HRSA HIT Innovations for Health Center Controlled Networks (HCCNs) Outline

Basic Grant Summary

This grant program is under the auspices of the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (DHHS). Projects are overseen by HRSA's Division of Health Information Technology (HIT) State and Community Assistance (DHITSCA) within the Office of Health Information Technology (OHIT). The funding for this opportunity is in accordance with section 330(e)(1)(C) of the Public Health Service (PHS) Act (42 U.S.C. 254b), as amended.

The purpose of the funding opportunity is to support PHS Section 330 Health Center Controlled Networks (HCCNs) in the new implementation of Health Information Technology (HIT) other than electronic health records (EHR) that will substantially enhance the quality and efficiency of primary and preventive care in the health center delivery system. These enhancements should result in measurable improvements in patient outcomes and reductions in health disparities. Common examples of HIT may include practice management systems, disease registry systems, care management systems, clinical messaging systems, personal health record systems, oral and/or behavioral electronic health record systems and health information exchanges. In addition, the aims of this funding opportunity support creation of sustainable business models for deploying HIT in HCCNs as well as enhancing the capacity of health centers to engage in strategic partnerships that leverage other HIT initiatives and resources (including knowledge, experience, and funding) already present in their communities.

This funding will support two types of projects that propose the implementation of innovative health information technologies (HIT) other than electronic health records. These other technologies include, but are not limited to electronic prescribing, physician order entry, personal health records, community health records, health information exchanges, smart cards, clinical decision support technologies, using telehealth to advance previous investments (e.g., using e-prescribing to build a telepharmacy), and creating interoperability with outside partners such as health departments, State Medicaid, other HRSA grantees and other public or private partners. At the end of the project period, grantees must demonstrate that they have implemented the HIT innovation selected in the sites they initially proposed. Grantees must also demonstrate how this innovation has or will lead to improvements in health outcomes within the project period and over the longer term. All grantees must demonstrate steps taken to achieve sustainability of the initiative after Federal funds end. **This funding is not to support the implementation, and/or upgrading electronic medical records (EMR) or electronic health records (EHR) or technical support.** The two types of categories available for funding are:

Category 1, Early HIT Innovative Implementations is driven towards health center controlled networks that currently do not have an HIT system in place but want to begin work in HIT and are not ready to move into EHR. Category 1 will provide up to $200,000 to fund up to 2 HCCNs to implement early stages of HIT adoption such as but not limited to: e-prescribing, disease registries, physician order entry, bar coding, use of PDA's, master patient index, clinical messaging, and the integration of existing electronic health and electronic oral health records. Funding will not exceed $100,000 for year one and 50% less than year one for years two and three per year. The project period will be up to 3 years.

Category 2, Advanced HIT Innovations Implementations, is driven towards HCCNs that have an HIT infrastructure in place (e.g. EHR, health information exchange (HIE), etc) that wish to enhance and/or build upon it. Category 2 will provide up to $600,000 to fund up to 2 HCCNs to implement advanced HIT innovations that build upon previous investments in HIT such as but not limited to: community health records, personal health records, health information exchanges, smart cards, implementation of an electronic oral health record integrated with existing electronic health record, and creating interoperability with outside partners horizontally or vertically. With regard to the latter, applicants might propose projects that build upon or enhance existing HIT systems to create interoperable information systems that facilitate the provision of telehealth services. For example, school-based programs might consider projects that partner with schools and other providers in the community to expand hard to access services, such as mental health or dental health services, through telehealth technologies that employ interoperable information systems. Applicants who wish to implement telehealth-related projects should demonstrate a clear understanding of the potential operational and legal challenges in doing so. Funding will not exceed $300,000 for year one and will decrease 15%

Basic Grant Expectations:

Based on a strong history of collaboration and an active quality improvement program, successful applicants will be expected to describe and demonstrate how the impact of an HIT innovation enhances the effectiveness, efficiency, safety and quality on their health center delivery system.

1. **Effectiveness.** The extent to which the implementation of an HIT innovation enables the provision of services based on scientific knowledge to all who could benefit and the extent to which integrating a clinical quality improvement program with HIT will improve both health outcomes and systems of care. For example, a Network may use clinical decision support systems to generate reminders that promote preventive care to help manage chronic diseases and to improve population health.

2. **Efficiency.** The extent to which the implementation of the HIT innovation enables waste to be avoided; specifically, the extent to which inefficiencies such as lost medical records, lab results, and inadequate appointment systems are eliminated through the combination of HIT and a clinical quality improvement program. Projects should be able to quantify projected return on investment related to time saved, increases in revenue and other potential savings related to the resources used on the investment as well as increased tracking and reporting of patient's quality and health outcomes.

3. **Safety and Quality.** The extent to which the implementation of the HIT innovation enables patients to avoid injuries from the care that is intended to help them; specifically, the extent to which mechanisms, such as computerized provider order entry (CPOE), enhance patient safety and improve risk management practices by preventing medication and other medical errors.

4. **Patient Centered-ness**. The extent to which the implementation of the HIT innovation enables the provision of care that is respectful of and responsive to individual patient preferences, needs, and values, and ensures that patient values guide all clinical decisions. Specifically, the extent to which patients will be connected to their health information and

also the extent to which the applicant describes the support/educational tools, such as disease management and patient management information, in place to support this.

Applicants interested in requesting funds for the **Category 1, Early HIT Innovations Implementation** will be expected to demonstrate that an integrated and networked HIT infrastructure will be developed through the following four phases:

1. A brief **planning phase** where the network will be in the final three to six months of the planning for the HIT innovation selected.
2. A **testing phase** where the plan/product will be thoroughly tested and modified as necessary before implementation.
3. An **infrastructure building phase** where the establishment of a secure platform for c communication, the HIT innovation selected and the sharing of clinical and other key data will occur. These data should facilitate performance outcome measures with national benchmarks. Sustainability should be emphasized here.
4. A **roll out phase** where the HIT innovation selected will be rolled out to members of the network in a coordinated and integrated approach.

Applicants interested in requesting funds for **Category 2, Advanced HIT Innovations Implementations** will be expected to demonstrate that an integrated and networked infrastructure is already in place and will be enhanced through the following four phases:

1. A **planning phase** where the network will develop an HIT innovation plan to expand the current capacity of the existing integrated and networked infrastructure.
2. A **testing phase** where the innovation will be thoroughly tested and modified as necessary before implementation.
3. An **expansion of infrastructure** where the expansion of the integrated and networked infrastructure already in place will be expanded to support the new innovation.
4. A **roll out phase** where the HIT innovation will be rolled out to members of the network in a coordinated and integrated approach.

All applicants seeking funding for implementing an HIT innovation project through this announcement will be expected to demonstrate the following in their proposal:

1. Compelling rationale for integrating an HIT innovation.

2. Evidence that the system integration and interfaces will use generally acceptable interface standards for clinical messaging and will integrate data using a common data structure and common business rules and practices to facilitate a centralized system.

Grant Award Details

This program will provide funding during Federal fiscal years 2008-2009. Approximately $800,000 is expected to be available to fund up to 4 awards.

For Category 1: Category 1 will provide up to $200,000 to fund up to 2 HCCNs to implement early stages of HIT adoption. The project period may be up to three years in length, and the funding will not

exceed $100,000 for year one. Funding beyond the first year is dependent on satisfactory grantee performance, the availability of appropriated funds, and a determination that continuation of this project is in the best interest of the Federal government. Any funding provided in years two and three will be 50% less than awarded in year one.

For Category 2: Category 2 will provide up to $600,000 to fund up to 2 HCCNs to implement advanced HIT innovations. The project period may be up to three years in length, and the funding will not exceed $300,000 for year one. Funding may not exceed $746,250 for the entire project period. Funding beyond the first year is dependent on satisfactory grantee performance, the availability of appropriated funds, and a determination that continuation of this project is in the best interest of the Federal government. Any funding provided in year two will be 15% less than that awarded in year one; funding in year three will be 25% less than that awarded in year two.

HRSA expects that recipients in Category 1 or 2 will be able to sustain the project beyond the project period and requests specific information on sustainability as well as decreasing Federal reliance each year in the section of the guidance entitled: "Resolution of Challenges."

Basic Eligibility Information

Eligible applicants are limited to section 330 grantees from one of the following categories:

- Network controlled by and acting on behalf of the health center(s), as defined and funded under section 330(e)(1)(C) of the PHS Act. At the request of all the member health centers, a Network may apply for direct funds if it is at least majority controlled and, as applicable, at least majority owned, by such health centers as defined and funded under section 330(e)(1)(C). For the purposes of this grant opportunity, the term "controlled" means to have the authority collectively to appoint a minimum of 51 percent of the Network's board members in the Network.

- A health center, as defined and funded under section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b), as amended, applying on behalf of a managed care Network or plan, that has received Federal grants under subsection 330(e)(1)(A) for at least the two consecutive preceding years; or,

- A health center as defined and funded under section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b), as amended, applying on behalf of a practice management Network.

HCCNs must consist of at least three collaborator organizations and be 51% controlled by health centers. If a health center applies for this funding opportunity on behalf of the Network, then the health center will count as one of the collaborating organizations. Three separate organizations must be in place. Please see what constitutes such as relationship under Section VIII-Definitions-Network.

A managed care Network is one that is owned and controlled by the health centers and negotiates managed care contracts for its members. A practice management Network refers to the ongoing operations and practices including financial, clinical, IT and other functions. A Network may include organizations in addition to section 330 grantees that are community based and have similar goals and missions such as a Federally Qualified Health Center Look- Alike, locally funded clinics, etc.

Cost Sharing/Matching

Cost sharing and matching are not required components for this funding opportunity. However, applicants are strongly encouraged to demonstrate cost participation as an indicator of community and organizational support for the project and also to delineate the likelihood that the project will continue after Federal grant support has ended. Cost participation may be in the form of cash or in-kind contributions (e.g. equipment, personnel, building space, indirect costs). Applicants are expected to maximize the use of non-Federal funds to the greatest extent possible and to present a plan for decreasing dependence on Federal funds each year of the grant to assure the long-term sustainability of the program. Applicants are encouraged to explore the flexibility provided under the recent self-referral safe harbor for Federally Qualified Health Centers (FQHC) that allows providers to work with hospitals to purchase and to implement software systems. Applicants should also describe how they will work with their proposed partners to share costs. Note that the reasonableness of the total budget and the extent to which other appropriate resources are obtained and leveraged within the budget each year are both key evaluation elements in the review of the proposed project.

Other

In order to increase access to comprehensive and preventative primary care, **eligible applicants are encouraged to invite HRSA grantees other than those with 330 funds, (e.g. Ryan White, MCH, rural providers, Healthy Start), as well as other entities that have a similar primary care mission (public health departments, other community-based clinics, and faith-based organizations) to participate in developing HIT networks that will facilitate increased access to comprehensive primary and preventive health care.**

All applicants must ensure that the community-based boards of the collaborating centers/members are knowledgeable and supportive of the network's activities. All applicants are expected to have a Memorandum of Agreement (MOA) signed by all CEOs and Board Chairs of the network members. (See MOA in Appendix C).

Prospective grantees should be aware that they will be required to participate in any agency performance review of the HRSA funded program(s) by the Office of Performance Review (OPR). The purpose of performance review is to improve the performance of HRSA funded programs.

Throughout the application the grantee shall, wherever appropriate, describe the program's or institution's strategic plan, policies, and initiatives that demonstrate a commitment to providing culturally and linguistically competent health care and developing culturally and linguistically competent health care providers, faculty, staff, and program participants. This includes participation in, and, support of programs that focus on cross-cultural health communication approaches as strategies to educate health care providers serving diverse patients, families, and communities.

Basic Submission Information

1. Applications must be submitted electronically through Grants.gov using the Public Health Service (PHS) Application Form 5161-1 found at http://www.hrsa.gov/grants/forms.htm.
2. Relevant Dates:
    - Release Date: January 24, 2008

- Conference Call: February 27, 2008, 2:00 pm Eastern Time, Call in number: 800 779 9573, Passcode: 5811144
- Submission Due Date: **March 28, 2008 by 8:00p.m. ET.** Late submissions are not accepted under any circumstances.

3. Registration is required in Grants.gov. To register, applicant will need to provide or obtain the following:
    - An organizational DUNS number
    - Registration with Central Contractor Registry (CCR)
    - Identification of the organization's E-Business Point of Contact (POC)
    - Confirmation of the organization's CCR "Marketing Partner ID Number (M-PIN)" password
    - Registration of an Authorized Organization Representative (AOR)
    - Username and password from the Grants.gov Credential Provider

Basic Format Information

1. Font specifications are no less than 12pt., 1.0 line spacing with Times Roman, Courier, or CG Times. Type for charts, graphs, footnotes, etc. may be as small as 10pt. if clear and readable.
2. No colored, oversized, or folded materials. No organizational brochures, slides, films, etc.
3. Margins must be at least one inch on all sides. Text must be aligned left.
4. Applicant name and 10-digit-grant number (if competing continuation, supplemental or non-competing continuation) on each page.
5. All headers must be flush left in bold type.
6. Number electronic attachment pages sequentially, resetting the numbering for each attachment. Do not number the standard OMB approved form pages.
7. Attachments may be:
    - .DOC – Microsoft Word
    - .RTF – Rich Text Format
    - .TXT – Text
    - .WPD – Word Perfect Document
    - .PDF – Adobe Portable Document Format
    - .XLS – Microsoft Excel
8. Narrative documents, including abstract, project and budget narratives, and any other attachments such as appendices and letters of support, must not exceed **80 pages**.

Basic Application Content

1. Application Face Page
2. Table of Contents
3. Application Checklist
4. Budget Form
5. Budget Justification Narrative
    - Personnel Costs
    - Indirect Costs
    - Fringe Benefits

- Travel
- Equipment
- Supplies
- Subcontracts
- Other

6. Staffing Plan and Personnel Requirements
7. Assurances
8. Certifications
9. Project Abstract
10. Program Narrative
    - Introduction
    - Needs Assessment
    - Response
    - Workplan
    - Resolution of Challenges
    - Evaluative Measures
    - Impact
    - Resources and Capabilities
    - Technical Support
    - Organizational Information
11. Attachments
    - Attachment 1: Tables, Charts, etc.
    - Attachment 2: Job Descriptions for Key Personnel
    - Attachment 3: Biographical Sketches of Key Personnel
    - Attachment 4: Letters of Agreement and/or Description(s) of Proposed/Existing Contracts (project specific).
    - Attachment 5: Project Organizational Chart
    - Attachment 6: Other Relevant Documents (including dated letters of support)

<u>Basic Review Criteria</u>

1. Need – 10 points
2. Response – 30 points
3. Evaluative Measures – 10 points
4. Impact – 10 points
5. Resources/Capabilities – 30 points
6. Support Requested – 10 points