a specific diagnosis in regions of NYS which may be helpful in identifying high

prevalence diagnoses in a defined geography;

[\(https://apps.nyhealth.gov/statistics/prevention/quality\\_indicators/\)](https://apps.nyhealth.gov/statistics/prevention/quality_indicators/)

6.8 Clinical Scenario Template and Examples

Attachment 6.8

Clinical Scenario Template and Examples

(One scenario template and examples should be complete for each of the diagnoses proposed in the project)

MENTAL HEALTH OR CHRONIC DISEASE SCENARIO EXAMPLE: \_\_\_\_\_

MENTAL HEALTH OR CHRONIC DISEASE POPULATION: \_\_\_\_\_

Clinical Scenario Overview:

In addition to describing your project’s proposed clinical scenario in narrative format, using the chart below, fill out the medical settings/clinical transfer points, clinical stakeholders and include a workflow summary of how care coordination and management will be improved through an EHR and Health Information Exchange. Also include in the scenario the value associated with the implementation of PCMH and EHRs. See clinical scenario example in Appendix 1 below.

Site of Care / Care Transition	Stakeholders	Workflow summary	Comments

Appendix 1: Detailed Case Example

Detailed Scenario Narrative:

**CHRONIC DISEASE SCENARIO EXAMPLE: OSTEOPOROSIS AND HIP FRACTURE**

**CHRONIC DISEASE/HIGH RISK POPULATION: OSTEOPOROSIS IN THE ELDERLY**

**Clinical Scenario Overview:** Ms P., a patient of a primary care practice participating in the PCMH model through HEAL 17, was admitted from home to an acute hospital for an acute left femoral neck fracture. She is being discharged from the hospital to a nursing home facility where she is to receive 30 days of skilled and rehabilitative care and then return home or to independent or assisted senior housing. She was recently diagnosed with osteoporosis by a DXA scan as well as Vitamin D deficiency but had not yet begun treatment prior to the fracture. She is also diagnosed with a MRSA positive wound infection following hip surgery that requires further treatment; follow up by public health and specialty care referral management.

Site of Care / Care Transition	Stakeholders	Workflow summary	Comments
Home to acute care and acute care to nursing home	Acute care and Nursing home staff	Pertinent hospital admission/discharge information to including a complete medication list is available in the PCMH primary care physicians EHR and is available electronically to the acute care facility on the patient’s admission to the emergency center via the health information exchange. This information is also available when the patient is admitted to the hospital for surgical repair of the fracture. An updated medical history including a discharge summary, discharge medications, problem list and test results are all available to the Nursing/Rehab center when the patient is transferred following initial recovery from surgery. Due to the availability of information about the previous diagnosis of osteoporosis and Vitamin D deficiency, the patient is treated for both during the hospitalization and in follow up care resulting in a significantly decreased risk of further	

		fractures or death.	
	Nursing home facility clinical staff:	Medical director, administrator, and clinical staff can input/access administrative and clinical information via EHR and RHIO data exchange access.	
Nursing home to ambulatory care at senior independent living facility	PCP Participating in the PCMH:	The PCP is able to access admission/discharge information from the RHIO as it is made available to his/her EHR via the data exchange; this timely availability of this information allows the PCP to contact and/or visit the patient within 24 hours of discharge as well as coordinate home nursing and other services needed for her safe transition back to independent senior housing.	
	Specialty care	Orthopedics specialist, Infectious disease specialist and a wound care specialist all have access to the patient's clinical information via exchange of data with their EHRs. These clinicians are able to coordinate services with the PCP including timely specialty follow up visits as well as rapid availability of clinical recommendations which results in improving the patient's recovery from a wound infection.	
	Home health care	Home health care services for wound care, etc are coordinated and arranged through the referral capabilities of the PCMH program EHR at the PCP office and patient clinical information is viewable by the home care team via a web-based EHR with clinical information supplied through the data exchange. Home	

		monitoring equipment is available for blood pressure, pulse and temperature.	
	Rehabilitative Services Coordinated Through the PCMH:	The medical home team coordinates PT and OT services which are arranged through the referral capabilities of the EHR and data exchange and the service results are monitored using the EHR and data exchange.	
	Pharmacy	Pharmacy and the PCP are able to adjust the patient's medications by monitoring lab results (PT/INR) and Coumadin dose via availability of lab results in the EHR and using a fully functional electronic prescribing system.	
	Communication with Patient and Caregiver:	Use of a secure electronic system to communicate with the patient (as able) and her authorized caregiver allows communication of test results, medication dosing changes, and scheduling of appointments and tests as well as other coordination of care.	
	Public Health:	The patient screened positive for MRSA when evaluated for a post surgical wound infection. The lab is able to report the result electronically through the data exchange to county and state DOH as legally required. State and county departments of health also have access to reportable infections through RHIO data exchange and are able to access follow up information as needed.	

This case is typical of a vulnerable long-term care patient who can benefit from improved communication of care givers during transfer of care between clinical settings. An EHR coupled with a simplified transfer form and a local RHIO project help assure that Ms P. is discharged promptly to a facility that meets her needs. Upon arrival her care givers have prompt access to key medical information needed to plan for her care. Her primary care physician is able to coordinate her care throughout the transition between care settings through an EHR that is connected to a regional information exchange.

### **Medical Settings/Clinical Transfer Points and Clinical Stakeholders**

Home → Acute Care Hospital → Skilled Nursing Facility → Senior independent living facility (County Public Health, Orthopedics, Infectious disease, Pharmacist, Home healthcare nurse, Nutritionist; Wound specialist; PT, OT all coordinated through Primary Care Physician working in the PCMH)

### **Summary of How Clinical Information is Shared Through the EHR and Data Exchange to Improve Care During Transitions of Care:**

#### **Potential Project Cost Areas and Incentives:**

##### **Costs:**

EHR purchase and implementation and support costs

Office cost for implementation of the PCMH

EHR - RHIO data exchange implementation and support costs

**Incentives for Implementation of EHRs and the PCMH model:** Patient is in the high tier risk category for health care cost and the primary care physician office implementing the PCMH receives a monthly management fee of \$100.35 for such patients through a voluntary incentive program by a major insurer.

### **Appendix 1: Detailed Case Example**

#### **Clinical Example: Osteoporosis Chronic Disease Patient in a Long Term Care setting at High-Risk for Hip Fracture:**

**Transfer Points:** Home → Acute Care Hospital → Nursing Home → Senior independent living facility

### **Hospital Admission**

Ms. P. is an 82 year old widowed female who resided at home. She had lived alone for several years. She is Ukranian and speaks some English. She has one daughter who recently moved back to the area and provides some support. She was admitted to hospital after she was found on the floor, having fallen in her kitchen. Medical history obtained from the on hospital admission was significant for osteoarthritis, osteoporosis and Vitamin D deficiency. She had a pnuemococcal vaccination in the past 3 years.

On examination, extensive bruising was noted on her left side. She was conscious but confused. Other features on examination included left flank pain, atrial fibrillation with a ventricular rate of 55/min. Temperature was 36.5 C.

Medications: Tylenol #3 up to 6 tabs a day, multivitamin, Caltrate 600 plus D, brought by ambulance.

X-rays of her hips and pelvis revealed a left femoral neck fracture and osteopenia. Urinalysis proved positive for bacteria, CPK 300 U/L and a WMC of 400/mmm<sup>3</sup>. Estimations of Hgb, Na, K, Cl, CO<sub>2</sub>, BUN, creatinine, Ca & Mg were all within normal limits. The patient underwent successful surgical stabilization of the fracture. Patient was treated per hip fracture standard hospital protocol.

### **Hospital Day 4**

On day four of the hospitalization, the patient remained lethargic, slightly confused and mostly immobile. Further work-up to more fully assess current status was undertaken:

TSH =44 (normal <6.0) **CS**

Albumin =24 (normal >35) **CS**

Urine culture showed a mixed growth of 3 organisms. **NCS** (bacteruria,10-20% prevalence)

**MRSA: CS**

CT of head shows atrophy only. **Significance unsure** (perform MMSE)

The patient had hypothyroidism as a contributing precipitant for her fall. In addition, there was biochemical evidence of malnutrition. A neurology consultation revealed a MMSE score of 17/30, (mild cognitive impairment possibly reversible once malnutrition and hypothyroidism are treated). BADLs (Katz): Patient is dependent in bathing and dressing. Patient needs assistance to go to toilet. Continence: Patient has occasional accidents. In addition, the nursing staff reported a 2x3 cm sacral decubitus ulcer, stage2.

### **Discharge Orders: Day 7, Regional Nursing Home**

The D/C team determined to move Ms P to a nursing home closer to her daughter for follow up care and rehabilitation with plans for her to return home later on if possible. Following a 6 week stay she was discharged a senior independent living facility from the nursing home.

Discharge plans included follow up home health nursing care as well as follow up P.T. and O.T. care coordinated through the patient's primary care physician office.

**Follow-up with primary care physician in one week:**

- Hypothyroidism
- Fall work-up
- Osteoporosis
- Vitamin D deficiency
- Malnutrition
- R/O depression
- R/O dementia
- Pressure Ulcer Stage 2
- MRSA+ post surgical wound infection

**Follow-up with Orthopedics in 1 week**

**Other consults:**

- Physiotherapy
- Wound care therapy

**Discharge Medications:**

- Remeron 15 mg qd (anti-depressant that increases appetite)
- L-thyroxine 50 mcg po qd (hypothyroidism)
- Arixtra 2.5 mg sc (DVT prophylaxis, Atrial Fib)
- Tylenol #3, up to 6 tabs qd
- Vancomycin 40-50 mg tid
- Calcium 600mg twice a day
- Vitamin D 2000 IU one time a day

(Received 5 mg IV treatment with Reclast during the hospitalization which will need to be repeated in one year for treatment of osteoporosis)

**F/U labs needed:** TSH, B12, Folate, PT/INR, adjust to INR of 2-3.0., Vitamin D level in 2 months

**Weight Bearing Status:** Partial, use walker

## 6.9 Technical Architectural and Interoperability Plan

### Attachment 6.9 Technical Architecture and Interoperability Plan

#### 1. Overview

##### 1.1 Purpose of the Document

The purpose of this document is to provide a description of the technical architecture and interoperability plan and timelines for achieving the plan [your project name] will implement in compliance with the current versions of NHIN requirements and NYS Statewide Policy Guidance (Section 6.14). Statewide Policy Guidance is developed through the Statewide Collaboration Process which is managed by NYeC and approved by the DOH.

#### 2. Architectural Description Summary

This section should include a narrative description of the technical architecture and interoperability plan for connecting practice and other organization EHRs and other health IT tools to exchange clinical information via health information exchange (HIE). The components depicted in Figure 1, detail the key elements that need to be addressed as part of the plan.

Component A is the RHIO's or other SHIN-NY compliant HIE that you will be connecting to as part of your HEAL 17 grant. You should describe the vendor(s) that the RHIO or other SHIN-NY compliant HIE is or will be using to implement their HIE, the functionality envisioned, the design at the EHR level to exchange data and the health information types to be exchanged. Please use Row A in the grid to complete your Current and Future state of connectivity. For all connections between the EHR and an HIE/RHIO, please indicate the vendor and number of practices using that vendor.

The rest of the diagram depicts connections that are or will be established as part of your plan and should be completed as follows:

**B** – This represents a connection between a local practice's or other organization's EHR and the RHIO/SHIN-NY compliant HIE /“(“little bus”). . Identify the clinical data types that will be transmitted between the practice and the RHIO/SHIN-NY compliant HIE, the nomenclature standards used, and the directionality of the transmission (ie. one way or bidirectional). Do not forget to include consent and other transaction types (ie. referrals, prescriptions, etc.).

**C** – This represents the legacy connection between a local practice's or organization's EHR and a local Legacy HIE. Identify the clinical data types that will be (or are currently) transmitted between the practice and the local legacy HIE, the protocol used, the nomenclature standards used, and the directionality of the transmission (ie. one way or bidirectional). Do not forget to include consent and other transaction types (ie. referrals, prescriptions, etc.).

**D** – This represents a connection from other clinical data sources to the Legacy or Future HIE. For each clinical data source please indicate the protocol used, the nomenclature standards used, and the directionality of the transmission (ie. one way or bidirectional). Please include a plan to transition from a local connection to the HIE to a plan that connects directly to a RHIO “little bus”(as in “E”).

**E** – This represents a future connection using a CHIxP compliant connection. For each clinical data source please indicate the nomenclature standards used, and the directionality of the transmission (ie. one way or bidirectional).

**F** – This represents the legacy connection between a Regional Enterprise (ie. hospital, IDN, etc.) and a Legacy HIE. Identify the clinical data types that will be transmitted between the practice and the HIE, the protocol used, the nomenclature standards used, and the directionality of the transmission (ie. one way or bidirectional). Do not forget to include consent and other transaction types (ie. referrals, prescriptions, etc.).

**G** - This represents a CHIxP compliant connection between a Regional Enterprise and a RHIO or other SHIN-NY compliant HIE “little bus”.. Identify the clinical data types that will be transmitted between the practice and the RHIO/HIE via the “little bus”, the nomenclature standards used, and the directionality of the transmission (ie. one way or bidirectional). Do not forget to include consent and other transaction types (ie. referrals, prescriptions, etc.).

**H** – This represents a Legacy connection between a Regional Enterprise (ie. Hospital, IDN, etc.) and a practice’s or other organization’s EHR. Identify the clinical data types that will be transmitted between the practice and the Regional Enterprise, the protocol used, the nomenclature standards used, and the directionality of the transmission (ie. one way or bidirectional). Do not forget to include consent and other transaction types (ie. referrals, prescriptions, etc.).

**I** – This represents the Legacy connection between a practice’s or other organization’s EHR and other clinical sources (ie. local lab vendor). For each clinical data source please indicate the protocol used, the nomenclature standards used, and the directionality of the transmission (ie. one way or bidirectional).

## 2.1 Current architectural summary (narrative)

Using Figure 1 as a general reference, please provide an architectural summary of the current state of your project.

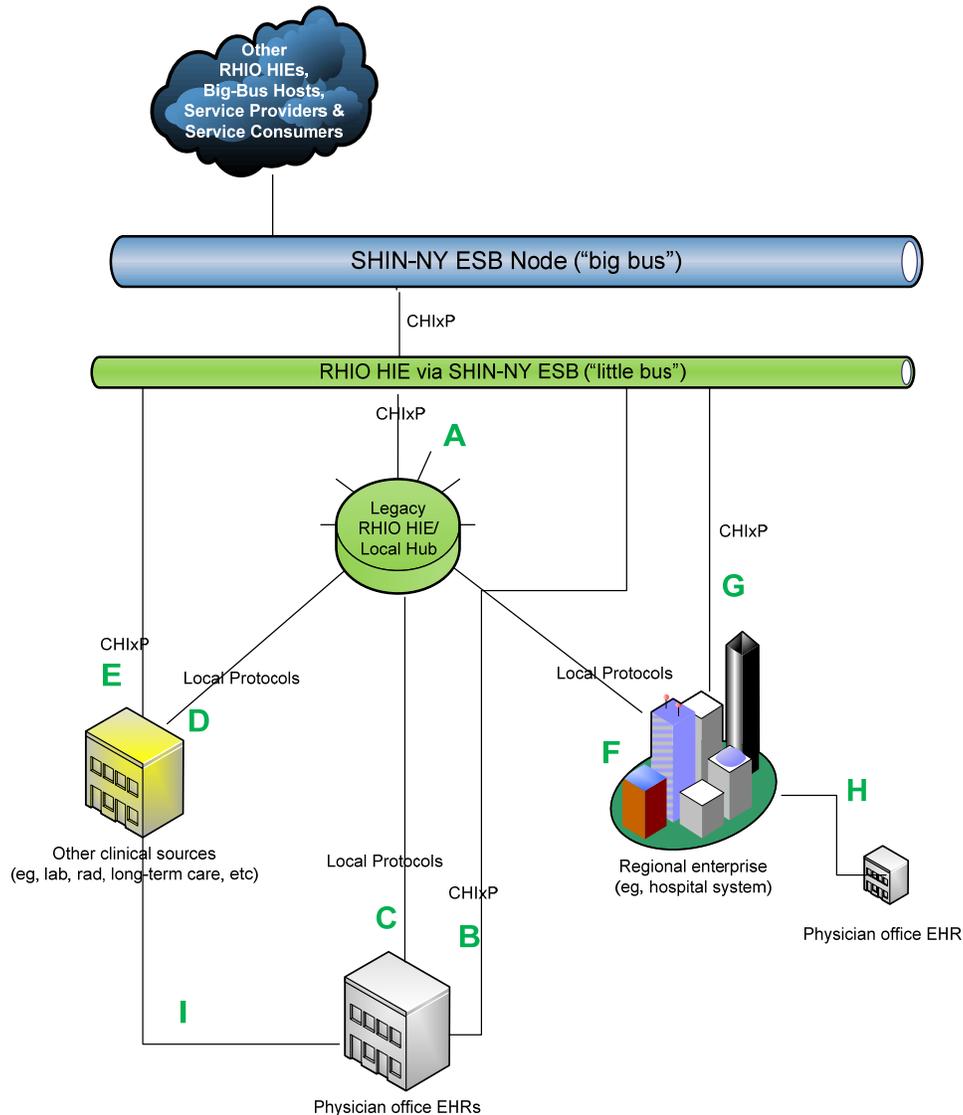
Projects utilizing technology in addition to EHRs must provide a description of the technical strategy for connecting this technology to the SHIN-NY. If a connection to a local hub is employed, it must be clearly explained and justified.

## 2.2 Planned architectural summary (narrative)

Using Figure 1 as reference, please provide an architectural summary of the proposed HEAL17 project.

Projects utilizing technology in addition to EHRs must provide a description of the technical strategy for connecting this technology to the SHIN-NY. If a connection to a local hub is employed, it must be clearly explained and justified.

**Figure 1**



## 3. Grids for Completion

In addition to the narrative, the following table(s) provides a way to summarize the project’s approach to satisfying the SHIN-NY architectural requirements for connectivity between EHRs and other connections for data exchange and the SHIN-NY.

**Instructions to Complete the Grids:**

Based on the labeled diagram above, please provide connectivity and interoperability information, based on connections labeled in the diagram:

1. Complete the project overview information.
2. Grid 1 represents the current state of your project;
  - a. For the first row, provide the description of your HIE approach, ; and
  - b. For each connection type provided (B – I), please include details around that connection type. For each practice or other type of information system, you will need to add a row to represent that entity and its connectivity, and then details around that connection type (Add a row by highlighting the area above where you would like the row to be entered. Keeping that area highlighted go to the Table menu and select Insert and then select Rows Below). For example, if you have two physician offices currently connected to either labs, imaging centers, or other clinical sources or entities, you will need to describe the specifics of each practice’s connectivity in the grid. If a practice has no connections, then you do not need to detail it. For each connection type/practice you will need to have a row added to the appropriate lettered connection type. If there are 2 physician practices all connecting to the local hospital for labs, then under connection type “H”, there will be three lab rows listed, one for each practice connecting to the hospital.
3. In addition to describing your current connectivity, the second table should be completed as a depiction of the future state of connectivity as described in your HEAL 17 project plan.

<b>PROJECT OVERVIEW INFORMATION</b>	
Project Name	
What (RHIO’s or other SHIN-NY compliant HIE) are you connecting to?	
How many practices or other provider organizations are in this project?	
How many providers in this project?	
How many providers are currently using an EHR?	
Which EHR vendors are part of this project?	
List number of providers by EHR vendor	
Which vendors are being used by Enterprise (ie. Hospital) or other organizations in the project ?	

**CURRENT STATE**

Diagrammatic Label	Diagrammatic Description	HIE Platform ("A")	Components - Solutions	Implementation Date	Source System ←-→ Destination System	Vendor	Protocol Used	Data Shared	Nomenclature - Standard	Integration approach
A	Legacy to RHIO/SHIN-NY compliant HIE "little bus" via CHIxP									
B	CHIxP protocols from vendor apps to HIE									
C	Local protocols from vendor apps to HIE		Lab							
			Radiology/Imaging							
			Other Clinical Data							
D	Local protocols from other clinical sources to HIE		Lab							
			Radiology/Imaging							
			Other Clinical Data							
F	Local protocols from enterprise systems to HIE		Lab							
			Radiology/Imaging							
			Other Clinical Data							
G	CHIxP-compliant enterprise systems									
H	Local protocols from vendor apps to Regional Enterprise		Lab		<i>EMR System – 3 Physicians to Local Community Hospital System</i>	<i>Vendor 1</i>	<i>HL7 – results delivery only</i>	<i>Lab, Pathology</i>	<i>Hospital Lab Dictionary</i>	<i>Point-to-point connection</i>
			Lab		<i>EMR System – 15 Physicians to Local Community Hospital System</i>	<i>Vendor 2</i>	<i>HL7 – order entry, results delivery</i>	<i>Lab, Pathology</i>	<i>Hospital Lab Dictionary</i>	<i>Point-to point connection</i>
			Radiology/Imaging							

Diagrammatic Label	Diagrammatic Description	HIE Platform ("A")	Components - Solutions	Implementation Date	Source System ←-→ Destination System	Vendor	Protocol Used	Data Shared	Nomenclature - Standard	Integration approach
			Other Clinical Data							
1	Local protocols from vendor apps to Other Clinical Sources		Lab							
			Radiology/Imaging							
			Other Clinical Data							

## HEAL 17 PLANS

Diagrammatic Label	Diagrammatic Description	Connection Approach ("A")	Components - Solutions	Implementation Date	Source System ←-→ Destination System	Vendor	Protocol Used	Data Shared	Nomenclature - Standard	Integration approach	Milestone Number
A	Legacy to RHIO/SHIN-NY compliant HIE "little bus" via CHIxP										
B	CHIxP protocols from vendor apps to HIE										
C	Local protocols from vendor apps to HIE		Lab								
			Radiology/Imaging								
			Other Clinical Data								
D	Local protocols from other clinical sources to HIE		Lab								
			Radiology/Imaging								
			Other Clinical Data								
E	CHIxP connection from Other Clinical Sources to HIE										
F	Local protocols from enterprise systems to HIE		Lab								
			Radiology/Imaging								
			Other Clinical Data								
G	CHIxP-compliant enterprise systems										
H	Local protocols from vendor apps to Regional Enterprise		Lab								
			Radiology/Imaging								
			Other Clinical Data								
I	Local protocols from vendor apps to Other Clinical Sources		Lab								
			Radiology/Imaging								

Diagrammatic Label	Diagrammatic Description	Connection Approach ("A")	Components - Solutions	Implementation Date	Source System ↔ Destination System	Vendor	Protocol Used	Data Shared	Nomenclature - Standard	Integration approach	Milestone Number
			Other Clinical Data								

## Movement of Transactions and Services Across the Project Architecture

Using the technical architecture schematic (Figure 1 above) as a reference, the Project Connections.xls should be completed for the project “Future State”. This document captures the type of transactions and services that will be incorporated into each project and how the data will be moved across the project’s proposed architecture.

In each cell of the grid identify:

1. Through which component of the network the data will be transferred, and
2. Whether the stakeholder is (1) sending the data, (2) receiving the data or (3) receiving the data.

Example

KEY (1 = Send, 2 = Receive, 3 = Send and Receive)	PCPs	Specialists	MH Providers	SNFs	Home Health Agencies	Hospitals	Pharmacies	PBMs	Local DOH	State DOH	Use additional columns for additional stakeholder types
<b>Transactions</b>											
e-Prescribing											
Medication Hx	c3										
Lab Order Entry	c1					e2					
Lab Results Reporting	c2					e1					

In the above example,

- The PCP are both sending and receiving medication history (c3) through their connection to the RHIO/HIE.
- The PCPs are sending lab orders (c1) and receiving lab results (c2) through their connection to the SHIN-NY
- Hospitals are receiving lab orders (e2) through their connection to the SHIN-NY and also sending lab results (e1) through their connection with the SHIN-NY.

If the project needs to make comments related to either the transaction or the stakeholder connection, a separate document should be used for those comments.

## 6.10 Allowable Project Costs

### Attachment 6.10 Allowable Project Costs

The application must describe what specific technology will be purchased directly with HEAL 17 funds or covered with matching funds and implemented, and why the proposed technical solutions and services are critical to project success. The application must also include how the technical solutions and services will provide interoperable health information exchange that meets the requirements outlined through the Statewide Collaborative Process.

NOTE: DOH reserves the right to approve all technology paid for with HEAL 17 funds or included as matching costs.

Grant funds (and matching funds) can be used to pay for:

1. EHRs for primary care and appropriate specialty physician practices:
  - a. All primary care practices receiving EHR funding must participate in the PCMH.
  - b. All specialty practices receiving EHR funding must participate in PCMH. The inclusion of any specialty physician practices must include a detailed explanation of how they provide a critical role in care of the chosen target diagnosis population.. EHRs for mental health providers
  - d. All mental health providers receiving EHR funding must participate in the PCMH.
3. EHRs for other health providers
  - a. All providers receiving EHR funding must participate in the PCMH.
  - b. The inclusion of any other health care providers must include a detailed explanation of how they provide a critical role in care of the chosen target diagnosis populations proposed.
  - c. A maximum of 50% of the costs of long term care or home health care providers EHRs is also permitted. No funds may be used for acute care facility EMRs
4. Clinical Informatics Services (CIS):
  - a. Aggregate, analyze, measure and report data for population health and quality purposes.
  - b. Clinical decision support software which must be directly related, but not limited to the target population diagnosis/es proposed
  - c. . Medication reconciliation services across all transitions of care.
5. Connections to SHIN-NY:
  - a. Must incorporate fully electronic e-prescribing (no faxing) including medication history and medication reconciliation. If a project includes multiple medications history data sources, the proposal should also include explanation of how this

information will be presented to the clinician electronically in a reconciled form. to provide a single reconciled medication list to the clinician within the HER.

- b. Connecting ambulatory, inpatient, sub-acute EHRs to RHIO or other SHIN-NY compliant HIE (SHIN-NY sub network), or local hub solution as a bridge to the SHIN-NY, including but not limited to results reporting and summary record exchange;
  - i. Lab, radiology, hospital reports, transfer of care documents connected to SHIN-NY or local hub solution using CHiP; and
  - ii. Summary record exchange among EHRs utilizing CHiP.
6. Portals:
  - a. Only if appropriate for access to clinical data for care support of patients with the chosen diagnosis and no appropriate EHR is available.
7. Implementation, configuration, maintenance and operational support services for all of the above. Inclusion of costs for EHRs must include complete CHITA support planning.
8. CHITA Services: Health IT adoption and support services, including quality improvement services.
9. Project organization and administration of the PCMH.
10. Project evaluation, in addition to and/or in cooperation with HITEC, to document improvements in care coordination and outcomes.

## 6.11 Budget Forms

### Attachment 6.11 Budget Forms (including CHITA Services Template)

See Excel Budget Forms (Section 8.2.4) – Excel version posted with package

- Project Budget Form
- Project Funding Form
- Revenue and Expense Projections
- Technical Architecture Budget

## 6.12 Leadership and Personnel Qualifications

### Attachment 6.12 Leadership and Personnel Qualifications

Applicants are required to clearly describe the roles and responsibilities of all staff involved in the proposed project. Roles and responsibilities include: staff time contributed from stakeholders and the lead applicant organization and hours paid for with HEAL funding. The description should also describe which participating organization staff is from, their primary expertise (supported by experience), role in the project, and anticipated role in the Statewide Collaboration Process. Resumes for all project staff (paid and in-kind) should be included as part of this Attachment.

-NARRATIVE-

Resumes

- 1.
- 2.
3. (as many as necessary)

## 6.13 Chronic Care model

### Attachment 6.13 Chronic Care Model

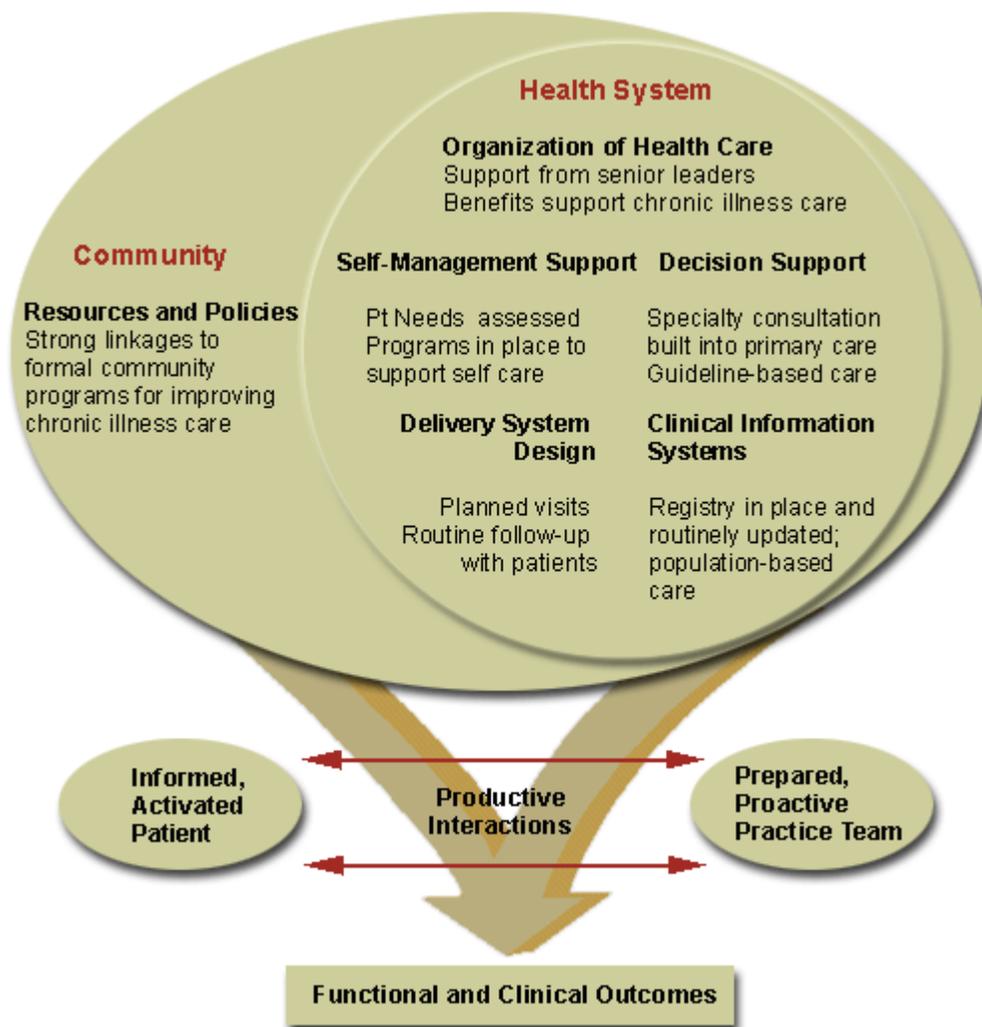
**From: Interactive Textbook on Clinical Symptom Research**  
[http://symptomresearch.nih.gov/chapter\\_10/sec5/cabs5pg1.htm](http://symptomresearch.nih.gov/chapter_10/sec5/cabs5pg1.htm)

#### **Chronic Care Model**

The Chronic Care Model (Figure 5.1) is an attempt to synthesize available evidence of system changes that improve care for chronic illness, relevant to arthritis and other conditions causing symptoms and disability ([Wagner et al, 1996a; 1996b; 1999; 2000](#)). It was based on a survey of best practices, expert opinion, more promising interventions in the literature, and quality improvement work on diabetes, depression, and cardiovascular disease ([Wagner et al., 1999](#)).

Figure 5.1 shows how system changes in the six areas of the Chronic Care Model influence interactions between patients and providers to produce better care and improved outcomes.

Figure 5.1 The Chronic Care Model



There are three overarching themes in the Chronic Care Model:

1. It is population-based, meaning that care is planned and organized for all arthritis patients in the practice, whether they present for care or not. Standardized assessment and follow-up, for example, are routinely provided for all arthritic patients in a given system, rather than for select high-risk patients. Clinical information systems that include key information on all patients with arthritis facilitate population surveillance and reminders of needed services. This population-based approach differs from usual care, where providers respond to whatever is scheduled for that day.

2. It is [evidence-based](#) in that clinical management is based on the best randomized studies.
3. It is [patient-centered](#); that is, the patient's concerns are a priority in the practice and a central feature of improvement efforts. Enhanced collaboration between patients and providers leads to improved patient outcomes, including better symptom control. Collaborative management of chronic illness involves setting goals and developing a care plan with patients, training and support for self-management, and active follow-up to monitor success and modify care ([Von Korff et al., 1997](#)). These elements of care are essential in a condition like arthritis, where outcomes depend on keeping patients active and motivated over the long run to care for their condition.

As outlined in the Chronic Care Model, there are several types of practice changes that can influence effective chronic illness interventions.

- [Practice re-design](#) - This focuses on increasing roles and responsibilities of the practice team, with an emphasis on patient follow-up and use of alternative mechanisms (ie. group visits; drop-in medical group appointments) to increase the efficiency of care.
- [Self-management support](#) - Since patients are an integral part of care, they should be offered training and provided with ongoing support to proactively manage the day-to-day complications of their condition.
- [Clinical information systems](#) - Clinical information systems or registries are essential for tracking the care and outcomes of an entire population of patients, as well as for prompting providers about follow-up.
- [Decision support](#) - Decision support involves, for example, access to guidelines or joint visits involving primary care providers and specialists.
- [Community resources](#) - Links to key community resources facilitate the delivery of care to a larger population of patients and individuals in the community, and may enhance self-management delivery.
- [Leadership](#) - In order for all the elements of care to take effect, strong support from leadership within a health care organization is needed. The Malcolm Baldrige National Quality Award Criteria, the standard for organizational excellence in other industries, include leadership as a central component of effective organizations ([US Chamber of Commerce, 1993](#)). [Shortell and colleagues \(1995\)](#) have adapted these criteria to health care organizations and have reported the need for support from senior leadership in making health care system changes.

## 6.14 Statewide Policy Guidance

### Attachment 6.14 Statewide Policy Guidance

See the New York State Department of Health, Office of Health Information Technology Transformation website for the current version of Statewide Policy Guidance:

[http://www.health.state.ny.us/technology/statewide\\_policy\\_guidance.htm](http://www.health.state.ny.us/technology/statewide_policy_guidance.htm)

## 6.15 Pass/Fail Review

### Attachment 6.15

#### Pass/Fail Review

**If applicants do not meet the pass/fair criteria provided in this attachment (Attachment 6.15) the submitted application will not be evaluated for funding.**

#### Criteria from the RGA:

- The proposed projects must identify a target patient population, and list it in the Stakeholder Template, (Attachment 6.3) with a chronic disease or high risk/high cost diagnosis and a PCMH through which the care of the target patient population will be coordinated and managed.
  - P – Identified chosen diagnosis/target patient population on line one of Attachment 6.3.
  - F – Blank line and/or unapproved diagnosis (not in attachment 6.7, or unexplained).
  
- The proposed project must also include a plan, using CHITA Services Template (Attachment 6.2), for providing Community Health Information Technology Adoption Collaboration (CHITA) services for promoting and supporting implementation of interoperable EHRs and other health IT tools and ensuring their effective adoption and use to support the PCMH model. Collectively, the target patient population, PCMH and CHITA are organized as a CCZ to ensure effective organization and management of the project.
  - P – 6.2 is present and complete.
  - F – 6.2 is missing or incomplete.
  
- An eligible lead applicant
  - P – EA is identified as either a PCMH stakeholder or a CHITA.
  - F – EA is not identified as either a PCMH stakeholder or a CHITA.
  
- A letter of support must also be included from each stakeholder participant included in the Stakeholder Template Attachment 6.3. See Attachment 6.3 for the Letter of Support Requirements.
  - P – One letter of support for each stakeholder in the Project Stakeholders table in 6.3.
  - F – A missing letter.
  
- Letters of support must also be included from the CHITA and RHIO. See Attachment 6.3 for the Letter of Support Requirements.
  - P – RHIO and CHITA letters of support present.
  - F – RHIO and CHITA letters of support missing.
  
- The application must include a detailed description of the CCZ by clearly completing all 6.3, Section III tables.

- P – Elements present in 6.3.
  - F – Elements absent in 6.3.
- A summary of the PCMH providers and other care givers who provide care to the target patient population. At least 50% of the providers and other care givers who provide care to the target patient population must be a part of the PCMH. A detailed listing must be completed as part of the participant stakeholder template (Attachment 6.3), as noted in Section 3.2.2.
    - P – 50% of all providers involved in care of target patient population included (6.3, Section III tables).
    - F – 50% of all providers involved in care of target patient population not included (6.3, Section III tables).
  - Applicants must describe and include a technical design, by completing the Technical Architectural and Interoperability Plan (Attachment 6.9), for how EHRs will be connected to the SHIN-NY to enable health information exchange among all providers in a PCMH.
    - P – Complete 6.9.
    - F – Incomplete or missing 6.9.
  - Applicants must include a RHIO partnership and governance plan describing how the PCMH providers are participating in a RHIO and how they plan on utilizing SHIN-NY services that includes a commitment to share information with all appropriate providers in the PCMH.
    - P – Exists as part of 6.3.
    - F – Is not part of 6.3 or is absent.
  - Applicants must include a detailed description of what health IT products and services will be purchased, for which PCMH providers in the proposed project and why these tools are critical for the success of the project.
    - P – Included as part of Budget Justification (see RGA Section 8.2.4) in the Financial Application and copied as part of the Technical Plan section of the Program Narrative (see Section 4.1.6).
    - F – Not included, or includes an unallowable cost per Attachment 6.10.
  - The applicants are required to provide a project sustainability plan in their application (per section 4.1.4.3), including all current and potential future funding and reimbursement opportunities.
    - P – Plan is present as part of the Organizational Plan in the Program Application narrative.
    - F – Plan is not clearly labeled and present as part of the Organizational Plan in the Program Application.
  - Representatives must be staff members with expertise that align with the mission of the specific workgroup (ie., technical liaisons are members of the Protocols and Services workgroup, providers are members of Clinical Priorities, etc.).

- P – Clearly indicated as part of 6.12.
  - F – Not clearly indicated as part of 6.12.
- Applications are required to include a list of project goals and a model project work plan that details high level milestones for the project. Applicants will be required to complete Attachment 6.4 to provide this information.
    - P – Complete Attachment 6.4.
    - F – Incomplete Attachment 6.4.

General (Application Structure and Format) – Each of the items that follow are considered Pass/Fail items as well and should be regarded by the applicant as such.

### **General**

- Applicant has selected a region on both Financial and Program Application Cover pages.
- Applicant has selected award type (Limited \$10M or Expanded \$20M) that they are applying for, on both Financial and Program Application Cover pages.
- 

### **Eligible Applicant**

- Have designated a legal entity as the lead applicant to contract with New York State (see section 3.2.1).

### **Budget**

- Have allocated a 50% match. Applicants are required to contribute at least 50% of the project budget in the form of matching funds. These funds can be in the form of cash or in-kind contributions from project stakeholders. It should be noted that governmental grant program funds (state or federal) may not be considered and/or counted as matching funds. Of the 50% match identified, a minimum of 20 percent must be in the form of stakeholder cash contributions.
- Applicants should specifically identify matching funds and associated source(s) of these funds on the Project Funding / Project Fund Source Worksheet. The total match funds (combined cash and in-kind) should equal the Total Match (N) on the Project Budget Worksheet.
- Commission on Healthcare Facilities in the 21st Century Review. The awardee is not in fundamental conflict with the Commission mandates and DOH policy.
- (105, 5) - Each capitalized expense listed on Budget Form must include a detailed explanation as to how the determination was made that the expense is capitalizable.
  - P – Is present in the budget justification.
  - F – Is absent from the budget justification.

### **Structure**

- The Program Application and Financial Application Templates are included in Section 8. Applicants are required to follow these formats to complete the application.

- After the initial screening of grant applications, the next step in the review process is the scoring of grant applications based on the grant requirements outlined throughout the RFA. All grant applications must include two narratives, not to exceed 30 pages each – Program and Financial. Applications will be evaluated based on responsiveness and completeness of all requirements.
- The Program Application narrative must be organized and clearly labeled by the five following sections, each of which will be evaluated as part of the review and award process. The sections are:
  - Organizational Plan;
  - Technical Plan;
  - Clinical Plan;
  - Leadership and Personnel Qualifications – Provide detail in Attachment 6.12; and
  - Project Management – Provide Detail in Attachment 6.2.
- Attachments must be as follows and appear as SEPARATE documents (see Attachments).
- Applications must be submitted in two separate and distinct parts, following the formats shown in Section 8.
  - Part I: Program Application
  - Part II: Financial Application
- Each cover page must be signed by an individual authorized to bind the Eligible Applicant to any GDA resulting from the application.
  - Applications must be submitted in electronic form (on a CD or Flash Drive), however all signature pages must accompany the electronic application in original form. These pages will bind the applicant to everything in their electronic submission. Digital files:
    - Must have a back-up copy (identical folders on the same Flash Drive are acceptable).
    - Be in native format (Excel, Word, etc...) AND also have a Portable Document Format (PDF) copy.
    - ALL PDFs MUST BE SEARCHABLE! Scanned or otherwise generated PDF images of documents will not be accepted.
    - Must have a separate folder for the Program Application and components and the Financial Application and components.
    - Not adhering to these requirements will result in application disqualification.

**Attachment Screening Guidance (consult to determine “completeness” of each Attachment)**

6.2 – CHITA Services Template

- A description of health IT adoption and support services is required that includes all services listed below to promote EHR adoption, ensure adoption and effective use and achieve patient care improvements.
- Applicants are required to complete the matrix in the “CHITA Services” tab – “HEAL 17 Budget Worksheet.xls” outlining the EHR adoption and support services needs and a plan (narrative in 6.2) to address those needs.

- On the spreadsheet (“CHITA Services” tab – “HEAL 17 Budget Worksheet.xls”) the applicant must list by service how much the service will cost, the quantity of full time equivalents that will be required for that service, the anticipated portion of HEAL funding that will cover that service cost, the anticipated portion of other funding/support that will cover that service cost and where/who the other funding/support is coming from (Other Funding/Support Source). All service cost estimates must be based upon a comprehensive assessment from multiple vendors.
- Narrative - This section must include the following:
  - Describe, in detail, the process undertaken to consider cost estimates; and
  - Include assumptions made as part of estimating costs for services; be sure to address how each component in the table above is going to be delivered and offered as a package with all necessary services (ie. directly by a CHITA or through a CHITA partnership).

### 6.3 – Stakeholder Template

- All project stakeholders must be documented in the tables.
- Letters of support must appear in section IV of this attachment. Each letter of support must include the following components:
  - Corporate name of the stakeholder.
  - Contact information for the stakeholder (primary contact & backup contact, including project manager or equivalent).
  - Full commitment to sharing information among the PCMH participants. This includes data for HIE, quality reporting and data for research and evaluation purposes.
  - Signature of the stakeholder executive.
  - Commitment to project including;
    - Financial contributions (personnel, cash, etc.);
    - Role in the project;
    - Reason for participation; and
    - Future plans for participation.
  - Percentage of population served for target patient population in the PCMH which is the total number of patients with the specified diagnosis covered by the stakeholder divided by the total number of patients with that diagnosis in the PCMH.
- RHIO Letter of Support:
  - RHIO name and contact information for the executive director and a back up contact.
  - Signature of the RHIO Board Chair and Executive Director.
  - Commitment to project including:
    - Description of the role in the project;
    - Providing connections between and among EHR and other health IT tools and the SHIN-NY technical infrastructure; and
    - How PCMH participants fit into the SHIN-NY governance structure.
- CHITA Letter of Support (not lead):

- CHITA name and contact information for the executive director and a back up contact.
- Signature of the CHITA Director.
- List of all organizations that are a part of the CHITA and providing health IT technical services and adoption and support services to the project.
- Commitment to project including:
  - Describe role in the project; and
  - List of PCMH projects to which the CHITA is providing services.
- PCMH Letters of Support (CHITA lead):
  - Corporate name of the stakeholder.
  - Contact information for the stakeholder (primary contact & backup contact; including project manager or equivalent).
  - Full commitment to sharing information among the medical home participants. This includes data for HIE, quality reporting and data for research and evaluation purposes.
  - Signature of the stakeholder executive.
  - Commitment to project including:
    - Financial contributions (personnel, cash, etc.);
    - Role in the project;
    - Reason for participation; and
    - Future plans for participation.
  - Percentage of population served for target patient population in the CCZ which is the total number of patients with the specified diagnosis covered by the stakeholder divided by the total number of patients with that diagnosis in the CCZ.
- Project stakeholders table:
  - Each stakeholder name must be listed in the first column.
  - The applicant must assign a number to each stakeholder letter of support and that number must appear in column two.
  - In column three the applicant must describe the type of healthcare provider that the stakeholder is and indicate what services they provide.
  - Column four must describe what the stakeholder's role(s) and responsibilities will be for the PCMH and CHITA.
  - Column five is where the role(s) of the stakeholder in the RHIO must appear. Column six should indicate the stakeholder's overall role in the project.
  - Column seven must indicate the percentage of the total number of stakeholder patients that are Medicaid patients.
  - Finally, column eight must indicate the percentage of the total stakeholder patient population that is associated with the chosen diagnosis for the project.
- Narrative - This must include a detailed RHIO partnership and governance plan, including but not limited to:
  - Describe how the PCMH providers are participating in a RHIO and what role the PCMH provider are playing and activities in which they are participating.

- Describe how the PCMH providers are planning on utilizing SHIN-NY services and committing to sharing information with all appropriate providers in the PCMH. RHIOs are a part of the statewide governance structure managed by NYeC and are responsible for implementing the SHIN-NY pursuant to Statewide Policy Guidance.

6.9 – Technical Architectural and Interoperability Plan:

- Projects utilizing technology other than EHRs must provide a description of the technical strategy for connecting to the SHIN-NY.
- If a connection to a local hub is employed, it must be clearly justified.