

2007 Application for Health Information Technology Funding

Application Process

1. The Washington Health Information Collaborative (Collaborative) *must receive Application* for funding by close of business, 5:00 PM PDT August 15, 2007.
2. *Application may be submitted via e-mail to Thecollaborative@fchn.com, (Subject: Collaborative Application)*. If submitting via e-mail, applicant may include a scan of the signed *Statement of Assurances* (PDF or JPEG file).
3. *Applicant* may also deliver the application as an original document to:

First Choice Health
ATTN: The Collaborative
600 University Street, Suite 1400
Seattle, WA 98101.
4. *Applicant* should not submit *Application* as a faxed document. *Applicant* may choose to follow up an e-mailed application with a faxed copy of the *Statement of Assurances* if unable to convert that document to electronic format. Please send faxes to (206) 268-2882, attn: The Collaborative.
5. Please be aware, it is *Applicant's* responsibility to ensure the timely receipt of your entire *Application* by the Collaborative. ***Failure to submit complete Application by the specified deadline will disqualify Applicant from further consideration in this award cycle.***
6. *Applicant* is encouraged to review the document "Determining If Your Practice is Ready to Adopt Health IT" for guidance on what elements should be reflected in your strategic, funding, project plans and your budget. The document can be found here: www.wahealthinfocollaborative.org/#How

Important information

1. *Applicant* refers to the organization on whose behalf *Application* is submitted.
2. *Application* refers to a submission of a request for funding, including all attachments thereto, in response to the 2007 *Announcement of Health Information Technology Funding Opportunity (Announcement)*.
3. Funding for *direct costs only* of up to \$20,000 for projects of up to 18 months in duration may be requested.
4. The anticipated number of awards is not known. Awards issued by the Collaborative under the *Announcement* are contingent upon availability of funds and submission of a sufficient number of meritorious applications.

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5. Because the nature, scope and duration of proposed projects will vary from application to application, it is anticipated that the size of each award will also vary. The total amount awarded and the number of awards will depend upon the quality and costs of the applications received.
6. *Applications* will be evaluated by scoring across multiple dimensions including: Planning; IT Selection; Budget; Implementation and Grant Goals.
7. Decision to fund *Application* will be based on whether *Applicant* meets eligibility criteria, on available funds, and on *Application* scoring. By submitting an *Application*, *Applicant* recognizes that a decision not to award or to award funds at a particular funding level to *Applicant* is discretionary and is not subject to appeal.
8. The signature of an authorized individual on *Statement of Assurances* certifies that *Applicant* will comply with all applicable rules of the application process and all assurances contained in the *Statement of Assurances*.
9. Applicants for and recipients of award funds are responsible for complying with and must adhere to all applicable Federal and State statutes, codes, regulations, and policies including income tax regulations. Questions relating to the applicability of income tax regulations to awarded funds should be directed to the IRS.
10. Funding to successful applicants will be provided by either First Choice Health (First Choice) or the Health Care Authority (HCA). HCA funding is contingent upon receipt of funding under the parameters of Section 1621 of SHB 1128.
11. *Application* allows *Applicant* to request funds from First Choice, the HCA or both entities. Checking both boxes will not increase the possible funds to be received but will ensure that both organizations will review your application. Please refer to the eligibility criteria outlined on page four the *Announcement* to determine if you are eligible for funding from either source.
12. Please remember that all applications submitted for review to the HCA are subject to applicable public disclosure laws.

Selection process

1. Applicants must meet the eligibility criteria outlined on page four of the *Announcement*. If review of the *Application* shows your organization does not meet these criteria, the *Application* will be disqualified from further consideration
2. To be considered for review, the *Application* must also:
 - a. Include responses to all questions of the attached questionnaire (including documentation when requested).

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- b. Include Statement of Assurances signed by an individual authorized to make binding arrangements on behalf of *Applicant*.
3. Responses should be clear, complete and concise to allow for an adequate understanding of your *Application* and the information contained therein.
4. The evaluation and selection procedures will be performed under the direction of the Collaborative Steering Committee. Final selection will be made by evaluators at First Choice and the HCA.
5. Successful applicants will be presented with an *Award Agreement* which is a prerequisite for distribution of funds by First Choice or the HCA. No funds will be disbursed to parties unable or unwilling to sign the *Award Agreement*. The *Award Agreement* will outline:
 - a. Agreement to complete the scope of work under the project as described in the application (including adherence to timeline, planned outcome of project implementation, and support of grant goals).
 - b. Agreement to comply with monitoring processes designed to insure proper use of funds.

Statement of Assurances

I make the following certifications on behalf of the *Applicant* named herein: As an individual authorized by the *Applicant* to make binding agreements, I make the following statement of assurances as a required element of this *Application*. On behalf of the applicant, I understand that the truthfulness of the facts affirmed here and the continuing compliance with these requirements are conditions precedent to review of this *Application* and subsequent potential award:

1. *Applicant* warrants that, in connection with this *Application*:
 - a. All information presented in this proposal is true, correct, and complete to the best of applicant’s knowledge.
 - b. None of the funds requested in this application are requested for duplicate or equivalent budgetary items (i.e. equipment, salaries, consulting) for which funding from another source is being provided.
 - c. *Applicant* is not requesting funding aside from that necessary to pay for services specifically earmarked in the *Application*, and that costs for such services do not exceed those that would be paid by a prudent person for same or similar services.
2. Applicant acknowledges that the submission of a timely and complete application in no way guarantees award or receipt of funds from First Choice Health or the Washington State Health Care Authority.
3. Applicant certifies agreement to all the terms and conditions of this application including, but not limited to the discretionary nature of a decision by either First Choice Health or the Health Care Authority to not award funds or to award funds at a particular funding level.
4. Applicant acknowledges that submission of false or misleading information will automatically disqualify this application from further consideration.

Signature

Date

Title

Applying Organization

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Please read the entire Application before completing the questionnaire. It contains important information necessary for a successful submission. For more information, go to www.wahealthinfocollaborative.org

2007 Application Questions

Background Information

1. Organization Name:
2. Please describe your practice or facility. Please address the following elements:

Description:
Size and nature of practice or facility (numbers of providers, corporate structure).

Patients (mix of payers and size of active panel):

Community partners:
3. Amount of Requested Funds:
4. Principal Contact Information:

Name
Phone number(s)
Fax number (s)
E-mail address
6. Are you applying for funding from First Choice Health? (Must be member of the First Choice Health network)
Yes No
7. Are you applying for funding from the Washington State Health Care Authority (HCA)?
 Yes No

Planning

1. Please describe the nature of your project and the driving forces behind it.
2. Please outline your expectations of costs, timelines, ROI, and necessary practice redesigns involved in this project.

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3. Please list the key goals you expect this project to help your practice achieve.
4. What specific features within the Health IT system/solution will support achieving these goals?
5. How and when you will know your goals are being met?
6. Attach a document of signatures indicating current consensus on moving forward with your Health IT project.
7. Attach a copy of the strategic business plan for the practice (if available).
8. Does your organization use any Evidence Based Care tools?
Health IT Selection
9. What process and criteria were used to make the final Health IT selection for your organization (or used up to this point)? Which vendor systems/tools were considered?
10. Who was (will be) involved in the final decision?
Finances and Budget
11. Please attach copies of your organization's detailed budget for the Health IT project. Please identify the specific line items for which you are requesting funding.
12. Please explain how you intend to fund this Health IT implementation project outside of funding for which you are applying.
Implementation
13. Please list project team members and roles, as well as amount of their project dedicated time up to now and going forward. Include a description of relevant experience for project leaders (project manager and clinical champion), and explain why these individuals were selected for leadership roles.
14. Which features and capabilities of the Health IT system are planned for implementation immediately? Which will be implemented at a later time period and what is that timeframe?

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15. Which workflows do you hope to impact the most as a result of this project?
16. What interfaces or integration will be included as part of your Health IT implementation? Who has responsibility for developing any needed interfaces?
17. Please provide a copy of your practice's project plan including the implementation timeline for this project. (Please see the document "Determining If Your Practice is Ready for Health IT Adoption" located at www.wahealthinfocollaborative.org/#How for elements of a project plan).
Grant Goals
18. Will your project directly support sharing of clinical data to improve patient care? If so, how?
19. Will your project directly support providers' use of patient/disease registries? If so, how?
20. Will your project directly support providers' use of decision support tools? If so, how?
21. Will your project directly support provider utilization of comparative performance feedback mechanisms? If so, how?
22. Will your project directly support patients in developing an active role in their care, understand their problems and care options, fully participate in the decision making process regarding their care, and set care goals? If so, how?
23. Are you willing to take active steps to contribute to a shared knowledge base through contacts with local press, blog contributions, and conference presentations as a condition of receiving funding? If so, how?