RFA Number 1207121030

New York State Department of Health
Office of Health Systems Management
Nursing Home and ICF/MR Surveillance

Request for Applications

Evaluation of the Medical Direction and Medical Care in Nursing Homes Project

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KEY DATES

RFA Release Date:	June 4, 2014
Applicants Conference:	June 13, 2014, 10:00 AM – 1:00 PM
Questions Due:	June 20, 2014, by 4:00 PM
RFA Questions, Answers And Updates Posted (on or about):	June 27, 2014
Applications Due:	July 25, 2014, by 4:00 PM
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Table of Contents

I. Introduction

A. Description of Program

The New York State Department of Health (Department) certifies, surveys and conducts complaint investigations for over 600 nursing homes. These facilities provide short and long-term care to residents who are unable to live independently due to physical or other limitations associated with age or medical need. Residents of nursing homes are provided with medical supervision and personal care services necessary to maintain their highest physical, mental and psychosocial well-being. Under contract with the federal Centers for Medicare and Medicaid Services (CMS), to ensure compliance with federal and State minimum standards, Department inspectors survey all nursing homes on average every 12 months, and conduct investigations of complaints from nursing home residents regarding the care and services received.

The Department also collaborates with nursing homes, nursing home associations, resident advocacy groups, academic organizations and other stakeholders and experts to help nursing homes meet and exceed federal and State minimum standards. The quality improvement initiative described in this RFA – strengthening medical direction and medical care in nursing homes - is one such effort. But it must be rigorously evaluated. The design and conduct of the evaluation is the deliverable sought through this RFA.

B. Background/Intent

1. Nursing Home Quality Improvement Program

In 2004, the Department established the Nursing Home Quality Improvement (NHQI) Program. Funding to support program activities is derived from the State's share of federally-imposed civil monetary penalties (CMP) and from State-imposed enforcement fines collected from nursing homes that are non-compliant with federal and State health and safety standards. CMS must approve all expenditures of these funds and has approved the evaluation described in this RFA as an acceptable use of CMP funds.

2. Medical Direction and Medical Care in Nursing Homes Guidelines

A stakeholders work group, convened in May, 2010, by the NYS Department of Health and the NY Medical Directors Association (NYMDA), developed best practices or guidelines for the credentials, roles, responsibilities and accountabilities of nursing home medical directors and attending medical practitioners (i.e., physicians, nurse practitioners and physician assistants). The guidelines are process (not clinical) guidelines and incorporate federal and NYS regulatory requirements. Implementation is voluntary. They were completed in May, 2011 and distributed to all nursing homes in the State a few months later. See Attachments 1, 2 and 3 for the guidelines, the "Dear Administrator" cover letter and development work group membership. Upon completion of the guidelines, the development work group met its charge and was disbanded.

An implementation work group was then convened. Many members of the development work group are also members of the implementation work group. Implementation work group membership (see Attachment 4) includes representation from all major trade associations whose members include nursing homes, NYMDA, Medical Society of the State of New York (MSSNY), the New York Chapter of the American College of Health Care Administrators NYACHCA), and medical directors, attending

physicians and administrators from both urban and rural nursing homes.

The implementation work group as a whole possesses intimate knowledge of New York's nursing homes and the people who work in them. It has many years of experience working with nursing home staff and physicians to strengthen management practices and operational capabilities with the ultimate goal of providing the best care and services possible to a very frail and medically complex population living in a highly regulated environment. The work group determined that many nursing homes (NHs) would require a formal program of education, training and technical assistance tailored to their specific circumstances, strengths and weaknesses to successfully implement the guidelines.

The Department of Health has allocated a portion of NHQI funds to the Medical Direction and Medical Care in Nursing Homes Project. NHQI funds were allocated to both: (1) the education, training and technical assistance that nursing homes need to implement the guidelines, and (2) an evaluation of the effectiveness of the education, training and technical assistance as well as the impact of the guidelines themselves on residents' health, quality of life and health care services utilization and other outcomes and variables.

The contract to provide education, training and technical assistance (ETTA) services has been awarded to the Health Education and Research Foundation (HERF), a subsidiary of the Healthcare Association of New York State (HANYS). This three-year grant contract started January 1, 2014.

This RFA seeks a contractor to design and conduct an evaluation of the effectiveness of the education, training and technical assistance provided to nursing homes that wish to implement the guidelines as well as the impact of the guidelines themselves.

3. Education, Training and Technical Assistance (ETTA)

This section of the RFA is a description of the interventions provided by the ETTA contractor. Not all of them must be evaluated. The ETTA contractor, (who will sub-contract with additional entities) will:

(a) Develop and conduct on a regional basis, half-day high level educational sessions on the guidelines. These sessions will be an introduction to the guidelines and open to any nursing home (NH) that wishes to attend. They will be marketed to NH leadership teams, e.g., the administrator, the director of nursing services and the medical director. It is anticipated that this education session will be offered several times in each of 4-7 locations across the State to minimize travel time and expense for staff at participating NHs. The sessions will be repeated in years 2 and 3 of the ETTA contract to "pick up" any NHs that did not participate in prior year sessions. The evaluator will **not** evaluate this specific activity.

(b) Develop and conduct a series of education and training sessions for nursing home leadership teams (administrator, medical director and director of nursing services) from approximately 50 facilities across the State. This training and education, offered over a period of 28 months (from September 1, 2014 – December 31, 2016), and based on a needs assessment, will address not only the guidelines themselves, but also the knowledge, skills and experience the leadership teams need to implement the guidelines. Participating nursing homes will pay a nominal team-based registration fee for the training and education sessions. The evaluator will evaluate this activity.

(c) Provide technical assistance (TA) to participating nursing homes to help them work through barriers to implementation. The TA will begin during the first year of the three-year contract with HERF and will continue through December 31, 2016. The evaluator will evaluate this activity.

The implementation work group has developed and pilot-tested assessment and self-assessment tools (to be completed by the administrator, director of nursing services, medical director, medical attendings and others in leadership positions) whose purpose is to enable nursing home leadership teams to identify the extent to which they have already implemented the guidelines prior to participating in the education, training and technical assistance project, and how much remains to be implemented. These assessments are being modified to serve as fidelity measures and guidelines implementation measures. See Attachment 5 for a draft version of these assessment and self-assessment tools. Baseline data on the extent to which facilities have implemented the guidelines prior to receiving education, training and technical assistance on them will be collected by an "interim" contractor (The Foundation for Long Term Care) as the current competitive procurement for an evaluation contractor will not be complete until October, 2014, and the intervention is scheduled to begin in September, 2014. More information on the interim contractor's responsibilities and deliverables for the evaluation is in Section III C 8 below.

While nursing home leadership teams need education and training on the guidelines themselves, especially the guidelines for medical direction, it is anticipated that a significant portion of training time will be allocated to such topics and skills as team building and nurturing at all levels of the organization; clear, consistent and timely horizontal and vertical communication methods; creating a culture of accountability; problem identification and solving; root cause analysis, quality and process improvement; managing relationships with the community, including admitting physicians; credentialing; moving to a closed medical staff model; support for the medical director and efficient use of his/her time, e.g., data collection, analysis and reports, and policies and protocols; billing and financial requirements; and re-engineering work flow and work processes to facilitate communication, team work, education and learning, and appropriate and timely medical care.

The ETTA contractor will also use grant funds to offer technical assistance to nursing homes as leadership teams return to their facilities to implement what they've learned after each training session has been completed. A facilitator will be assigned to each nursing home to help its staff identify and prioritize gaps in guidelines implementation, develop an implementation action plan, and identify and address implementation issues. Technical assistance could be provided via conference calls with one or more facilities that have the same need, in person on-site, audio-conferences, webinars, or other technologies. Possible technical assistance needs include strategies for obtaining medical director and physician support for the guidelines; mapping and re-engineering work flow processes; quality and process improvement; development of policies and procedures; contract development; and performance improvement and evaluation. Some facilities may find that they need a level of technical assistance that HERF cannot provide under its contract with the Department of Health. The facilitator assigned to the nursing home will help the facility to identify such situations and to find appropriate consultants who can provide, at the facility's expense, the needed consultation.

4. Problem/Issue

According to a 2007 report prepared for the National Commission for Quality Long Term Care by the Institute for the Future of Aging Services (The Long Term Care Workforce: Can the Crisis Be Fixed?),

NHs are medically underserved communities - little medical direction and little medical care is found in them. The dearth of timely and appropriate medical care for nursing home residents has been documented in multiple studies of ambulatory care sensitive conditions in nursing home residents that result in hospitalizations that could have been prevented had timely and appropriate primary medical care been provided.

The absence of timely and appropriate medical care in nursing homes is not attributable to lack of payment sources. In New York, most of those admitted to a New York State nursing home (long stay or short stay) are dual eligibles – they are eligible for both Medicaid and Medicare. Medicare and New York's Medicaid plan are very comprehensive health care insurance plans. For the dual eligible population, there is little out-of-pocket expense. Rather, the less-than-optimal medical care is attributable to social and environmental factors and beliefs about long term care.

The NH environment is unlike any other setting in which physicians practice medicine. It is very highly regulated. NHs are regularly surveyed to ensure compliance with myriad rules and regulations. Residents who move in and make the NH their home are, on average, sicker and more medically complex than their elderly counterparts who do not live in NHs. As many as 75% are cognitively impaired and up to 66% have a diagnosis of dementia, presenting additional obstacles to accurate and timely diagnosis and treatment. Even the most competent and motivated geriatrician faces a host of challenges to providing appropriate and timely medical care to long stay residents of NHs. The practice of geriatric medicine in NHs is unlike the practice of this specialty in virtually any other setting[1]. It is so different, that Katz et al propose a new sub-specialty modeled on the hospitalist[2], i.e., the nursing home physician specialist.

As noted above, the guidelines are not clinical but rather process-oriented – they lay out the roles, responsibilities and accountabilities of NH medical directors and medical practitioners (physicians, nurse practitioners and physician assistants) who provide care to NH residents. (Other tested tools, such as Interact 2, address clinical pathways and decision-making.) As process guidelines, they address three of the root causes of the less-than-optimal medical care for residents in many NHs: (1) when they are providing services to NH residents, some physicians do not practice medicine the way they were taught to practice it and/or the way they practice medicine for their patients who do not live in nursing homes; (2) some NH medical directors are not sufficiently present in their facilities, do not provide sufficient supervision and guidance to medical practitioners, and are not sufficiently engaged in the specific day-to-day NH operations that affect quality of medical care; and (3) NH executives and managers are sometimes unsure regarding medical director and medical attending roles, responsibilities and accountabilities, and what the facility should be doing to support the medical director and attending physicians.

Poor medical care leads to several undesirable outcomes, e.g., residents' risk factors, symptoms and conditions are not recognized, assessed and appropriately managed, their health and quality of life deteriorates, and they may be hospitalized. Hospitalization itself can result in negative outcomes for frail nursing home residents at risk for many conditions such as pressure ulcers, incontinence, decline in functional health (e.g., ambulation, feeding oneself, grooming and toileting), and cognitive impairment. An example of this situation is as follows. A resident is transferred to the hospital for an acute condition. The information the hospital needs to provide appropriate care to the resident may not be provided to hospital staff by nursing home staff and/or hospital staff may not be aware of the special needs of nursing home residents, especially if those needs are not related to the acute condition that precipitates the hospital admission. At time of transfer to the hospital, the resident may not have any of the conditions for which she is at risk. The hospital addresses the acute condition

appropriately and discharges the resident back to her nursing home. The resident arrives back home incontinent, unable to ambulate or feed herself, on multiple medications from which she had been weaned in the nursing home, and with pressure ulcers.

The guidelines are intended to be one "piece of the puzzle" required to address these issues. The evaluation described in this RFA is needed to determine if they do. The evaluation will also identify opportunities to make the education, training and technical assistance more effective.

II. Who May Apply

Eligible applicants are: public, not-for-profit or for profit (proprietary) private institutions, such as a university, college, faith-based or community-based organization, or health care provider, with the following exception. Nursing homes licensed under Article 28 of the Public Health Law who apply to and are accepted into the education, training and technical assistance project are not eligible to be awarded the evaluation contract resulting from this RFA. However, the entity awarded the contract may sub-contract with such nursing homes (or other nursing homes) to conduct such tasks as they are qualified to conduct.

At the time the contract is executed, and for the term of the contract thereafter, if the applicant awarded the evaluation contract is an Article 28 nursing home, it may not participate in any ETTA subject to the evaluation in any capacity other than that of evaluator without the approval of the Department of Health in advance of the ETTA. This will be a contractual requirement. The Department reserves the right to decline to approve the contractor's participation in any ETTA.

Because the purpose of this program is to improve healthcare in the United States, foreign institutions are not eligible applicants but may participate only as subcontractors.

The grant recipient is expected to perform a substantive role in the conduct of the planned project and not merely serve as a conduit of funds to another party or parties. If consortium or sub-contracted activities represent a significant portion of the overall project, the applicant must justify why the applicant organization, rather than the party(s) performing this portion of the overall project, should be the grantee and what substantive role the applicant organization will play. There is no budget allocation guideline for determining substantial involvement; determination of substantial involvement is based on a review of the primary project activities for which grant support is provided and the organization(s) that will be performing those activities.

III. Detailed Specifications

A. Anticipated Timeframes

The three-year ETTA contract with HERF started January 1, 2014 and ends December 31, 2016. The five-year contract resulting from this procurement has an anticipated start date of December 1, 2014 and end date of November 30, 2019. A December 1, 2014 start date provides an eight-week overlap with the Foundation for Long Term Care's (FLTC) contract (see Section C.8. below for a detailed description of the scope of FLTCs contractual responsibilities for evaluation activities) and will facilitate the transfer of the web-based data collection tools, data and other deliverables associated with the evaluation from FLTC to the evaluation contractor. A contract end date of November 30, 2019 for the contract resulting from this procurement reflects the following:

(1) HERF will be providing ETTA through the end of its contract on December 31, 2016.

(2) Three waves of data collection are required:

(a) Baseline - approximately April, 2014 – September, 2014,

(b) First follow-up – approximately October, 2016 – March, 2017, and

(c) Second follow-up – approximately October, 2017 – March, 2018.

(3) There are long time lags before certain data become available for analysis. The longest of these time lags is probably associated with nursing home cost data. Nursing homes must submit to the Department of Health an annual (calendar year) cost report (RHCF-4) for each year within six months of the end of that year. The Department processes the data into datasets and makes it available to the public via the Freedom of Information Law (FOIL). (NOTE: The nursing home cost report data available through www.health.data.ny.gov is aggregated data and thus has limited utility for the evaluation.) 2016 calendar year data won't be available for first follow-up analyses until late 2017 or early 2018. 2017 calendar year data required for the second follow-up will not be available until late 2018 or early 2019. A similar time lag applies to calendar year SPARCS data.

Once the evaluation contractor has obtained the data, it will need several months to analyze it and prepare final reports and other deliverables. A contract end date of November 30, 2019 accommodates this time lag and provides the evaluation contractor with at least nine months in which to complete all contractually required deliverables.

While much of the data required for the evaluation is routinely collected without regard to the needs of the ETTA evaluation (for example, MDS 3, RHCF-4, SPARCS and Medicare and Medicaid claims data) there are raw data collection requirements for the baseline period as well as both follow-up waves of data collection. These include data for the fidelity measures and facility characteristics not routinely collected elsewhere that might affect or be affected by the intervention. Baseline data for these variables must be collected before the evaluation contract is in place. Section C.8 below describes how this will be accomplished and its impact on evaluation design, evaluation implementation, and the evaluator's contract with the Department of Health.

Anticipated timeframes for data collection, are:

DATA	TIME PERIOD COVERED B = Baseline F1= First follow-up F2 = Second follow-up	WHO IS RESPONSIBLE FOR COLLECTING/OBTAINING THE DATA?	WHEN WILL DATA BECOME AVAILABLE?
Raw data not routinely collected elsewhere	B: 1/1/14 – 9/30/14	FLTC	As collected and processed
	F1: 10/1/16 – 3/31/17	Evaluation contractor or sub-contractor	As collected and processed
	F2: 10/1/17 – 3/31/18	Evaluation contractor or sub-contractor	As collected and processed
RHCF-4	B: 2013 (calendar year)	Evaluation contractor or sub-contractor	Late 2014 or early 2015
	F1: 2016 (calendar year)	Evaluation contractor or sub-contractor	Late 2017 or early 2018
	F2: 2017 (calendar year)	Evaluation contractor or sub-contractor	Late 2018 or early 2019
MDS	B: 2014 – 1st quarter	Evaluation contractor or sub-contractor	2014 – 3rd quarter
	F1: 2016 – 4th quarter	Evaluation contractor or sub-contractor	2017 – 2nd quarter
	F2: 2017 – 4th quarter	Evaluation contractor or sub-contractor	2018 – 2nd quarter
SPARCS	B: 2013 (calendar year)	Evaluation contractor or sub-contractor	2014 - 3rd quarter
	F1: 2016 (calendar year)	Evaluation contractor or sub-contractor	2017 – 3rd quarter
	F2: 2017 (calendar year)	Evaluation contractor or sub-contractor	2018 – 3rd quarter
Medicaid and Medicare claims and utilization	B: 2013 (calendar year)	Evaluation contractor or sub-contractor	Late 2014 or early 2015
	F1: 2016 (calendar year)	Evaluation contractor or sub-contractor	Late 2017 or early 2018
	F2: 2017 (calendar year)	Evaluation contractor or sub-contractor	Late 2018 or early 2019

The contractor may use, with appropriate explanation and justification, and with Department of Health approval in advance, routinely collected datasets other than those listed above.

B. Available Funds

Approximately $840,000 will be available for this five-year contract, subject to availability of funds in each year of the contract. Applicants will compete on cost.

C. Contractual Deliverables

1. Work Plan

Within 14 calendar days of contract start date, the contractor will develop and submit to the Department for approval a final work plan.

2. Evaluation Research Design

Within 30 calendar days of contract start date, the contractor will develop and submit to the Department for approval a final research design.

3. Interventions To Be Evaluated

The contractor will evaluate only the ETTA provided to the 50 nursing homes. This ETTA is described in Section I.B.3 and comprises interventions (2) and (3). The evaluation contractor will not evaluate intervention (1). Thus for this group of 50 nursing homes, the interventions to be evaluated are:

- the training and education;
- the technical assistance; and
- the guidelines themselves.

4. Research Questions

Ultimately, the Department and the implementation work group need to ascertain the effectiveness and the effects of the guidelines on resident outcomes such as health, quality of life and health care utilization. But there are intervening or process variables that also need to be measured such as the effectiveness of the education, training and technical assistance. This information is critical to the design of future ETTA efforts.

"Effectiveness" of the education and training is defined as the extent to which those trained or educated on a topic return to their facilities and successfully practice and use what they have been taught. For example, some nursing homes do not rely on teams and team work at any level of the organization to accomplish mission and goals. Teams and teamwork at all levels of the organization are critically important to successful guidelines implementation. Thus education, training and "homework" will be offered on this topic. Nursing home staff that participates in this training (the administrator, medical director, director of nursing services, etc.) will be expected to return to their facilities and put what they have learned about teams into practice. The evaluation contractor would, in this case, ascertain the extent to which they successfully implement a team-based approach to implementing the guidelines and practicing in accordance with the guidelines.

"Effectiveness" of the technical assistance is defined as the extent to which the ETTA contractor correctly identifies and understands the problem or barrier and offers the information and/or guidance needed to resolve it, (or helps the nursing home to acquire the expertise it needs from sources other than the ETTA project) and the extent to which the problem or barrier is in fact resolved.

"Effectiveness" of the ETTA as a whole is the extent to which the nursing homes implement the guidelines themselves.

"Effectiveness" of the guidelines is defined as the extent to which guidelines implementation leads to improved resident outcomes in such areas as health, mental health, behaviors, medications, physical functioning, continence and health care services utilization including emergency department and hospital admissions.

The evaluation contractor will also collect and analyze the data required to understand: (1) why the ETTA is less effective for some nursing homes compared to others; (2) why the extent to which they implement the guidelines varies across nursing homes; and (3) the causal factors, predictors and correlates of effectiveness and the extent to which the guidelines are implemented. This information is critically important: the Department and implementation work group will use it to tailor future medical direction and medical care ETTA initiatives to each nursing home's individual needs, strengths and opportunities for improvement.

The above analyses must be completed comparing baseline data to first follow-up, baseline data to second follow-up, and first follow-up to second follow-up.

Throughout the research design, applicants should take care to distinguish the effectiveness and

impacts of the ETTA from the effectiveness and impacts of the guidelines themselves. Applicants should recognize that participation in this project and guidelines implementation is voluntary. Many nursing homes that participate in the project will have already implemented a good portion of the guidelines before they join the project but feel they need some extra "outside" help to complete the process. Still others may have "stalled" when they encountered barriers that appeared to be too difficult to overcome. These nursing homes may view the ETTA project as an opportunity to gain fresh insight into their own unique environmental barriers to guidelines implementation so that they can work their way through those barriers. In any case, applicants should assume that all 50 participating nursing homes will have implemented the guidelines to a greater or lesser extent prior to being exposed to any ETTA. Further, the extent to which the 50 nursing homes implement additional guidelines after they join the project, and the guidelines that they choose to implement, will vary across nursing homes.

Additional Deliverables

Additional deliverables include the following:

- Bench mark reports: Disaggregated guidelines implementation, impact and effectiveness analyses (at the facility-specific level) at baseline, first follow-up and second follow-up for each of the 50 ETTA nursing homes, to be shared with the nursing home. Each nursing home would see only its data and analyses compared to the aggregated results for the other 49 nursing homes and sub-groups of these 49 facilities. These "bench marking" reports must be easily understood and interpreted by nursing home leadership teams. The format for these reports must be approved by the Department of Health before the reports are produced for distribution to nursing homes.

- Cost effectiveness analyses (CEA) at both first and second follow-up:

    - From the point of view of the Department of Health, is the ETTA a cost-effective strategy to obtain nursing home alignment with the guidelines?
    - From the point of view of Medicaid and Medicare as payers, is guidelines implementation by nursing homes a cost-effective strategy to achieve CMS' triple aim*?
        - NOTE: All Medicare and Medicaid expenditures for residents in the 50 participating nursing homes must be included in the analyses addressing this question, e.g., nursing home, hospital, emergency department, ancillary services, physician services, medications, laboratory, imaging, hospice, etc.
    - From the point of view of participating nursing homes, is guidelines implementation a cost-effective strategy to produce better quality of life and quality of care outcomes for residents?

- Develop the business case for nursing homes to implement the guidelines.

- Evaluate the impact of guidelines implementation at both first follow-up and second follow-up on, among other variables: (1) hospital admissions and emergency department utilization; (2) services, treatments and therapies provided by participating nursing homes, (3) costs of care and services; (4) nurses' scope of practice in participating nursing homes, and (5) nursing staff (includes CNAs, LPNs and RNs) turnover and absences.

- Develop a return on investment (ROI) analysis based on the value of the ETTA contract.

* CMS' triple aim is defined as: (1) better care for individuals; (2) better health for populations; and (3) reducing per-capita health care costs. More information on "triple aim" can be accessed via internet search engines.

Confounding Events

It should be noted that the Department of Health plans to begin the transition of certain groups of nursing home residents to managed care in July, 2014. The transition will apply only to Medicaid-eligible individuals who are at least 21 years old and who are not permanent residents of the nursing home on the date that the nursing home begins its transition to managed care. This transition will start in NYC and Nassau, Suffolk and Westchester counties. The rest of the State will transition to managed care several months later. Medicaid eligible residents who have made the nursing home their home as of the date the nursing home transitions to managed care will remain fee-for-service and will not be required to enroll in a managed care plan. Six months after the transition begins, the permanent nursing home residents initially excluded from enrollment in a managed care plan may voluntarily enroll in a managed care plan. Residents in the 50 nursing homes receiving ETTA will be included in the transition to managed care. The complete policy paper on the transition of nursing home residents and admissions to managed care is posted here: http://www.health.ny.gov/health_care/medicaid/redesign/docs/2013-12-18_trns_of_nh_services.pdf

Additional environmental factors that must be accounted for include implementation of the Delivery System Reform Incentive Payments (DSRIP) program and the State Health Innovation Plan (SHIP). The overall goal of DSRIP is to reduce hospital admissions by 25%. It is very likely that most if not all of the nursing homes that participate in the ETTA project will also participate in and/or be affected by these two initiatives. More information on DSRIP and SHIP is available on the Department's public website: www.health.ny.gov.

The evaluation contractor will be expected to propose analytic strategies to distinguish the impact on resident outcomes and health care utilization of managed care, DSRIP, SHIP and other exogenous variables from the impact of the ETTA and the medical direction and medical care guidelines themselves.

5. Data Sources

The Department is aware of concerns in the research community regarding the quality of locally collected data such as the MDS. However, original data collection must be minimized due to cost. To that end, the contractor should use existing databases such as MDS 3.0, SPARCS, RHCF-4, Medicare claims and Medicaid claims data whenever possible to measure resident outcomes including health care utilization and costs *unless compelling reasons are provided for collecting raw or original data.* The contractor must have a data use agreement (DUA) with CMS to access New York's MDS data, and must obtain approval from the Department's Data Protection Review Board (DPRB) in order to obtain SPARCS data. The contractor must meet all Department of Health requirements if it proposes to use RHCF-4 and Medicaid claims data. If Medicare claims data is required, the contractor is responsible for obtaining it from CMS. An applicant who does not have staff who has experience with these data sets is encouraged to sub-contract with organizations that do.

The evaluation contract will not be executed in time for raw baseline data collection from the 50

nursing homes participating in the ETTA project. The Department has contracted with the Foundation for Long Term Care to collect the raw baseline data needed for fidelity measures and any other data not routinely otherwise collected. Nursing homes will supply this data via web-based data collection tools.

Baseline raw data collection is described in Section C.8. below. The evaluation contractor (i.e., the organization awarded the contract resulting from this RFA) will be responsible for collecting this data at first and second follow-up.

As noted above, MDS, RHCF-4, SPARCS, and Medicare and Medicaid claims data can be used for all other baseline and follow-up measures. The evaluation contractor will be responsible for obtaining these data from the organizations that own and/or maintain it, and for meeting all requirements that these organizations place on accessing and using the data, for all three data collection periods, i.e., baseline, first follow-up and second follow-up.

6. Nursing Home Sample Selection

All participating nursing homes must be included in the evaluation. Control samples are required when needed for any analyses that do not require raw data collection, such as analyses that rely on SPARCS and MDS 3.0. At the contractor's discretion, controls may also be used in analyses that require raw data collection.

7. IRB and HIPPA Approvals

The contractor is responsible for obtaining all IRB approvals and meeting all HIPPA requirements. The contractor may not apply to the Department's IRB for review and approval.

8. Baseline Raw Data Collection

The Department is contracting with the Foundation for Long Term Care (FLTC), an affiliate of Leading Age NY, to collect all raw baseline data. Specifically, FLTC, working closely with the ETTA Steering Committee, will design, pilot test and host on its servers a web-based application to collect baseline data not routinely collected through other means. The data to be collected include the data required to construct fidelity measures and describe some of the characteristics of participating nursing homes. A secure, web-based data collection application will be developed and implemented to collect the data, track compliance by ETTA facilities in completing required data collection activities, and, to the extent that it is collected, process the raw data into datasets. When the FLTC contract expires, the software application, application documentation and processed and raw data will be transferred to the organization to which the Department of Health awards the contract resulting from this RFA.

Specific FLTC tasks include:

1. Develop and clearly define the raw data elements to be collected at baseline and follow- up. Data elements may include but are not limited to:
   a. Medical director characteristics (e.g., hours per week, medical specialty, certification credentials, patient caseload, etc.);
   b. Attending physician characteristics (e.g., hours per week, patient caseload, etc.);
   c. Use of physician extenders (e.g. type of extender, hours per week at facility, caseload

characteristics, etc.);
   d. Nursing staff turnover;
   e. Nursing staff/resident ratios;
   f. Types of services, treatments and therapies provided by NH and the delivery method of these services; and
   g. Medical staff organizational model.
2. Develop, test and implement fidelity measures that can be used to measure the extent to which ETTA facilities implement the medical direction and medical care guidelines.
3. Develop instructions for ETTA facility staff on completing the data collection instruments.
4. Develop a web-based system for data collection, working under the assumption that the application and database will be transferred to another party at some later date.
5. Maintain the application and database on a secure server until such time as they are transferred to another organization.
6. Develop system documentation. Provide the documentation to the organization to whom the application and database are transferred.

The specifications for these web-based tools will be released as part of the Questions and Answers on this procurement.

The Department is seeking to extend the FLTCs contract ten months to end on January 31, 2015. The evaluation contract resulting from this RFA has a start date of December 1, 2014. The 8-week overlap between contracts will facilitate a smooth transition of all data collection tools, documentation, and data, from the FLTC to the evaluation contractor. The evaluation contractor will then assume full responsibility for the evaluation and the deliverables specified in this RFA.

If the ten-month FLTC contract extension is approved, FLTC will also develop the bench mark reports (described on page 9 of this RFA) for each facility using the baseline raw data it collects via its web-based data collection tools. These bench marking reports will enable each facility to compare itself and its progress implementing the guidelines to the other facilities that are participating in the project. The reports will be facility-specific in that they will display aggregated data for all facilities other than the one for which the report is produced. The organization awarded the contract resulting from this RFA will be responsible for producing similar bench marking reports for facilities at time one and time two follow-up.

NOTE: The only data that FLTC will collect is raw data not already routinely submitted by nursing homes, hospitals and other Medicare and Medicaid providers to CMS or the Department of Health. As shown in the chart in Section III A of this RFA, the organization awarded the contract resulting from this procurement will be accountable for obtaining all other data from the organizations that own it.

D. Ownership of Products Developed With Department Funds

Any products developed with funds awarded under this program are the property of the Department of Health. The contractor may not license, sell or copyright the products of this contract, nor may it limit in any way public access to and use of the final products, without the explicit and written agreement of the Department of Health.

IV. Administrative Requirements

A. Issuing Agency

This RFA is issued by the New York State Department of Health, Offices of Primary Care and Health Systems Management, Division of Nursing Home and ICF/IID Surveillance. The Department is responsible for the requirements specified herein and for the evaluation of all applications.

B. Question and Answer Phase

All substantive questions must be submitted in writing to:

Beth Dichter, Ph.D.,
Division of Quality and Surveillance for ICF/IID
NYS Department of Health
875 Central Avenue
Albany, NY 12206
or
Beth.Dichter@health.ny.gov

To the degree possible, each inquiry should cite the RFA title, section and paragraph to which it refers. Written questions will be accepted until the date posted on the cover of this RFA.

Questions of a technical nature can be addressed in writing or via telephone by calling or emailing Dr. Dichter at 518-408-1297 or Beth.Dichter@health.ny.gov. Questions are of a technical nature if they are limited to how to prepare your application (e.g., formatting) rather than relating to the substance of the application.

Prospective applicants should note that all clarifications and exceptions, including those relating to the terms and conditions of the contract, are to be raised prior to the submission of an application.

This RFA has been posted on the Department's public website at: http://www.health.ny.gov/funding/. Questions and answers, as well as any updates and/or modifications, will also be posted on the Department's website. It is anticipated that all such updates will be posted by the date identified on the cover sheet of this RFA.

C. Applicant Conference and Letter of Intent

The Applicant Conference for this project will be June 13, 2014, 10:00 – 1:00 PM, at 875 Central Avenue, Albany, NY 12206. Those interested in attending are requested to register with Kayla Rooney or Monisha Maitra, Administrative Assistants, Department of Health at 518-408-1297 or via email at profcred@health.ny.gov. Attendance is optional. Registration is not required but will assist staff in their planning efforts.

Organizations that intend to submit an application for this grant opportunity are requested, but not required, to submit a letter of intent by July 7, 2014. Letters of intent should be emailed to Beth.Dichter@health.ny.gov.

D. How To File An Application

Applications must be received at the following address by the date and time posted on the cover sheet of this RFA:

Beth Dichter, Ph.D.
Division of Quality and Surveillance
for Nursing Homes and ICF/IID
NYS Department of Health
875 Central Avenue
Albany, NY 12206

It is the applicant's responsibility to ensure that its application is delivered to the address above prior to the due date and time. Late applications will not be accepted with the following possible exception. Late applications due to a documentable delay by the carrier may be considered at the Department of Health's discretion.

Applicants shall submit one (1) original, signed application and 5 copies. Application packages should be clearly labeled with the name and number of the RFA as listed on the cover of this RFA document. **Applications will not be accepted via fax or e-mail.**

E. The Department's Reserved Rights

The Department of Health reserves the right to:

1. Reject any or all applications received in response to this RFA.

2. Withdraw the RFA at any time, at the Department's sole discretion.

3. Make an award under the RFA in whole or in part.

4. Disqualify any applicant whose conduct and/or proposal fails to conform to the requirements of the RFA.

5. Seek clarifications and revisions of applications.

6. Use application information obtained through site visits, management interviews and the state's investigation of an applicant's qualifications, experience, ability or financial standing, and any material or information submitted by the applicant in response to the agency's request for clarifying information in the course of evaluation and/or selection under the RFA.

7. Prior to application opening, amend the RFA specifications to correct errors or oversights, or to supply additional information, as it becomes available.

8. Prior to application opening, direct applicants to submit proposal modifications

addressing subsequent RFA amendments.

9. Change any of the scheduled dates.

10. Waive any requirements that are not material.

11. Award more than one contract resulting from this RFA.

12. Conduct contract negotiations with the next responsible applicant, should the Department be unsuccessful in negotiating with the selected applicant.

13. Utilize any and all ideas submitted with the applications received.

14. Unless otherwise specified in the RFA, every offer is firm and not revocable for a period of 60 days from the bid opening.

15. Waive or modify minor irregularities in applications received after prior notification to the applicant.

16. Require clarification at any time during the procurement process and/or require correction of arithmetic or other apparent errors for the purpose of assuring a full and complete understanding of an offerer's application and/or to determine an offerer's compliance with the requirements of the RFA.

17. Negotiate with successful applicants within the scope of the RFA in the best interests of the State.

18. Eliminate any mandatory, non-material specifications that cannot be complied with by all applicants.

19. Award grants based on geographic or regional considerations to serve the best interests of the state.

F. Term of Contract

Any contract resulting from this RFA will be effective only upon approval by the New York State Office of the Comptroller.

It is expected that the contract resulting from this RFA will have the following multi-year time period: December 1, 2014 – November 30, 2019.

Continued funding throughout this period is contingent upon satisfactory contractor performance and availability of funds. The Department also reserves the right to revise the funding amounts for awards as necessary due to changes in the availability of funds.

G. Payment & Reporting Requirements

The Department may, at its discretion, make an advance payment to not for profit grant contractors in an amount not to exceed 0 percent. Therefore, no advance payment to not for profit grant

contractors will be made.

The grant contractor will be required to submit quarterly vouchers and required reports of expenditures to the State's designated payment office:

Karen Cornwell, Director
Division of Administration and Operations
NYS Department of Health
ESP – Tower Building – Room 1861
Albany, NY 12203

Grant contractors shall provide complete and accurate billing vouchers to the Department's designated payment office in order to receive payment. Billing vouchers submitted to the Department must contain all information and supporting documentation required by the Contract, the Department and the State Comptroller. Payment for vouchers submitted by the CONTRACTOR shall only be rendered electronically unless payment by paper check is expressly authorized by the Commissioner, in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with ordinary State procedures and practices. The CONTRACTOR shall comply with the State Comptroller's procedures to authorize electronic payments. Authorization forms are available at the State Comptroller's website at www.osc.state.ny.us/epay/index.htm, by email at epayments@osc.state.ny.us or by telephone at 855-233-8363. CONTRACTOR acknowledges that it will not receive payment on any vouchers submitted under this contract if it does not comply with the State Comptroller's electronic payment procedures, except where the Commissioner has expressly authorized payment by paper check as set forth above.

Payment of such vouchers by the State (NYS Department of Health) shall be made in accordance with Article XI-A of the New York State Finance Law. Payment terms will be: Contractor will be reimbursed for actual expenses incurred as allowed in the contract budget and work plan, subject to successful and timely completion of the tasks and milestones in the Department-approved work plan for the project.

The grant contractor will be required to submit the following periodic reports:

1. Quarterly narrative reports and quarterly reimbursement vouchers are due within 30 calendar days of the end of the quarter. The first quarter begins April 1, 2014. The Department will provide the format for the quarterly narrative report and the quarterly reimbursement voucher.

2. Annual reports are due within 45 days of the last day of the contract year. The first contract year begins April 1, 2014. The fourth quarter report for each contract year should be part of the annual report for that year. The Department will provide the format for the annual report.

All payment and reporting requirements will be detailed in Attachment D of the final grant contract.

H. Minority & Woman-Owned Business Enterprise Requirements

Pursuant to New York State Executive Law Article 15-A, the New York State Department of Health ("DOH") recognizes its obligation to promote opportunities for maximum feasible participation of certified minority-and women-owned business enterprises and the employment of minority group

members and women in the performance of DOH contracts.

In 2006, the State of New York commissioned a disparity study to evaluate whether minority and women-owned business enterprises had a full and fair opportunity to participate in state contracting. The findings of the study were published on April 29, 2010, under the title "The State of Minority and Women-Owned Business Enterprises: Evidence from New York" ("Disparity Study"). The report found evidence of statistically significant disparities between the level of participation of minority- and women-owned business enterprises in state procurement contracting versus the number of minority- and women-owned business enterprises that were ready, willing and able to participate in state procurements. As a result of these findings, the Disparity Study made recommendations concerning the implementation and operation of the statewide certified minority- and women-owned business enterprises program. The recommendations from the Disparity Study culminated in the enactment and the implementation of New York State Executive Law Article 15-A, which requires, among other things, that DOH establish goals for maximum feasible participation of New York State Certified minority- and women – owned business enterprises ("MWBE") and the employment of minority groups members and women in the performance of New York State contracts.

Business Participation Opportunities for MWBEs

For purposes of this solicitation, the New York State Department of Health hereby establishes a goal of **20%** on any subcontracted labor or services, equipment, materials, or any combined purchase of the foregoing greater than $25,000 under a contract awarded from this solicitation. The goal on the eligible portion of this contract will be 10% for Minority-Owned Business Enterprises ("MBE") participation and 10% for Women-Owned Business Enterprises ("WBE") participation (based on the current availability of qualified MBEs and WBEs and outreach efforts to certified MWBE firms). A contractor ("Contractor") on the subject contract ("Contract") must document good faith efforts to provide meaningful participation by MWBEs as subcontractors or suppliers in the performance of the Contract and Contractor agrees that DOH may withhold payment pending receipt of the required MWBE documentation. For guidance on how DOH will determine "good faith efforts," refer to 5 NYCRR §142.8.

The directory of New York State Certified MWBEs can be viewed at: https://ny.newnycontracts.com. The directory is found in the upper right hand side of the webpage under "Search for Certified Firms" and accessed by clicking on the link entitled "MWBE Directory" Engaging with firms found in the directory with like product(s) and/or service(s) is strongly encouraged and all communication efforts and responses should be well documented.

By submitting an application, a grantee agrees to complete an MWBE Utilization plan as directed in **Attachment 11** of this RFA. DOH will review the submitted MWBE Utilization Plan. If the plan is not accepted, DOH may issue a notice of deficiency. If a notice of deficiency is issued, Grantee agrees that it shall respond to the notice of deficiency within seven (7) business days of receipt. DOH may disqualify a Grantee as being non-responsive under the following circumstances:

a) If a Grantee fails to submit a MWBE Utilization Plan;
b) If a Grantee fails to submit a written remedy to a notice of deficiency;
c) If a Grantee fails to submit a request for waiver (if applicable); or
d) If DOH determines that the Grantee has failed to document good-faith efforts to meet the established DOH MWBE participation goals for the procurement.

In addition, successful awardees will be required to certify they have an acceptable Equal Employment Opportunity policy statement.

I. Limits on Administrative Expenses and Executive Compensation

Effective July 1, 2013, limitations on administrative expenses and executive compensation contained within Governor Cuomo's Executive Order #38 and related regulations published by the Department (Part 1002 to 10 NYCRR – Limits on Administrative Expenses and Executive Compensation) went into effect. Applicants agree that all state funds dispersed under this procurement will, if applicable to them, be bound by the terms, conditions, obligations and regulations promulgated by the Department. To provide assistance with compliance regarding Executive Order #38 and the related regulations, please refer to the Executive Order #38 website at: http://executiveorder38.ny.gov.

J. Vendor Identification Number

Effective January 1, 2012, in order to do business with New York State, you must have a vendor identification number. As part of the Statewide Financial System (SFS), the Office of the State Comptroller's Bureau of State Expenditures has created a centralized vendor repository called the New York State Vendor File. In the event of an award and in order to initiate a contract with the New York State Department of Health, vendors must be registered in the New York State Vendor File and have a valid New York State Vendor ID.

If already enrolled in the Vendor File, please include the Vendor Identification number on the application cover sheet. If not enrolled, to request assignment of a Vendor Identification number, please submit a New York State Office of the State Comptroller Substitute Form W-9, which can be found on-line at: http://www.osc.state.ny.us/vendors/substitute_formw9.pdf.

Additional information concerning the New York State Vendor File can be obtained on-line at: http://www.osc.state.ny.us/vendor_management/index.htm, by contacting the SFS Help Desk at 855-233-8363 or by email to: ciohelpdesk@osc.state.ny.us.

K. Vendor Responsibility Questionnaire

The New York State Department of Health recommends that vendors file the required Vendor Responsibility Questionnaire online via the New York State VendRep System. To enroll in and use the New York State VendRep System, see the VendRep System Instructions available at http://www.ocs.state.ny.us/vendrep/vendor_index.htm or go directly to the VendRep system online at https://portal.osc.state.ny.us.

Vendors must provide their New York State Vendor Identification Number when enrolling. To request assignment of a Vendor ID or for VendRep System assistance, contact the Office of the State Comptroller's Help Desk at 866-370-4672 or 518-408-4672 or by email at ciohelpdesk@osc.state.ny.us.

Vendors opting to complete and submit a paper questionnaire can obtain the appropriate questionnaire from the VendRep website www.osc.state.ny.us/vendrep or may contact the Office of the State Comptroller's Help Desk for a copy of the paper form.

Applicants should complete and submit the Vendor Responsibility Attestation (Attachment 6).

L. Vendor Prequalification for Not-for-Profits

All not-for-profit vendors subject to prequalification are required to prequalify prior to grant application and execution of contracts.

Pursuant to the New York State Division of Budget Bulletin H-1032, dated June 7, 2013, New York State has instituted key reform initiatives to the grant contract process which requires not-for-profits to register in the Grants Gateway and complete the Vendor Prequalification process in order for applications to be evaluated. Information on these initiatives can be found on the Grants Reform Website.

Applications received from not-for-profit applicants that have not Registered and are not Prequalified in the Grants Gateway on the application due date listed on the cover of this RFA cannot be evaluated. Such applications will be disqualified from further consideration.

Below is a summary of the steps that must be completed to meet registration and prequalification requirements. The Vendor Prequalification Manual on the Grants Reform Website details the requirements and an online tutorial are available to walk users through the process.

1. **Register for the Grants Gateway**

   On the Grants Reform Website, download a copy of the Registration Form for Administrator. A signed, notarized original form must be sent to the Division of Budget at the address provided in the instructions. You will be provided with a Username and Password allowing you to access the Grants Gateway.

   If you have previously registered and do not know your Username, please email grantsreform@budget.ny.gov . If you do not know your Password, please click the Forgot Password link from the main log in page and follow the prompts.

2. **Complete your Prequalification Application**

   Log in to the Grants Gateway. **If this is your first time logging in,** you will be prompted to change your password at the bottom of your Profile page. Enter a new password and click SAVE.

   Click the *Organization(s)* link at the top of the page and complete the required fields including selecting the State agency you have the most grants with. This page should be completed in its entirety before you SAVE. A *Document Vault* link will become available near the top of the page. Click this link to access the main Document Vault page.

   Answer the questions in the *Required Forms* and upload *Required Documents*. This constitutes your Prequalification Application. Optional Documents are not required unless specified in this Request for Application.

   Specific questions about the prequalification process should be referred to your agency representative or to the Grants Reform Team at grantsreform@budget.ny.gov.

3. **Submit Your Prequalification Application**

After completing your Prequalification Application, click the ***Submit Document Vault*** Link located below the Required Documents section to submit your Prequalification Application for State agency review. Once submitted the status of the Document Vault will change to *In Review*.

If your Prequalification reviewer has questions or requests changes you will receive email notification from the Gateway system.

Once your Prequalification Application has been approved, you will receive a Gateway notification that you are now prequalified to do business with New York State.

Vendors are strongly encouraged to begin the process as soon as possible in order to participate in this opportunity.

M. General Specifications

1. By signing the "Application Form" each applicant attests to its express authority to sign on behalf of the applicant.

2. Contractors will possess, at no cost to the State, all qualifications, licenses and permits to engage in the required business as may be required within the jurisdiction where the work specified is to be performed. Workers to be employed in the performance of this contract will possess the qualifications, training, licenses and permits as may be required within such jurisdiction.

3. Submission of an application indicates the applicant's acceptance of all conditions and terms contained in this RFA, including the terms and conditions of the contract. Any exceptions allowed by the Department during the Question and Answer Phase (Section IV.B.) must be clearly noted in a cover letter attached to the application.

4. An applicant may be disqualified from receiving awards if such applicant or any subsidiary, affiliate, partner, officer, agent or principal thereof, or anyone in its employ, has previously failed to perform satisfactorily in connection with public bidding or contracts.

5. Provisions Upon Default

    a. The services to be performed by the applicant shall be at all times subject to the direction and control of the Department as to all matters arising in connection with or relating to the contract resulting from this RFA.

    b. In the event that the applicant, through any cause, fails to perform any of the terms, covenants or promises of any contract resulting from this RFA, the Department acting for and on behalf of the State, shall thereupon have the right to terminate the contract by giving notice in writing of the fact and date of such termination to the applicant.

c. If, in the judgment of the Department, the applicant acts in such a way which is likely to or does impair or prejudice the interests of the State, the Department acting on behalf of the State, shall thereupon have the right to terminate any contract resulting from this RFA by giving notice in writing of the fact and date of such termination to the Contractor. In such case the Contractor shall receive equitable compensation for such services as shall, in the judgment of the State Comptroller, have been satisfactorily performed by the Contractor up to the date of the termination of this agreement, which such compensation shall not exceed the total cost incurred for the work which the Contractor was engaged in at the time of such termination, subject to audit by the State Comptroller.

V. Completing the Application

A. Application Content

General Format Requirements

Hand written applications will not be accepted. PDF and copies of documents, such as resumes, must be readable. Reviewers are not responsible for deciphering poor quality copies and PDFs in the application. They are not required to consider the information in poor quality copies and PDFs in the application scoring process. Use no smaller than 10 point font. Margins (top, bottom, left, right) should be no less than .5 inches.

Material that is not required to be included in the application should be appended to the application after all of the required attachments. Reviewers are under no obligation to consider such information regardless of where it is placed in the application. Paginate the application.

Observe the page limits for each section of the application. Material in excess of the page limits for each section will not be considered when your application is scored.

Use the Application Table of Contents (Attachment 7). Do not alter it in any way other than to change font or font size and enter page numbers. The organization of the Application Table of Contents explicitly reflects the information required to rate or score the application on the evaluation criteria.

The Department's application reviewers and raters are not required to search an application to find the information required to score applications on a criterion. They will consider the information contained in section(s) of the application that address each criterion, as specified by the Application Table of Contents in Attachment 7. They may, at their sole discretion, also consider information included in other sections of the application. But they are not required to do so.

Applicants are advised to use the section and sub-section headings in the Application Table of Contents verbatim in their applications to ensure that reviewers are able to locate the information that the applicant intends to be used to score its application on each criterion.

Applicants are required to provide the names and addresses of New York State nursing homes in their descriptions of organizational and staff qualifications. Nursing homes change their names over time. Verify the current name of each nursing home for which experience is described here:

http://nursinghomes.nyhealth.gov/. Provide both the name of the nursing home at the time the experience was acquired and the current name, if the current name varies from the name at the time the experience was acquired. Current name in the application should be identical to the nursing home's name on http://nursinghomes.nyhealth.gov/. At the Department's sole discretion, experience in nursing homes whose existence Department staff cannot verify may not be considered when reviewers score applications. If the applicant believes that the nursing home has closed or merged with another facility since the time the experience was acquired, this should be noted in the application.

Start dates and end dates must specify at least the month and year. Start and/or end dates that do not include month and year will not be considered when reviewers score applications.

The content of each section of the Application Table of Contents is described in more detail below.

Application Organization

Application Cover Sheet: Use Attachment 8. Information entered on the Application Cover Sheet must be identical to information provided in the Vendor Responsibility Questionnaire.

Application Table of Contents: Use Attachment 7, explained above.

Statement of Understanding: Page limit is one page. State your understanding of the issues addressed by this project and its scope.

Organizational Qualifications: Page limit is five pages. This section addresses the applicant organization's experience, i.e., the applicant's rather than the applicant's individual employees' experience. The applicant is the single organization shown on the Application Cover Sheet (Attachment 8) to whom all grant funds will be paid. Sub-contractors and consultants are not applicants. Their experience and qualifications are not relevant to this section.

Provide an overview of the research that the applicant organization designs and conducts. Then provide information specific to the applicant's experience in the past 15 years in each of the following four areas. Do not combine these four areas. If applicant is a nursing home, applicant's experience in its own nursing home may be included unless the criterion excludes nursing home settings. If the criterion requires nursing home experience, verify that the entity in which you acquired the experience is a nursing home licensed as a residential health care facility under Article 28 of NYs Public Health Law. ***Do not include the experience of sub-contractors and consultants.*** Failure to provide the information described below will not work in the applicant's favor.

(1) providing education, training and technical assistance (ETTA) to New York nursing homes (i.e., nursing homes licensed under Article 28 of the Public Health Law) to help them implement quality improvement projects and best practices. Provide the name and address of each nursing home, start and end dates for the ETTA, a brief description of the quality improvement project or best practice, and a brief description of the ETTA your organization provided, taking care to distinguish education and training from technical assistance;

(2) designing and conducting research in New York nursing homes (i.e., nursing homes licensed under Article 28 of the Public Health Law). Provide the name and address of each nursing home, start and end dates for the research project, funding source, and a brief

description of the goals, objectives and findings/conclusions of the research. The nursing homes listed for this area may be the same as those listed for area (1) immediately above. However, the ETTA described for area (1) must be clearly distinct from the research described in area (2). Failure to provide adequate distinction will not work in the applicant's favor and may result in one or both experiences being disqualified for consideration when reviewers score applications on these criteria;

(3) interviewing or otherwise collecting information from nursing home staff (staff includes administrator, medical director, director of nursing services and attending medical practitioners) for research purposes. These nursing homes may be any nursing facilities or skilled nursing facilities subject to 42 CFR 483 (Code of Federal Rules and Regulations). Provide the name and address of each nursing home, start and end dates for the research project, funding source, types of staff interviewed (i.e., administrator, medical director, director of nursing services, attending medical practitioner, etc.) and a brief description of the goals, objectives, data collection tools and how they were administered, and findings/conclusions of the research; and

(4) designing and conducting program evaluation research in any health or health-related setting <u>other than a nursing home subject to 42 CFR 483</u>. Provide the name and address of entity/setting, health care provider type (e.g., hospital, certified home health agency, adult care facility, assisted living program, etc., start and end dates for the research project, funding source, and a brief description of the goals, objectives, research design and findings/conclusions of the research.

Staff Qualifications: Page limit is five pages. Name the applicant's employees who will be assigned to the contract. ***Do <u>not</u> include sub-contractors and consultants.*** For each employee, first describe his/her responsibilities for the project. Then, describe his/her experience in the past 15 years in the following areas, along with start and end dates for this experience. If applicant is a nursing home, the employee's experience in the applicant's nursing home may be included unless the criterion excludes nursing home settings:

(1) providing education, training and/or technical assistance (ETTA) to New York nursing homes (i.e., nursing homes licensed under Article 28 of the Public Health Law) to help them implement quality improvement projects and best practices. Provide the name and address of each nursing home, start and end dates for the ETTA, a brief description of the quality improvement project or best practice, and a brief description of the ETTA the employee provided;

(2) designing and conducting research in New York nursing homes (i.e., nursing homes licensed under Article 28 of the Public Health Law). Provide the name and address of each nursing home, start and end dates for the research project, funding source, and a brief description of the goals, objectives and findings/conclusions of the research;

(3) interviewing or otherwise collecting information from nursing home staff (staff includes administrator, medical director, director of nursing services and attending medical practitioners) for research purposes. These nursing homes may be any nursing facilities or skilled nursing facilities subject to 42 CFR 483 (Code of Federal Rules and Regulations). Provide the name and address of each nursing home, start and end dates for the research project, funding source, types of staff interviewed (i.e., administrator, medical director, director

of nursing services, attending medical practitioner, etc.) and a brief description of the goals, objectives, data collection tools and how they were administered, and findings/conclusions of the research; and

(4) designing and conducting program evaluation research in any health or health-related setting other than a nursing home subject to 42 CFR 483. Provide the name and address of entity/setting, health care provider type (e.g., hospital, certified home health agency, adult care facility, assisted living program, etc., start and end dates for the research project, funding source, and a brief description of the goals, objectives, research design and findings/conclusions of the research.

(5) experience with MDS, SPARCS, RHCF-4, Medicare and Medicaid claims, and any other databases proposed to be used in this project. Include any special certifications to access and use specific databases;

(6) database development and processing; and

(7) data analysis using SAS, SPSS and other data processing and analysis software.

Include current and legible resumes at the end of this section for each employee assigned to the contract.

Work Plan: No page limit. Use Attachment 9. The work plan should lay out in appropriate chronological order for each objective, the associated deliverables and/or budget category, major tasks, start and end date for each task, and task performance measures.

Managerial and Supervisory Plan: Describe how all employees assigned to the project will be monitored, supervised and managed. Do not include sub-contractors and consultants.

Subcontractors and Consultants: Describe your organization's experience monitoring, managing and supervising consultants and sub-contractors with whom you have contracted in the past 15 years to produce work products similar to those that you propose to sub-contract for this project. For each experience, provide the following:

(1) consultant or sub-contractor name and contact information;

(2) description of work product;

(3) contract or agreement start and end date; and

(4) description of how you monitored and/or supervised the consultant or sub-contractor to ensure a timely and high quality work product.

Describe in detail each specific task and deliverable to be sub-contracted if you are awarded the evaluation contract through this RFA. For each task or deliverable, provide the following:

(1) description of the specific task or deliverable;

(2) name, address and contact information for the sub-contractor or consultant;

(3) qualifications of the sub-contractor or consultant to perform this work;

(4) how you will monitor and/or supervise the consultant or contractor to ensure a timely and quality work product; and

(5) the proportion (not the amount) of your total proposed five-year budget for the project that will be paid to the consultant or sub-contractor for this work.

Evaluation Research Design: Page limit is 20 pages. It is critical that the evaluation produces valid and reliable results. Applications whose evaluations will probably not produce valid and reliable results, as evidenced by poor evaluation design (e.g., the evaluation design has inadequate sample sizes or uses data or measures of questionable reliability and validity), will probably not score high enough on the technical review criteria to be funded. If such application does score high enough to be funded, the applicant will be required to correct the defects in evaluation design to the satisfaction of the Department, allocating additional funds to the evaluation if necessary (but without increasing the total amount of funds originally requested) as a condition of funding. If such applicants are not able to correct the defects in evaluation design in a timely fashion, the Department will withdraw its offer of the contract and the next highest scoring application will be considered for the contract.

The detailed evaluation design submitted as part of the application should present at minimum the following information:

a. conceptual model(s);

b. research questions;

c. research design and analytical approach to major research questions;

d. research design issues and how they will be handled, e.g., unequal sample sizes, clustering effects, contamination of experimental and/or control groups, etc.;

e. fidelity measures;

f. primary variables of interest, which must include resident outcomes, and their definitions;

g. specific measure for each primary variable of interest, why this measure was selected rather than other measures of the same variable and the measure's psychometric properties (e.g., validity, reliability, sensitivity, specificity, etc.);

h. data sources for each measure;

i. if raw data must be collected, who will collect the data;

j. training methods for data collectors, i.e., how will they be trained on data collection tools; who will train them and the qualifications of these trainers to train others on the tools; and minimum accuracy, reliability and inter-rater agreement scores that all data

collectors must achieve on items used in measures before they are allowed to collect such data;

k. nursing home sample sizes and power analyses including anticipated effect size;

l. cost effectiveness designs;

m. return on investment design; and

n. business case design.

References: Provide six (6) letters of reference and current contact information as follows:

(1) two of the New York State nursing homes used in your application to document your organization's and staff's experience providing education, training and technical assistance (ETTA) to nursing homes to help them implement quality improvement projects and best practices. The letters of reference should address the quality and effectiveness of the ETTA you provided, the credibility of your staff (e.g., how familiar were your staff with the nursing home work environment, care and work flow processes, regulatory requirements, perceived financial constraints, etc.);

(2) two of the New York State nursing homes used in your application to document your organization's and staff's experience designing and conducting research in New York nursing homes. The letters should address the types and quality of interactions between your staff and the nursing home's staff. For example, if applicant's staff conducted in-person interviews with the nursing home's staff, how satisfied was the nursing home with the interview scheduling process and the interview process itself? Did applicant's staff conduct themselves in a professional and respectful manner?

(3) two of the organizations with whom you contracted to design and conduct research projects and which you used to document your experience in program evaluation research in your application. The letters of reference should describe the work you contracted to do and the timeliness and quality of your work products.

Please note: Reference letters must include a contact person at each nursing home/organization who is still employed at that nursing home/organization and who is familiar with the work you did there. Information must be current. Reviewers are not required to track down current contact information if the information in the application is not correct or is no longer current. Failure to provide this information will not work in the applicant's favor.

In a separate sealed envelope place the following. Applications that do not submit the budget and budget narrative in a separate sealed envelope may be eliminated without further review at the Department's sole discretion.

Budget: No page limit. Use Attachment 10. Complete one set of budget forms for each year of the project and one set that sums the five annual budgets. Do not exceed $840,000 for the five-year term of the project. Calculate fringe benefits as a percentage of salary expense. Use the "Other" category for supplies. Do not include any expense typically included in overhead or indirect expense, in the "Other" category.

Overhead or indirect expense includes space/property(own/rent), utilities and operating expenses. The sum of all overhead or indirect expense (i.e., the sum of space/property(own/rent), utilities and operating expense) is capped at 10% of the sum of fringe benefits and salary expense. Expenditures will not be allowed for the purchase of major pieces of depreciable equipment or remodeling or modification of structure. Equipment such as computers, printers, fax machines and phones, is limited to $25,000 over the term of the five-year project.

Applicants who are Medicaid providers should be aware that grant funds may not be used to supplant Medicaid reimbursement. They may not be used to pay for services or expenses that are reimbursed through Medicaid rates of payment.

The Department will delete ineligible expenses, if any, from the budget of the applicant awarded the contract. However, such expenses will be included when the application is scored on the financial criterion.

B. Freedom of Information Law

All applications may be disclosed or used by DOH to the extent permitted by law. DOH may disclose an application to any person for the purpose of assisting in evaluating the application or for any other lawful purpose. All applications will become State agency records, which will be available to the public in accordance with the Freedom of Information Law. **Any portion of the application that an applicant believes constitutes proprietary information entitled to confidential handling, as an exception to the Freedom of Information Law, must be clearly and specifically designated in the application.** If DOH agrees with the proprietary claim, the designated portion of the application will be withheld from public disclosure. Blanket assertions of proprietary material will not be accepted, and failure to specifically designate proprietary material may be deemed a waiver of any right to confidential handling of such material.

C. Review Process

At the discretion of the Department of Health, all applications may be rejected. Late applications due to a documentable delay by the carrier and applications that do not submit the budget and budget narrative in a separate sealed envelope may be considered at the Department of Health's discretion.

Applications will be reviewed on the following pass/fail criteria. Those that fail one or more pass/fail criteria will be rejected, will not be further reviewed, and are ineligible to be awarded the contract:

(1) are not submitted by the due date and time (with the possible exception noted above); and/or

(2) applicant did not complete and submit without alterations (other than those specified in this RFA) the required Application Cover Sheet and Table of Contents; and/or

(3) applicant has a conflict of interest as described in Section II Who May Apply.

At the time that the sealed envelopes with project budgets are opened in order to do the financial review, projects that meet the following criteria will be eliminated from further consideration:

(1) did not use the required budget form; and/or

(2) total five-year budget exceeds $840,000.

Applications that pass the pass/fail criteria will be reviewed and scored on technical criteria (worth 75 points) that address the following areas:

(1) understanding of the project;

(2) organizational qualifications and experience;

(3) dedicated research staff;

(4) staff's qualifications and experience;

(5) work plan;

(6) managerial and supervisory plan for applicant's employees;

(7) sub-contractors and consultants (quantity of work sub-contracted, sub-contractor qualifications, supervisory and management plan for consultants and sub-contractors); and

(8) evaluation design.

Applicants must have a raw technical score of 57 or more technical points to proceed to the next step of the application evaluation process. The application with the highest technical raw score will be assigned a technical score of 75 points. All other applications will be assigned a weighted technical score according to the following formula:

(a/b)(75) = weighted technical score where a = score to be weighted and b = unweighted score of application with highest technical score.

Financial proposals will then be opened and reviewed. The financial criterion is worth 25 points. Any financial proposal that exceeds $840,000 in total for the five-year contract will not be further reviewed and is not eligible to be awarded the contract.

Financial scores will be calculated as follows. The application with the lowest three-year total budget cost will be assigned a financial score of 25 points. All other applications will be assigned a weighted financial score according to the following formula:

(a/b)(25) = weighted financial score where a = lowest cost application and b = cost of application to be weighted.

Each application's weighted technical score and weighted financial score will be summed. The applicant with the highest total weighted score will proceed to the next level of review.

<u>Procedure in the Event of a Tie in Scores</u>

In the event of a tie, the determining factor(s), in descending order of importance, will be:

- Lowest cost for the three-year contract;

- Minority/Women-owned Business Enterprise (MWBE) utilization;
- Past experience.

Vendor Responsibility and Reference Check

The top-rated application at this point will proceed to the next level of review. Its Vendor Responsibility Questionnaire will be reviewed to determine if the applicant is a responsible vendor. If it is a responsible vendor, staff will contact the applicant's references if they haven't already been contacted to resolve a tie on total score. If the references are acceptable, the applicant will be offered the contract.

Debriefings

Following the award of grants from this RFA, unsuccessful applicants may request a debriefing from the NYS DOH Bureau of Credentialing no later than three months from the date of the award announcement. This debriefing will be limited to the positive and negative aspects of the subject application. In the event that unsuccessful applicants wish to protest awards, follow the procedures established by the New York State Comptroller found at www.osc.state.ny.us.

VI. Attachments

Attachment 1: Medical Direction and Medical Care in Nursing Homes Guidelines
Attachment 2: Dear Administrator Letter (DAL)
Attachment 3: Development Work Group Membership
Attachment 4: Implementation Work Group Membership
Attachment 5: Assessments and Self-Assessments
Attachment 6: Vendor Responsibility Attestation
Attachment 7: Application Table of Contents
Attachment 8: Application Cover Sheet
Attachment 9: Work Plan Format
Attachment 10: Expenditure Based Budget Format
Attachment 11: M/WBE Required Forms
Attachment 12: NYS Master Grant Contract

Attachment 1

Medical Direction and Medical Care in Nursing Homes Guidelines

ROLE OF THE MEDICAL DIRECTOR IN THE NURSING HOME[3]

Executive Summary

Nationwide, nursing facility care is changing to include not only long-term care of frail residents but also complicated and resource-intensive post-hospital care. The population of people receiving care in nursing facilities is more medically complex as patients are discharged 'sicker and quicker' from the hospital to skilled nursing facilities and the hospitals focus on decreasing readmission rates. However, the majority of patients are still long term stay patients who themselves have increased in medical complexity and acuity. Both of these imperatives have resulted in an increased need for highly trained and committed, health care practitioners willing to provide care on-site to nursing facility residents.

The 2001 Institute of Medicine report *Improving the Quality of Long Term Care* urged facilities to give medical directors greater authority and hold them more accountable for medical services. The report further states that nursing homes should develop structures and processes that enable and require a more focused and dedicated medical staff responsible for patient care. These organizational structures should include credentialing, peer review, and accountability to the medical director (Institute of Medicine 2001, 140). These concepts were considered when the Centers for Medicare & Medicaid Services revised the Surveyor Guidance related to F-Tag 501 (Medical Director) in 2005.

The New York State Department of Health initiated and convened a workgroup of stakeholders in June of 2010 to address these issues with the goal of improving health outcomes and quality of life for nursing home residents by strengthening medical direction and medical care.

The charge to the workgroup was:

> Improve health outcomes and quality of life for nursing home residents by strengthening medical direction and medical care through the provision of written guidance and model policies and procedures for:
>
> (1) Credentialing;
> (2) The role, responsibilities and accountabilities of medical directors; and
> (3) The role, responsibilities and accountabilities of attending physicians, nurse practitioners and physicians' assistants.

Various stakeholders were called upon to help with this process. They included representation form the following organizations: New York Association of Homes and Services for the Aged (NYAHSA), The New York State Health Facilities Association, Inc. (NYSHFA), Healthcare Association of New York State (HANYS), Continuing Care Leadership Coalition (CCLC), Medical Society of the State of New York (MSSNY), The American Geriatrics Society (AGS), The American Medical Directors Association (AMDA), The New York Medical Directors Association, and SUNY Albany School of Public Health, as well as physicians and nursing home administrators with rural (upstate) and urban (downstate) experience.
After consideration of the multiple issues and factors involved in the way medical care was currently being provided in nursing homes in New York State, consideration of the current research in the field, an exhaustive

nationwide search of practices in other states, as well as holding its own medical culture change workshops and affinity exercises, the workgroup defined the new desired actions, beliefs and culture of medical care in the nursing home in order to develop these model best practice guidelines for medical directors, attending physicians and physician extenders. The following is an outline of the guideline for the medical director.

ROLE OF THE MEDICAL DIRECTOR IN THE NURSING HOME

A. Introduction
B. General Principles
C. Medical Director Training
D. Medical Director, Quality Assurance and Quality Improvement
E. Survey Considerations
F. The Assistant or Associate Medical Director
G. Certified Medical Director (CMD)
H. Credentialing
I. Roles, Functions and Tasks
  a. Roles
  b. Functions and Tasks
J. Facility Responsibilities
K. Conclusions

ROLE OF THE MEDICAL DIRECTOR IN THE NURSING HOME

A. Introduction

Nationwide, nursing facility care has been changing over the last 10 years from primarily long-term care of frail elders to complicated and resource-intensive post-hospital care. The population of people receiving care in nursing facilities is more medically complex as patients are discharged 'sicker and quicker' from the hospital to skilled nursing facilities. However, the majority of patients are still long-term stay patients who themselves have also had increased complexity and acuity. Both of these changes have resulted in an increased need for highly trained, committed and available health care practitioners willing to provide care on-site to nursing facility residents.

In recognition of the increased need of physician services for nursing facility residents and the vital role that physicians must play in both providing and overseeing care to nursing facility residents, The Nursing Home Reform Act ("OBRA '87") strengthened the requirement for physician medical directors in nursing facilities and ascribed specific responsibilities to them. As long-term care has assumed a more essential role in the care of recently hospitalized Medicare beneficiaries and as expectations for quality nursing facility care have risen, the importance of physicians and other health care practitioners in long-term care settings has been reaffirmed.

The 2001 Institute of Medicine report *Improving the Quality of Long Term Care* urged facilities to give medical directors greater authority and hold them more accountable for medical services. The report further states that nursing homes should develop structures and processes that enable and require a more focused and dedicated medical staff responsible for patient care. These organizational structures should include credentialing, peer review, and accountability to the medical director (Institute of Medicine 2001, 140). These concepts were considered when the Centers for Medicare & Medicaid Services revised the Surveyor Guidance related to F-Tag 501 (Medical Director) in 2005.

Many clinically based *Interpretative Guidelines* associated with various F-tags (for example 309, 314, 315, 323, 325, 329 and others) imply the medical director's oversight and responsibility roles as they pertain to quality assurance and quality improvement, but are not clearly delineated as to extent, methods, or authority. The medical director's broad mandate affects the quality of life of residents in all areas affected by medical care. Within this mandate, the provision of quality medical care in a resident-centered environment includes, among others, the optimizing of the most practicable level of resident functioning, addressing nutritional needs and maintaining dignity of the residents. All resident care policies aimed at providing medical care fall into this purview consistent with federal regulations. Thus, the role of the medical director is vital in promoting quality in the long-term care facility.

B. General Principles

The facility shall designate a full-time or part-time physician to serve as medical director. The medical director shall be responsible for:

- Implementing resident medical care policies;
- Coordinating physician services and medical care in the facility;
- Coordinating the review, prior to granting or renewing professional privileges or association, of any physician, dentist or podiatrist;

- Assuring that each resident's responsible physician attends to the resident's medical needs, participates in care planning, follows the schedule of visits maintained in accordance with 10 NYCRR 415.15, and complies with facility policies; and
- Collaborating with the health care team including the pharmacist, dentist and other clinical consultants.

The intent of these principles is that:

- The facility has a licensed physician who serves as the medical director to coordinate medical care in the facility and provide clinical guidance and oversight regarding the implementation of resident care policies;
- The medical director collaborates with the facility leadership, staff, and other practitioners and consultants to help develop, implement and evaluate resident care policies and procedures that reflect current standards of practice;
- The medical director helps the facility:
  - Assess the current resident population and identify current programmatic and educational needs; and
  - Develop new clinical programs as the resident population changes; and
- The medical director helps the facility identify, evaluate, and address/resolve medical and clinical concerns and issues that:
  - Affect resident care, medical care or quality of life; or
  - Are related to the provision of services by physicians and other licensed health care practitioners.

C. Medical Director Training

These guidelines endorse the appropriate training and education of all physician medical directors working in long-term care settings. As such, it is encouraged that long-term care facilities, administrators, owners and operators support their medical directors to seek and to obtain continuing professional education in medical direction and long-term care medicine in order to better carry out their various professional roles and responsibilities.

D. Medical Director, Quality Assurance and Quality Improvement

A facility is required by the nursing home reform provisions of the Omnibus Reconciliation Act (OBRA) of 1987 to have at least a quarterly meeting to address the facility's quality assurance activities. The medical director should take a leadership role on this committee in order to enhance his/her awareness of issues of quality and general trends in resident care within the facility.

The medical director should help the facility establish a relevant medical quality assurance program and help to implement an appropriate facility-wide quality improvement (QI) program that covers clinical and operational issues. The medical director should help the facility identify appropriate areas for review and data for collection; review and analyze this information; make recommendations to the administrator and director of nursing to help improve care and operational issues; and participate in problem-solving efforts. The development of monitoring systems can utilize available tools developed internally by the facility or from external sources, such as dashboards, statistical process control, root cause analysis and other proven quality improvement methods.

The medical director should assist in directing and participate in the QI process by:

- Assessing and evaluating, on a regular basis, the overall process and identifying the high risk, high volume resident care issues related to quality of care, quality of life, safety, and environmental concerns; and
- Working on subgroups for infection control, therapeutic medication management and nurse/physician unit issues.

The medical director should also be familiar with the facility's process of performance of the Resident Assessment Instrument (RAI) system, which includes gathering Minimum Data Set (MDS) data, developing care plans and reviewing the quality indicators/quality measures as a part of the ongoing quality assurance activities.

Thus, collaborating with the director of nursing, the administrator and other health professionals, medical directors should assist in developing formal patient care policies on quality of care that:

- Help the facility establish systems and methods to review and provide appropriate feedback on the quality of clinical care and other health-related services;
- Help the facility provide a safe and caring environment;
  - Provide guidance as to specific expectations for performance of physicians and other health care practitioners;
  - Help the facility ensure that a system is in place for monitoring the performance of health care practitioners; and
- Facilitate feedback to all practitioners on performance and practices.

Medical directors have an essential role in promoting quality and performance improvement within a long-term care facility. As a technical expert and leader in the formal program of quality assurance a medical director has the opportunity to emphasize the importance of the overall process. Independent of the regulatory requirement, staff education and buy-in for quality improvement is fundamental to improving and maintaining quality of care in the long-term care facility. A committed medical director can have a significant positive impact on facility culture and sense of staff professionalism, which in turn directly influences the quality of all services provided to all of the residents and families.

E. Survey Considerations

The medical director is in a position, because of his/her roles and functions, to provide input to surveyors on physician issues, individual residents' clinical issues and the facility's clinical practices. The text "Medical Direction in Long Term Care" asserts that:

> "The medical director has an important role in helping the facility deal with regulatory and survey issues…the medical director can help ensure that appropriate systems exist to facilitate good medical care, establish and apply good monitoring systems and effective documentation and follow up of findings, and help improve physician compliance with regulations, including required visits. During and after the survey process, the medical director can clarify for the surveyors clinical questions or information about the care of specific residents, request surveyor clarification of citations on clinical care, attend the exit conference to demonstrate physician interest and help in understanding the nature and scope of the facility's deficiencies, and help the facility draft corrective actions." The medical director should be part of the overall survey process by having a general and specific knowledge of the regulations and F-Tags specific to their direction but also associated with Quality of Care and Quality of Life issues.

Compliance for F501 may include (but is not limited to) the facility and medical director:

- Coordinating and evaluating the medical care within the facility, including the review and evaluation of aspects of physician care and practitioner services;
- Identifying, evaluating and addressing health care issues related to the quality of care and quality of life of residents;
- Assuring that residents have primary attending and backup physician coverage;
- Assuring that physician and health care practitioner services reflect current standards of care and are consistent with regulatory requirements;
- Addressing and resolving concerns and issues between the physicians, health care practitioners and facility staff;
- Resolving issues related to continuity of care and transfer of medical information between the facility and other care settings;
- Reviewing individual resident cases, as warranted, to evaluate quality of care or quality of life concerns or other problematic situations and taking appropriate steps to resolve the situation as necessary and as requested;
- Reviewing, considering and/or acting upon consultant recommendations that affect the facility's resident care policies and procedures or the care of an individual resident, when appropriate;
- Discussing and intervening (as appropriate) with the health care practitioner about medical care that is inconsistent with applicable current standards of care; and
- Assuring that a system exists to monitor the performance and practices of the health care practitioners.

F. The Assistant or Associate Medical Director

Due to the expanded role of medical director, some facilities or organizations have identified a need for an assistant or associate medical director. The assistant or associate medical director should be a physician who has knowledge and skills comparable to those of the medical director.

G. Certified Medical Director (CMD)

The American Medical Directors Certification Program's (AMDCP) Certification in Medical Direction (Certified Medical Director in Long Term Care - CMD) recognizes the dual clinical and managerial roles of the medical director. The CMD credential reinforces the leadership role of the medical director in promoting quality care and offers an indicator of professional competence to long-term care providers, government, quality assurance agencies, consumers and the general public.

In addition, as the Certification in Medical Direction has been shown to be clearly beneficial to residents of long-term care facilities, physician medical directors in long-term care should be encouraged to have as a professional career goal to seek and obtain sufficient training to ultimately qualify for AMDCP Certification in Medical Direction.

H. Credentialing

The medical director helps coordinate and evaluate the medical care within the facility by reviewing and evaluating aspects of physician care and practitioner services and helping the facility identify, evaluate and address health care issues related to the quality of care and quality of life of residents. The medical director should establish a framework for physician participation and physicians should believe that they are accountable for their actions and their care.

Medical directors should provide guidance in the development and implementation of policies on oversight, feedback and review of attending physician services, including those situations when the medical director is the

attending physician. All such performance reviews would be conducted under the auspices of the quality assessment and assurance process. These performance reviews may include physician behaviors in the facility, such as visitation practices, assuring not only timeliness, but also physician responsiveness to changes in resident conditions. This requires open communications with facility staff. The medical director should give practitioners pertinent information that includes information from evidence-based literature in medicine, geriatrics and long-term care medicine.

The medical director shall:

- Provide for the maintenance and continuous collection of information concerning the facility's experience with negative health care outcomes and incidents injurious to residents, resident grievances, professional liability premiums, settlements, awards and costs incurred by the facility for resident injury prevention and safety improvement activities;
- Periodically reconsider the credentials, physical and mental capacity and competency in delivery of health care services of all physicians, dentists or podiatrists and other practitioners who are employed by or associated with the facility;
- Gather information concerning individual physicians, dentists and podiatrists within the individual physician's, dentist's or podiatrist's personnel file maintained by the facility; and
- Prior to renewal of privileges of physicians, dentists or podiatrists and other practitioners, solicit and consider information provided by the Resident Council about each such practitioner.

I. Roles, Functions and Tasks

The position of the nursing facility medical director can be identified in terms of the Role, Functions and Tasks hierarchy:

- Role: the set of behaviors that an individual within an organization is expected to perform and feels obligated to perform.
- Functions: the major domains of activity within a role.
- Tasks: the specific activities that are undertaken to carry out those functions.

a. Roles

In defining the role of the medical director, it is important to begin with a framework that identifies core principles. This framework is based on functions related to providing high quality of care to the individuals served. These functions include providing input into the clinical policies governing the organization or facility, supervising the medical staff, reviewing and participating in quality assurance activities, and directly overseeing clinical safety and risk management.

The medical director is involved at all levels of individualized patient care and supervision, and for all persons served by the facility. The medical director serves as the clinician who oversees and guides the care that is provided, a leader to help define a vision of quality improvement, and an operations consultant to address day-to-day aspects of organizational function.

The four key roles of the long-term care medical director are:

- Role 1—Physician Leadership
  The medical director serves as the physician responsible for the overall care and clinical practice carried out at the facility.

- Role 2—Patient Care-Clinical Leadership
  The medical director applies clinical and administrative skills to guide the facility in providing care.
- Role 3—Quality of Care
  The medical director helps the facility develop and manage both quality and safety initiatives, including risk management.
- Role 4—Education, Information, and Communication
  The medical director provides information that helps others (including facility staff, practitioners, and those in the community) understand and provide care.

The degree to which these roles are expressed will vary from facility to facility due to size, resources, time allocation and facility strategic plan. These guidelines provide a "menu" of tasks identified to aid the creation of a center of excellence. Each facility administrative team (medical director, director of nursing services, administrator) should determine the "menu of tasks" the medical director will perform. Theses tasks could be included in the medical director's job description and monitored for implementation and outcome via the quality assurance /performance improvement facility process. AMDA has provided an approved set of functions and tasks which offer an opportunity to do this.

b. Functions and Tasks

Although individual job duties may vary among organizations, there are basic, universally relevant functions that are embedded in the overarching roles. The functions represent the foundation for developing the individual medical director's tasks. However, the relevance and nature of some tasks may vary; for example, due to different patient populations or facility requirements. It is useful, though, to delineate essential tasks that all medical directors should perform. The manner in which different medical directors perform the various tasks may vary and there also may be other tasks those certain facilities or medical directors may wish to pursue. The functions are:

- Function 1—Administrative
  The medical director participates in administrative decision making and recommends and approves relevant policies and procedures.
- Function 2—Professional Services
  The medical director organizes and coordinates physician services and the services provided by other professionals as they relate to patient care.
- Function 3—Quality Assurance and Performance Improvement
  The medical director participates in the process to ensure the quality of medical care and medically related care, including whether it is effective, efficient, safe, timely, patient-centered, and equitable.
- Function 4—Education
  The medical director participates in developing and disseminating key information and education.
- Function 5—Employee Health
  The medical director participates in the surveillance and promotion of employee health, safety, and welfare.
- Function 6—Community
  The medical director helps articulate the long-term care facility's mission to the community.
- Function 7—Rights of Individuals
  The medical director participates in establishing policies and procedures for assuring that the rights of individuals (patients, staff, practitioners, and community) are respected.
- Function 8—Social, Regulatory, Political, and Economic Factors
  The medical director acquires and applies knowledge of social, regulatory, political, and economic factors that relate to patient care and related services.
- Function 9—Person-Directed Care
  The medical director supports and promotes person-directed care.

Tasks are the specific activities that are undertaken to carry out these functions. The tasks for each function are described below.

Function 1—Administrative

- Task 1 The medical director communicates regularly with the administrator, the director of nursing and other key decision makers in the nursing home and provides leadership needed to achieve medical care goals.
- Task 2 The medical director participates in the development and periodic evaluation of care-related policies and procedures.
- Task 3 The medical director guides and advises the facility's committees related to quality assurance/performance improvement, pharmacy, infection control, safety, staff and human resources and medical care
- Task 4 The medical director participates in licensure and compliance surveys and interacts with outside regulatory agencies.
- Task 5 The medical director informs medical staff about relevant policies and procedures, including updates.
- Task 6 The medical director collaborates with the administrator to identify a job description that clearly defines the medical director's roles and functions in the facility.

Function 2 -Professional Services

- Task 1The medical director organizes, coordinates, and monitors the activities of the medical staff and helps ensure that the quality and appropriateness of services meets community standards.
- Task 2 The medical director helps the facility arrange for the availability of qualified medical consultative staff and oversees their performance.
- Task 3 The medical director assures coverage for medical emergencies and participates in decisions about the facility's emergency equipment, medications and supplies.
- Task 4 The medical director collaborates with the DON and other clinical managers to help ensure that practitioners in the facility have adequate support from staff to assess and manage the patients (e.g., when they are making patient rounds or responding to calls about changes in condition).
- Task 5 The medical director develops and periodically reviews and revises, as indicated, policies that govern practitioners in the facility other than physicians, including physician assistants and nurse practitioners; and guides the facility regarding the professional qualifications of other staff related to clinical decision making and the provision of direct care.
- Task 6 The medical director guides the administrator in documenting the credentials of the facility's practitioners.
- Task 7 The medical director collaborates with the facility to hold practitioners accountable for their performance and practice, including corrective actions as needed.

Function 3—Quality Assurance and Performance Improvement

- Task 1 The medical director participates in monitoring and improving the facility's care through a quality assurance and performance improvement program that encourages self-evaluation, anticipates and plans for change, and meets regulatory requirements.
- Task 2 The medical director applies knowledge of state and national standards for nursing home care to help the facility meet applicable standards of care.
- Task 3 The medical director monitors physician performance and practice.
- Task 4 The medical director helps ensure that the facility's quality assurance and performance improvement program addresses issues that are germane to the quality of patient care and facility services.

- Task 5 The medical director helps the facility use the results of its quality assurance and performance improvement program findings, as appropriate, to update and improve its policies, procedures and practices.
- Task 6 The medical director participates in quality review of care, including (but not limited to) areas covered by regulation (e.g., monitoring medications and laboratory).
- Task 7 The medical director sets an overall culture of quality with person-centered care as a primary value.

Function 4—Education

- Task 1 The medical director sustains his or her professional development through self-directed and continuing education.
- Task 2 The medical director helps the facility educate and train its staff in areas that are relevant to providing high quality patient care.
- Task 3 The medical director serves as a resource regarding geriatric medicine and other care-related topics, and helps the staff and practitioner identify and access relevant educational resources (e.g., books, periodicals and articles).
- Task 4 The medical director informs attending physicians about policies and procedures and state and federal regulations, including updates.

Function 5—Employee Health

- Task 1 The medical director helps the facility foster a sense of self-worth and professionalism among employees.
- Task 2 The medical director advises the facility about infectious disease issues related to employees, as well as preventative health maintenance programs, e.g., immunizations.

Function 6—Community

- Task 1 The medical director helps the facility identify and utilize collaborative approaches to health care, including integration with community resources and services and problem solving issues across the health continuum.

Function 7—Rights of Individuals

- Task 1 The medical director helps the facility ensure that its policies and practices reflect and respect residents' rights, including the opportunity for self-determination; e.g., via tools such as living wills and durable powers of attorney.
- Task 2 The medical director helps the facility ensure that the ethical and legal rights of residents (including those who lack decision-making capacity, regardless of whether they have been deemed legally incompetent) are respected. This includes the right of residents to request practitioners to limit, withhold or withdraw treatment(s).
- Task 3 If applicable, the medical director should participate in the facility ethics committee.
- Task 4 The medical director helps the facility accommodate the resident's choice of an attending physician.

Function 8—Social, Regulatory, Political and Economic Factors

- Task 1 The medical director helps the facility identify and provide care that is consistent with applicable social, regulatory, political and economic policies and expectations.
- Task 2 The medical director helps the facility identify, interpret and comply with relevant State and Federal laws and regulations.

Function 9—Person-Directed Care

In addition to the following tasks, many of the tasks covered under the other functions relate directly or indirectly to the provision of person-directed care.

- Task 1 The medical director oversees clinical and administrative staff, to help maintain and improve the quality of care including the success of person-directed care and patient and family satisfaction with all aspects of the care.
- Task 2 The medical director guides the physicians and other health care professionals and staff to provide person-directed care that meets relevant clinical standards.
- Task 3 The medical director collaborates with facility leadership to create a person-directed care environment while maintaining standards of care.

J. Facility Responsibilities

The facility should:

- Encourage and facilitate active medical direction by the medical director.
- Clearly delineate, to the medical director, the particular functions and tasks of medical direction that apply in the facility, especially those that may go beyond regulatory minimums.
- Actively involve the medical director in the quality assurance/quality improvement process in the facility, including consideration of requiring the medical director to be the physician member of the quality assurance committee.
- Make available to medical directors quality improvement tools and resources to include potential reports that are available and identify data needed for effective decision-making.
- Make available to medical directors as well as to other members of the interdisciplinary team, quality improvement education.
- Actively involve the medical director in policy decision-making, especially as concerns medical care policies.
- Look to the medical director for advice on day-to-day medical care issues and concerns.
- Look to the medical director for advice on overall facility strategic planning.
- Look to the medical director for guidance on how to bring education to the facility concerning current standards of medical practice.
- Understand the value that an educated medical director can bring to the facility.
- Appropriately remunerate the medical director for performing the functions and tasks of medical direction.
- Support the medical director in his or her educational endeavors to fulfill the role of medical direction, including obtaining the Certification in Medical Direction credential.

K. Conclusions

The regulatory requirements for medical direction of: (1) implementation of resident care policies, and (2) the coordination of medical care, are all-encompassing and somewhat non-specific, notwithstanding the guidance given in the State Operation Manual's Interpretive Guidelines. Medical directors can and should play a pivotal role in the care that is given to residents of long-term care facilities. The importance of the medical director's leadership in the realms of quality assurance, quality improvement, medical care and credentialing cannot be overstated. The medical director can and should become an asset to help a facility attain the goal of becoming a center of excellence in long-term care. Thus, it is as much the facility's responsibility as it is the medical director's, to further this process in order to provide the mechanism to facilitate appropriate medical direction. These guidelines offer an attempt to do so.

ROLE OF THE ATTENDING PHYSICIAN IN THE NURSING HOME[3]

Executive Summary

Nationwide, nursing facility care is changing to include not only long-term care of frail residents but also complicated and resource-intensive post-hospital care. The population of people receiving care in nursing facilities is more medically complex as patients are discharged 'sicker and quicker' from the hospital to skilled nursing facilities and the hospitals focus on decreasing readmission rates. However, the majority of patients are still long term stay patients who themselves have increased in medical complexity and acuity. Both of these imperatives have resulted in an increased need for highly trained and committed health care practitioners willing to provide care on-site to nursing facility residents.

Physician involvement in nursing facilities is essential to the delivery of quality long-term care. Attending physicians should lead the clinical decision-making for patients under their care. They can provide a high level of knowledge, skill, and experience needed in caring for a medically complex population in a climate of high public expectations and stringent regulatory requirements.

The New York State Department of Health initiated and convened a workgroup of stakeholders in June of 2010 to address these issues with the goal of improving health outcomes and quality of life for nursing home residents by strengthening medical direction and medical care.

The charge to the workgroup was:

> Improve health outcomes and quality of life for nursing home residents by strengthening medical direction and medical care through the provision of written guidance and model policies and procedures for:
>
> (1) Credentialing;
> (2) The role, responsibilities and accountabilities of medical directors; and
> (3) The role, responsibilities and accountabilities of attending physicians, nurse practitioners and physicians' assistants.

Various stakeholders were called upon to help with this process. They included representation form the following organizations: New York Association of Homes and Services for the Aged (NYAHSA), The New York State Health Facilities Association, Inc. (NYSHFA), Healthcare Association of New York State (HANYS), Continuing Care Leadership Coalition (CCLC), Medical Society of the State of New York (MSSNY), the American Geriatrics Society (AGS), the American Medical Directors Association (AMDA), the New York Medical Directors Association and SUNY Albany School of Public Health, as well as physicians and nursing home administrators with rural (upstate) and urban (downstate) experience.

After consideration of the multiple issues and factors involved in the way medical care was currently being provided in nursing homes in New York State, consideration of the current research in the field, an exhaustive nationwide search of practices in other States, as well as holding its own medical culture change workshops and affinity exercises, the workgroup defined the new desired actions, beliefs and culture of medical care in the nursing home in order to develop these model best practice guidelines for medical directors, attending physicians and physician extenders. The following is an outline of the guideline for the attending physician.

ROLE OF THE ATTENDING PHYSICIAN IN THE NURSING HOME

- **A. Introduction**
- **B. General Facility Responsibilities**
- **C. Physician Training, Qualifications and Medical Director Oversight**
- **D. Physician Supervision of Medical Care**
    - **a. Regulatory Visits**
        - **i. Physician Responsibilities**
        - **ii. Facility Responsibilities**
    - **b. Acute Illness Visits**
        - **i. Physician Responsibilities**
            - **1. Presence in the Facility**
        - **ii. Facility Responsibilities**
- **E. Initial Patient Care/Care Transitions**
    - **a. Physician Responsibilities**
    - **b. Facility Responsibilities**
- **F. Discharges and Transfers**
    - **a. Physician Responsibilities**
    - **b. Facility Responsibilities**
- **G. Physician Notification/Ongoing Coverage**
    - **a. Physician Responsibilities**
        - **i. Coverage**
        - **ii. Availability by Telephone**
    - **b. Facility Responsibilities**
- **H. Appropriate Care for Residents**
- **I. Appropriate, Timely Medical Orders and Documentation**
- **J. Relationship With Residents and Families**
- **K. Professional Conduct**
- **L. General**
- **M. Non-physician Providers**

ROLE OF THE ATTENDING PHYSICIAN IN THE NURSING HOME

A. Introduction

Nationwide, nursing facility care is changing to include not only long-term care of frail residents but also complicated and resource-intensive post-hospital care. The population of people receiving care in nursing facilities is more medically complex as patients are discharged 'sicker and quicker' from the hospital to skilled nursing facilities and the hospitals focus on decreasing readmission rates. However, the majority of patients are still long-term stay patients who themselves have increased in medical complexity and acuity. Both of these imperatives have resulted in an increased need for highly trained and committed health care practitioners willing to provide care on-site to nursing facility residents.

Physician involvement in nursing facilities is essential to the delivery of quality long-term care. Attending physicians should lead the clinical decision-making for patients under their care. They can provide a high level of knowledge, skill, and experience needed in caring for a medically complex population in a climate of high public expectations and stringent regulatory requirements.

The guidelines also endorse efforts to improve the training of all health care providers, including non-physician providers, in the principles and practice of geriatric medicine and other medical disciplines dealing with chronic care conditions in order to have all providers obtain a sufficient level of knowledge and skills so that care will be provided concomitant with patient's complex needs.

These guidelines support and encourage interdisciplinary, team-based care and are committed to promoting and celebrating the many unique and valuable contributions and perspectives of all disciplines to enhance the quality of care. In order to foster this interdisciplinary collaboration, in addition to delineating the role of the attending physician in the nursing home setting, these guidelines outline various responsibilities that the facility should entertain as well. The specifics are interspersed within the guideline. However, there are some overriding principles that are delineated here.

B. General Facility Responsibilities

The administrator and staff will:

- collaborate with the medical director to create an environment conducive to the delivery of appropriate medical practice and health-related services;
- provide reference and guidance to regulatory guidelines for the attending physicians as needed; and
- provide attending physicians with supports needed to fulfill responsibilities, including ensuring that the personnel, resources, supplies, and ancillary services are available to allow the staff and practitioners to care for residents appropriately.

With regard to physician supervision; the facility shall ensure that:

- the medical care of each resident is supervised by a physician who assumes the principal obligation and responsibility to manage the resident's medical condition; and
- another physician supervises the medical care of residents when the resident's attending physician is unavailable.

C. Physician Training, Qualifications and Medical Director Oversight

Physicians and others providing medical care to residents of nursing facilities and other long-term care facilities must possess a current and valid New York State license as a medical professional. This will be verified by the nursing facility as part of the process of granting privileges to the medical professionals.

Physicians and others providing medical care to residents of nursing facilities and other long-term care facilities must possess a unique set of knowledge and skills. This includes:

- understanding the principles and practice of geriatric medicine, and other pertinent medical disciplines dealing with chronic care conditions;
- understanding drug prescribing guidelines for older adults and other complex long term care patients;
- familiarity with pertinent regulations governing long-term care facilities;
- understanding systems of care delivery;
- the ability to work effectively as part of an interdisciplinary team; and
- flexibility to take on evolving competency-based physician education.

The medical director helps coordinate and evaluate the medical care within the facility by reviewing and evaluating aspects of physician care and practitioner services, and helping the facility identify, evaluate, and address health care issues related to the quality of care and quality of life of residents. A medical director should establish a framework for physician participation, and physicians should believe that they are accountable for their actions and their care.

D. Physician Supervision of Medical Care

The facility shall ensure that the medical care of each resident is supervised by a physician who assumes the principal obligation and responsibility to manage the resident's medical condition and who agrees to visit the resident as often as necessary to address resident medical care needs. Each resident shall remain under the care of a physician and shall be provided care that meets prevailing standards of medical care and services. Another physician supervises the medical care of residents when the resident's attending physician is unavailable (see Coverage below).

a. Regulatory Visits

i. Physician Responsibilities

Comprehensive regulatory visits, in coordination with the facility's overall plan of care for a resident, establish and guide the total program of care for each resident. The intent of these visits is to have the physician take an active role in supervising the care of residents. This should not be a superficial visit, but should include an evaluation of the resident's condition and a review of and decision about the continued appropriateness of the resident's current medical regimen.

The attending physician should:

- Maintain a schedule of visits appropriate to the resident's medical condition depending on the patient's medical stability, recent and previous medical history. The frequency of visits shall be no less often than once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

- Review the resident's total program of care, including medications and treatments, at each regularly scheduled visit, including reasons for changing or maintaining current treatments or medications, and a plan to address relevant medical issues. Total program of care includes all care the facility provides residents to maintain or improve their highest practicable mental and physical functional status, as defined by the comprehensive assessment and plan of care. Care includes medical services and medication management,

physical, occupational, and speech/language therapy, nursing care, nutritional interventions, social work and activity services that maintain or improve psychosocial functioning.

- Periodically review all medications and monitor both for continued need based on validated diagnosis or problems and for possible adverse drug reactions. The medication review should consider observations and concerns offered by nurses, consultant pharmacists and others regarding beneficial and possible adverse impacts of medications on the patient.

- Properly define and describe patient symptoms and problems, clarify and verify diagnoses, relate diagnoses to patient problems, and help establish a realistic prognosis and care goals.

- Participate as a member of the interdisciplinary care team in the development and review of the resident's comprehensive care plan with the understanding that the minimum level of physician participation in interdisciplinary development and review of the care plan shall be a person-to-person conference with the registered professional nurse who has principal responsibility for development and implementation of the resident's care plan.

- Determine progress of each patient's condition at the time of the regulatory visit by evaluating the patient, talking with staff as needed, talking with responsible parties and/or family as indicated, and reviewing relevant information, as needed.

- In consultation with the facility's staff, determine appropriate services and programs for a patient, consistent with diagnoses, conditions, prognosis, and patient and family goals and wishes, focusing on helping patients attain their highest practicable level of functioning in the least restrictive environment.

- Conduct or arrange for palliative care counseling and pain management interventions when the resident is determined to be terminally ill or has a life limiting condition that may benefit from these services.

- Prepare, authenticate and date progress notes at each visit.

- Maintain progress notes that cover pertinent aspects of the resident’s condition and current status and goals.

- Provide documentation needed to explain medical conclusions and decisions; permit effective, timely resident care.

- Over time, documentation related to physician visits should address relevant information about significant ongoing, active, or potential problems and cover at least the following:

    1. Status of chronic medical conditions;
    2. Status of any recent or current symptoms or changes in condition;
    3. Pertinent physical findings;
    4. How the individual’s acute and chronic conditions effect his/her functioning, quality of life, nutrition, hydration, cognition, mobility, prospects for improvement, and ability to socialize and participate in activities (for example, how a recent episode of pneumonia or exacerbation of COPD affected anticipated functional improvement);
    5. Clinically important abnormal lab results;
    6. Rationale for substantial changes in medication and treatment orders, including identification and management of complications of existing medications and treatments, and ensure that each medication has an indication for continued usage;
    7. Identified special needs such as dental services or restorative care;
    8. Review of the pertinence of the overall plan of care; and

9. Evaluation of any discharge potential.

ii. Facility Responsibilities

The administrator and staff will collaborate with the medical director to create an environment conducive to the delivery of appropriate medical practice and health-related services, for example:

- ensuring that physician orders are carried out properly; and
- facilitating an organized and efficient medical record.
- The facility will provide the physician with adequate staff support at the time of the regulatory visits in order to facilitate decision-making.

b. Acute Illness Visits

i. Physician responsibilities

Acute illness visits should be performed to meet the medical needs of the complex residents in the nursing home.

1. Presence in the facility.

Physicians should schedule their visits to the facility as frequently as possible and as warranted by the number and condition of residents to whom they provide medical care. This schedule should be made in advance and in consideration of facility resources in order to ensure that staff is aware of their scheduled visits. This reduces unnecessary phone calls for routine matters that can be deferred until the physician is present in the facility, reduces possible errors inherent in remote communications, and promotes direct physician-staff-resident interaction thereby improving care management and patient safety. Desirable physician practice should allow, as optimally as possible, for frequent visits to and significant presence in the nursing home.

The attending physician should:

- Respond promptly, in a manner determined jointly by the facility, administrator, medical director and medical staff, to notification of, and assess and manage adequately, reported acute and other significant clinical condition changes in patients. This includes visiting the resident whenever the resident's medical condition warrants medical attention;
- Make interim visits, as needed, for individuals with complex problems or unstable conditions that cannot be readily managed by phone;
- Properly define and describe patient symptoms and problems, clarify and verify diagnoses, relate diagnoses to patient problems, and help establish a realistic prognosis and care goals;
- Prepare, authenticate and date progress notes at each visit;
- Respond in an appropriate time frame (based on a joint physician-facility-developed protocol) to emergency notification;
- Note the presence of significant or previously unidentified medical conditions, or problems that cannot be handled readily by phone;

- Whenever safe and concordant with patient and family goals and wishes, the staff and practitioners will monitor, evaluate and treat problems in the nursing facility instead of transferring residents/patients to hospitals; and

- Communicate with family members/resident representatives as significant changes in medical condition occur.

ii. Facility responsibilities

Facility responsibilities include:

- Supporting the attending physicians with the resources needed to fulfill their responsibilities at times when the physician is present in the facility for acute visits;
- Instituting appropriate notification protocols so proper assessments of a resident's status will be relayed to the physician in a timely and complete manner; and
- Ensuring that the personnel, resources, supplies and ancillary services are available to allow the staff and practitioners to care for residents' acute changes of condition at an appropriate level of complexity.

E. Initial Patient Care/Care Transitions

a. Physician Responsibilities

The attending physician should assess a new admission in a timely fashion, based on a joint physician-facility-developed protocol and, depending on the individual's medical stability, recent and previous medical history, presence of significant or previously unidentified medical conditions, or problems that cannot be handled readily by phone.

The attending physician should:

- seek, provide, and analyze needed information regarding a patient's current status, recent history, and medications and treatments, to enable safe, effective continuing care and appropriate regulatory compliance;

- provide appropriate information and documentation to support the facility in determining the level of care for a new admission;

- authorize admission orders in a timely manner, based on a joint physician-facility-developed protocol, to enable the nursing facility to provide safe, appropriate, and timely care; and

- for a patient who is to be transferred to the care of another health care practitioner, continue to provide all necessary medical care and services pending transfer until another physician has accepted responsibility for the patient.

b. Facility Responsibilities

Facility responsibilities include:

- The admissions coordinator will identify that a qualified physician, who is licensed to practice in the state, has accepted responsibility as the attending physician.

- The staff will notify the attending physician of a resident/patient's admission.

- The nursing staff will obtain all orders needed at the time of admission from the attending physician or covering practitioner.
- Facilitate the procurement of appropriate medical records in a timely manner (for example, hospital records and prior physician office records) either at the time of admission or as soon thereafter as possible, in order to provide each resident with the medications, treatments and medical support needed to meet his/her immediate and longer term needs.

Essential transfer information for new admissions or readmissions should include the following:

- Discharge summary;
- Duration of orders;
- Authorization of level of care;
- Diet;
- Activity level;
- Laboratory and diagnostic tests (admission and follow-up);
- Frequency of monitoring (vital signs, finger sticks, weight, pacemaker checks, etc.);
- Medications and treatments, including indication for usage of medications;
- Medication and other allergies;
- Immunization status;
- Infection control related measures;
- Functional status;
- Precautions and contraindications (for example, limited weight-bearing or ambulation precautions);
- Consultations or follow-up evaluations; and
- Advanced directives.

For readmissions, the staff and physician should review the transfer information carefully to identify any item included above and:

- Any changes during hospitalization in medications and treatments that had been administered prior to the transfer;
- Any medications and treatments that were added during hospitalization, as some of those may need to be monitored closely or may not be appropriate for extended use in various individuals;
- Any medications that may not have been given while the individual was hospitalized, or may have been omitted from the transfer summary; and
- Any changes in advanced directives.

F. Discharges and Transfers

a. Physician responsibilities

Physician responsibilities include:

- Communicate with a physician or another health care practitioner at a receiving hospital as needed at the time of or after the transfer of an acutely ill or unstable patient;
- Provide appropriate documentation and other information that may be needed at the time of transfer to enable care continuity at a receiving facility and to allow the nursing facility to meet its legal, regulatory, and clinical responsibilities for a discharged individual; and
- Provide pertinent medical discharge information within 30 days of discharge or transfer of the patient.

b. Facility Responsibilities

Facility responsibilities include determining, in a joint facility-medical staff-medical director protocol, the appropriate facility documentation that will accompany and or be sent in a timely manner to a receiving entity (i.e. hospital or local physician).

G. Physician Notification/Ongoing Coverage

a. Physician Responsibilities

i. Coverage

The attending physician is responsible for the care of the resident at all times. This means that when a physician is not available, it is his or her responsibility to provide coverage by another physician to supervise the medical care of the residents. This may not always be practical or feasible, so physicians and facilities may rely on on-call and emergency coverage schedules. Covering physicians should be credentialed to practice in the facility. Care by covering physicians who are less familiar with the residents they see or are called about is a potential weak link in the process of care and is prone to errors. Therefore, physicians must ensure a robust system of communications between nursing staff and covering physicians and between attending physicians and their covering physicians or midlevel practitioners.

ii. Availability by Telephone

Physicians must be available to the staff for telephone consultations at all times except when an on-call coverage schedule is in effect. It is important to have a communication system established for such communications, such as facsimile or electronic transmission. In this situation, teamwork and familiarity with facility staff are invaluable, because the physician must rely on information conveyed verbally or electronically to make a decision on a medical condition. Again, protocols must be established for the purpose of communications as described above. To reduce transcription errors, physicians should, whenever possible, transmit orders via fax or electronically. It is a good risk management technique to keep a log of all conversations with facility staff as well as all verbal, electronic, and telephone orders. Physicians must document these conversations and orders in the medical record either by transmitting a progress note or documenting (with appropriate dating) when arriving next to the facility. More importantly, it is crucial that the physician, a covering physician or a midlevel practitioner follow the resident in a timely manner after providing a telephone or verbal order as the clinical condition dictates. For example, if order is given for antibiotics because infection is suspected, a resident should be followed and examined as soon as clinically indicated.

Other routine orders may not require an immediate follow-up. The facility should have a protocol for appropriate follow-up on telephone and electronic communications. State regulations require physician signature on telephone orders within 48 hours. These regulations are intended to ensure appropriate follow-up rather than paper compliance.

The attending physician should:

- Respond to notification of laboratory and other diagnostic test results in a timely manner, based on a protocol developed jointly by the physicians and the facility, considering the patient's condition and the clinical significance of the results;
- Analyze the significance of abnormal test results that may reflect important changes in the patient's status and explain the medical rationale for subsequent interventions or decisions not to intervene based on those results when the basis for such decisions is not otherwise readily apparent;
- Designate an alternate physician or appropriately supervised midlevel practitioner who will respond in an appropriate, timely manner in case the attending physician is unavailable;
- Respond to issues requiring a physician's expertise, including the patient's current condition, the status of any acute episodes of illness since the last visit, test results, other actual or high risk potential medical problems that are affecting the individual's functional, physical, or cognitive status, and staff, patient, or family questions regarding the individual's care and treatments;
- At the next visit after an acute change in condition, review the status of the condition change and document his/her evaluation, including the significance of the acute situation; for example, anticipated residual effects on the individual’s function, psychosocial status, or prognosis;
- Make an interim visit, if needed, to assess the situation (especially if the individual is not stable or is not improving as anticipated);
- Respond in an appropriate time frame (based on a joint physician-facility-developed protocol) to routine notification;
- Update the facility about his or her current office address, phone, fax, and pager numbers to enable appropriate, timely communications, as well as the current office address, phone, fax and pager numbers of designated alternate physicians or an appropriately supervised midlevel practitioner;
- Help ensure that alternate covering practitioners provide adequate, timely support while covering and intervene with them when informed of problems regarding such coverage;
- Adequately notify the facility of extended periods of being unavailable and of coverage arranged during such periods; and
- Adequately inform alternate covering practitioners about patients with active acute conditions or potential problems that may need medical follow-up during their on-call time.

b. Facility Responsibilities

The facility shall ensure that:
The medical care of each resident is supervised by a physician who assumes the principal obligation and responsibility to manage the resident's medical condition and who agrees to visit the resident as often as necessary to address resident medical care needs;

- Another physician supervises the medical care of the resident when the resident's attending physician is unavailable;
- Attending physicians receive the support needed to fulfill responsibilities at times when they are not present in the facility;
- Appropriate notification protocols are instituted whereby proper assessments of a resident's status are relayed to the physician in a timely and complete manner;
- Before contacting a physician about someone with an acute change of condition, the nursing staff makes pertinent observations and collects appropriate information to report to the physician; and
- Nursing staff assess acute changes of condition comprehensively and communicate with the attending or covering physician.

Nursing staff will continually re-evaluate the condition of anyone who received an order for new or additional medications and treatments during the previous evening or overnight shifts. Physicians or their coverage should be notified with updates as appropriate in this situation. The charge nurse or supervisor should contact the attending physician at any time if he/she feels a clinical situation requires immediate discussion and management. When contacting the practitioner, especially at night and on weekends (when physicians not familiar with the residents may be on call), the nurse should have at least the following information available:

- Detailed description of current issue or problem, including vital signs, symptoms and results of physical assessment;
- Active medical problems (problem list);
- Pertinent information from any recent hospitalizations (hospital discharge summary or admission history and physical form);
- Current medications (orders);
- Allergies to medications, food, etc.;
- Resuscitation ("Code") status/any limitations on intubation/hospitalization status; and
- Family/contact person.

H. Appropriate Care for Residents

The attending physician should:

- In consultation with facility staff, ensure that treatments, including rehabilitative efforts, are medically necessary and appropriate in accordance with relevant medical principles and regulatory requirements;

- In consultation with the facility staff, manage and document ethics issues consistent with relevant laws and regulations and with patients' wishes, including advising patients and families about formulating advance directives or other care instructions and helping identify individuals for whom aggressive medical interventions may not be indicated; and

- Provide orders that ensure individuals have appropriate comfort and supportive care measures as needed, for example, when experiencing significant pain or in palliative or end-of-life situations.

I. Appropriate, Timely Medical Orders and Documentation

The attending physician should:

- Provide timely medical orders based on an appropriate patient assessment, review of relevant pre- and post-admission information, and age-related and other pertinent risks of various medications and treatments;
- Provide sufficiently clear, legible written medication orders to avoid misinterpretation and potential medication errors, such orders to include pertinent information such as the medication strength and formulation (if alternate forms available), route of administration, frequency and, if applicable, timing of administration, and the reason for which the medication is being given;
- Verify the accuracy of verbal orders at the time they are given and authenticate, sign and date them in a timely fashion, no later than the next visit to the patient;
- Provide documentation required to explain medical decisions that promotes effective care and allows a nursing facility to comply with relevant legal and regulatory requirements; and
- Complete death certificates in a timely fashion, including all information required of a physician.

J. Relationship With Residents and Families

Physicians should understand:

- Federal regulations require that nursing facilities provide residents and their legal representative with their physician's name, specialty, office address and telephone number;
- Physicians are required to respond to calls from residents and their representatives to discuss the resident's medical care;
- It is important for physicians to contact families at critical times during a nursing facility stay, such as upon admission or at end of life, and approach families with sensitivity and compassion, particularly at these difficult times; and
- Communicate with family members/resident representatives as significant changes in medical condition occur.

K. Professional Conduct

Professional conduct includes the following:

- Abide by pertinent facility and medical policies and procedures;
- Maintain a courteous and professional level of interaction with facility staff, patients, family/significant others, facility employees, and management;
- Work with the medical director to help the facility provide high quality care;
- Keep the well-being of patients/residents as the principal consideration in all activities and interactions; and
- Be alert to, and report to the medical director -- and other appropriate individuals as named through facility protocol -- any observed or suspected violations of resident rights, including abuse or neglect, in accordance with facility policies and procedures.

L. General

General responsibilities for attending physicians include:

- Participation in facility training programs to familiarize him or herself with State regulations and facility policies;

- Being informed of and reviewing the results of all Department of Health surveys related to medical service deficiencies; involvement in resolving problems;

- Designate prognosis and the potential for functional improvement, if possible. The components of a statement of prognosis should include the physician's best professional judgment about the resident's expectations for medical and functional stability, the time frame for stability or not, and the potential for complications.

M. Non-physician Providers

The presence of nurse practitioners and other non-physician practitioners who work collaboratively with attending physicians and medical directors will maximize the value of all members of the interdisciplinary care team. Studies demonstrate that collaboration with midlevel practitioners, particularly in the context of long-term care, may reduce emergency department use and hospitalization of nursing facility residents and potentially improve primary care. Physicians should commit to fostering and strengthening this collaboration. Physicians and midlevel practitioners should document their collaboration and the supervision of care by physicians.

Physicians and midlevel practitioners should be familiar with Medicare billing requirements and with the specific regulatory requirements of New York State.

These guidelines support and encourage interdisciplinary, team-based care and are committed to promoting and celebrating the many unique and valuable contributions and perspectives of all disciplines to enhance the quality of care. The guidelines also endorse efforts to improve the training of all health care providers, including non-physician providers, in the principles and practice of geriatric medicine in order to have all providers obtain a sufficient level of knowledge and skills so that care will be provided concomitant with patient's complex needs.

Attachment 2

Dear Administrator Letter

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

January 20, 2012
DAL: NH 11-13
RE: Guidelines on Medical Direction and Medical Care in Nursing Homes

Dear Administrator:

This letter announces a best practice: Guidelines on Medical Direction and Medical Care in Nursing Homes. These are process guidelines (they are not clinical guidelines) and incorporate federal and New York regulatory requirements. They lay out the roles, responsibilities and accountabilities of medical directors and attending medical practitioners (physicians, nurse practitioners and physician assistants) in nursing facilities. Implementation is voluntary and strongly encouraged. We offer these guidelines to you for several reasons. If appropriately implemented, they will:

- ✓ Help you and your medical director, attending practitioners and nursing staff provide optimal medical care, leading to better health and quality of life outcomes for residents which in turn produces:
  - o greater resident and family satisfaction;
  - o greater staff satisfaction with and pride in the quality of care they provide;
  - o an enhanced reputation in your community for providing high quality care; and
  - o fewer emergency room visits and hospitalizations.
- ✓ Help your facility to provide the quality care and positive health outcomes that all stakeholders demand.
- ✓ Help your facility define performance expectations sought by the Medicare Advantage Plans that enroll your residents.
- ✓ Strengthen your facility's capacity to function effectively and successfully in health care reform both in: (a) Medicaid's managed care environment, and (b) Medicaid's and Medicare's coordinated and integrated care environment.

We partnered with the NY Medical Directors Association, convening a stake holders group to develop the guidelines over the course of the year beginning June, 2010. This group included medical directors, attending practitioners and administrators, provider associations (LeadingAge NY (formerly NY Association of Homes and Services for the Aging), Healthcare Association of NYS, NY Health Facilities Association and Continuing Care Leadership Coalition), Board of Examiners of Nursing Home Administrators and Medical Society of the State of NY. A special effort was made to ensure that rural nursing homes and their unique circumstances were represented. The development work group, having met its charge, has been disbanded. A new work group has been created to plan the "roll out" of the guidelines, including training for your leadership team on the guidelines and related topics. Associations representing nursing homes are on this work group.

This initiative, like the Gold STAMP initiative, provides you with valuable tools and resources that can transform your nursing facility's response to the extraordinary forces that are reshaping the nation's and New York's health care environment. We urge you to share the guidelines with your leadership team and begin the discussion of how to implement them.

Yours truly,

Jackie Pappalardi

Jackie Pappalardi, Director
Division of Residential Services

Attachment 3

Development Work Group Membership

WORKGROUP ON MEDICAL CARE AND MEDICAL DIRECTION IN NURSING HOMES - MEMBERSHIP		
Name	**Title**	**Work Address/Phone #**
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Jeffrey Nichols, MD	VP for Medical Services Representative: American Geriatrics Society & NY Metropolitan Area Geriatrics Society	**Cabrini Eldercare Consortium** 542 East 5th Street New York, NY 10009
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Roxanne Tena-Nelson, JD, MPH	Executive Vice President	**Continuing Care Leadership Coalition (CCLC)** 555 West 57th St., 15th fl. New York, NY 10019
Stanley Wojciechowski		**County Nursing Facilities of New York** 540 Broadway 5th Fl. Albany, NY 12207-1010
Yuchi Young, PhD.	Assistant Professor	**SUNY Albany School of Public Health** Department of Health Policy, Management, & Behavior School of Public Health One University Place Rensselaer, NY, 12144-3456

Attachment 4
Implementation Work Group Membership

Name	Title	Work Address
Andy Cruikshank	CEO	**Fort Hudson Health System** 319 Upper Broadway Fort Edward, NY 12828
Jacob Dimant, MD, CMD	Medical Director	**Lutheran Augustana Center** 5434 Second Avenue Brooklyn, NY 11220
Evelyn Dooley-Seidman, MD		**Medical Society of the State of NY (MSSNY)** 1 Commerce Plaza 99 Washington Ave, Suite 408 Albany, NY 12210
Conn Foley, MD, FACP	Senior VP & Chairman, Dept. of Medicine	**Parker Jewish Institute for Health Care & Rehabilitation** 271-11 76th Ave New Hyde Park, NY 11040-1433
Leonard Gelman, MD, CMD	Medical Director/President, NY Medical Directors Assoc.	**Capital Care** 20 Prospect St., Suite 106 Ballston Spa, NY 12020
Jeffry Nichols, MD, CMD	Senior Vice President for Clinical Services and Medical Director	**Our Lady of Consolation Geriatric Care Center** 111 Beach Drive West Islip, New York 11795
Debbie LeBarron	Senior Director	**Healthcare Association of New York State (HANYS)** 1 Empire Drive Rensselaer, NY 12144
Nancy Leveille		**The New York State Health Facilities Association, Inc. (NYSHFA)** 33 Elk St., Suite 300 Albany, NY 12207-1010
Steven Levenson, MD, CMD	Multi-facility Director	**Genesis Healthcare** 515 Fairmount Avenue Towson, MD 21286
Roxanne Tena-Nelson, JD, MPH	Executive Vice President	**Continuing Care Leadership Coalition (CCLC)** 555 West 57th St., 15th fl. New York, NY 10019
Kathryn Santos	Associate for Quality Improvement Initiatives	**Continuing Care Leadership Coalition (CCLC)** 555 West 57th St., 15th fl. New York, NY 10019
Elliot Frost	Policy Analyst,	**New York Association of Homes and Services for the Aged (NYAHSA)** 13 British American Blvd., Suite 2 Latham, NY 12110
Jeff Hoffman, M.S., C.N.H.A.		**American College of Health Care Administrators**
Tony Marmo, MPA, LNHA	Administrator ACHCA member	**Diamond Hill Nursing and Rehabilitation Center** 100 New Turnpike Road Troy, NY 12182

Attachment 5

Assessments and Self-Assessments

MEDICAL DIRECTOR ASSESSMENT

(This assessment to be completed by the facility)

Name: _____ Facility: _____ Date: _____

ITEM	RATING
1. Does your facility have a full-time or part-time medical director?	[ ]Full time [ ] Part time
2. To what extent does your facility actively involve the medical director in the quality assurance/quality improvement process, including having the medical director to be the physician member of the quality assurance committee? *Section D. Medical Director, Quality Assurance and Quality Improvement and Section I. Roles, Functions and **Tasks** – Function 3.*	*Not at All* 1 2 3 4 5 6 *Highly Involved*
3. To what extent does your medical director take an active leadership role on Quality Assurance Committee? *Section D. Medical Director, Quality Assurance and Quality Improvement and Section I. Roles, Functions and Tasks – Function 3.*	*Not at All* 1 2 3 4 5 6 *Active Leadership*
4. To what extent does your medical director make recommendations to the administrator and director of nursing to help improve care and operational issues? *Section I. Roles, Functions and Tasks – Function 1.*	*Never* 1 2 3 4 5 6 *Always*
5. To what extent does your medical director participate in problem-solving efforts? *This is addressed throughout the guidelines.*	*Never* 1 2 3 4 5 6 *Always*
6. To what extent does your medical director help the facility establish systems and methods to review and provide appropriate feedback to individuals regarding their performance, including the quality of clinical care? *Section I. Roles, Functions and Tasks – Functions 1and 2.*	*Never* 1 2 3 4 5 6 *Always*
7. To what extent does your medical director have a positive impact on facility culture and sense of staff professionalism?	*No Impact* 1 2 3 4 5 6 *Positive Impact*
8. To what extent does your medical director review and help resolve individual resident care issues and facility problems as warranted? *Section I. Roles, Functions and Tasks – Functions 2 and 3.*	*Never* 1 2 3 4 5 6 *Always*
9. To what extent does your medical director monitor the performance and practices of the health care practitioners? *Section I. Roles, Functions and Tasks – Functions 1, 2and 3.*	*Never* 1 2 3 4 5 6 *Always*
10. Is your medical director certified by the American Medical Directors Certification Program's (AMDCP) Certification in Medical Direction as a Certified Medical Director in Long Term Care – CMD?	[ ] Yes [ ] No

MEDICAL DIRECTOR ASSESSMENT

(This assessment to be completed by the facility)

Name: _____ Facility: _____ Date: _____

ITEM	RATING
11. Does the medical director review physician performance as part of the quality assessment and assurance process? *Section I. Roles, Functions and Tasks – Function 3.*	[ ] Yes [ ] No
12. To what extent does your medical director give practitioners pertinent information about general medicine, geriatrics and long-term care practice? *Section I. Roles, Functions and Tasks – Function 4.*	*Never* 1 2 3 4 5 6 *Regularly*
13. How often does your medical director review the credentials, physical and mental capacity and clinical competency of all physicians, dentists, podiatrists and other practitioners who are employed by or associated with the facility? *Section I. Roles, Functions and Tasks – Function 2.*	*Never* 1 2 3 4 5 6 *Always*
14. To what extent does your facility encourage and facilitate the active involvement of the medical director? *Section J. Facility Responsibilities.*	*None* 1 2 3 4 5 6 *Always*
15. To what extent does your facility clearly delineate to the medical director the performance expectations of the particular functions and tasks of medical direction that apply in the facility, including those that may go beyond regulatory minimums? *Section J. Facility Responsibilities.*	*No Clear Delineation* 1 2 3 4 5 6 *Very Clear Delineation*
16. To what extent does your facility actively involve the medical director in clinical and operational policy-making, especially as relates to medical care delivery? *Section J. Facility Responsibilities.*	*Never* 1 2 3 4 5 6 *Always*
17. To what extent does your facility look to the medical director for advice on day-to-day medical care issues and concerns? *Section J. Facility Responsibilities.*	*Never* 1 2 3 4 5 6 *Always*
18. How do you feel you compensate your medical director for performing medical direction tasks? *Section J. Facility Responsibilities.*	*Not Enough* 1 2 3 4 5 6 *Adequately*
19. Do you support your medical director's self-education efforts such as obtaining the Certified Medical Director status? *Section J. Facility Responsibilities.*	*Not Enough* 1 2 3 4 5 6 *Adequately*
20. Considering the overall performance of your medical director and considering that the definition of a role is the set of organizational behaviors that one is expected to perform and that one feel obligated to perform : *Section I. Roles, Functions and Tasks*	
a. How well does your medical director fulfill the role of physician leader?	*Poor* 1 2 3 4 5 6 *Outstanding*
b. How well does your medical director fulfill the role of clinical leader?	*Poor* 1 2 3 4 5 6 *Outstanding*
c. How well does your medical director fulfill the role of quality leader?	*Poor* 1 2 3 4 5 6 *Outstanding*
d. How well does your medical director fulfill the role of education leader?	*Poor* 1 2 3 4 5 6 *Outstanding*

MEDICAL DIRECTOR ASSESSMENT

(This assessment is to be completed by the medical director considering his/her role as medical director.)

Name: _____ Facility: _____ Date: _____

ITEM	RATING
1 Are you a full-time or part-time medical director?	[ ]Full time [ ] Part time
2 To what extent does your facility actively involve you in the quality assurance/quality improvement process, including having you as the physician member of the quality assurance committee? *Section D. Medical Director, Quality Assurance and Quality Improvement and Section I. Roles, Functions and Tasks – Function 3.*	*Not at All* 1 2 3 4 5 6 *Highly Involved*
3 To what extent do you take an active leadership role on Quality Assurance Committee? *Section D. Medical Director, Quality Assurance and Quality Improvement and Section I. Roles, Functions and Tasks – Function 3.*	*Not at All* 1 2 3 4 5 6 *Active Leadership*
4 To what extent do you make recommendations to the administrator and director of nursing to help improve care and operational issues? *Section I. Roles, Functions and Tasks – Function 1.*	*Never* 1 2 3 4 5 6 *Always*
5 To what extent do you participate in problem-solving efforts? *This is addressed throughout the guidelines.*	*Never* 1 2 3 4 5 6 *Always*
6 To what extent do you help the facility establish systems and methods to review and provide appropriate feedback to individuals regarding their performance, including the quality of clinical care? *Section I. Roles, Functions and Tasks – Functions 1 and 2.*	*Never* 1 2 3 4 5 6 *Always*
7 To what extent do you feel that you have a positive impact on facility culture and sense of staff professionalism? *Section I. Roles, Functions and Tasks – Function 7.*	*No Impact* 1 2 3 4 5 6 *Positive Impact*
8 To what extent do you review and help resolve individual resident care issues and facility problems as warranted? *Section I. Roles, Functions and Tasks – Functions 2 and 3.*	*Never* 1 2 3 4 5 6 *Always*
9 To what extent do you monitor the performance and practices of the health care practitioners? *Section I. Roles, Functions and Tasks – Functions 1, 2 and 3.*	*Never* 1 2 3 4 5 6 *Always*
10 Are you certified by the American Medical Directors Certification Program's (AMDCP) Certification in Medical Direction as a Certified Medical Director in Long Term Care – CMD?	[ ] Yes [ ] No

MEDICAL DIRECTOR ASSESSMENT

(This assessment is to be completed by the medical director considering his/her role as medical director.)

Name: _____ Facility: _____ Date: _____

ITEM	RATING
11 Do you review physician performance as part of the quality assessment and assurance process? *Section I. Roles, Functions and Tasks – Function 3.*	[ ] Yes [ ] No
12 To what extent do you give practitioners pertinent information about general medicine, geriatrics and long-term care practice? *Section I. Roles, Functions and Tasks – Function 4.*	*Never* *Regularly* 1 2 3 4 5 6
13 How often do you review the credentials, physical and mental capacity and clinical competency of all physicians, dentists, podiatrists and other practitioners who are employed by or associated with the facility? *Section I. Roles, Functions and Tasks – Function 2.*	*Never* *Always* 1 2 3 4 5 6
14 To what extent does your facility encourage and facilitate your active involvement as the medical director? *Section J. Facility Responsibilities.*	*Never* *Always* 1 2 3 4 5 6
15 To what extent does your facility clearly delineate to you the performance expectations of the particular functions and tasks of medical direction that apply in the facility, including those that may go beyond regulatory minimums? *Section J. Facility Responsibilities.*	*No Clear Delineation* *Very Clear Delineation* 1 2 3 4 5 6
16 To what extent does your facility actively involve you in clinical and operational policy-making, especially as relates to medical care delivery? *Section J. Facility Responsibilities.*	*Never* *Always* 1 2 3 4 5 6
17 To what extent does your facility look to you for advice on day-to-day medical care issues and concerns? *Section J. Facility Responsibilities.*	*Never* *Always* 1 2 3 4 5 6
18 How do you feel you are compensated as medical director for performing medical direction tasks? *Section J. Facility Responsibilities.*	*Not Enough* *Adequately* 1 2 3 4 5 6
19 Do you feel that your facility supports your self-education efforts such as obtaining the Certified Medical Director status? *Section J. Facility Responsibilities.*	*Not Enough* *Adequately* 1 2 3 4 5 6
20 Considering your overall performance as medical director and considering that the definition of a role is the set of organizational behaviors that one is expected to perform and that one feel obligated to perform : *Section I. Roles, Functions and Tasks*	
e. How well do you fulfill the role of physician leader?	*Poor* *Outstanding* 1 2 3 4 5 6
f. How well do you fulfill the role of clinical leader?	*Poor* *Outstanding* 1 2 3 4 5 6
g. How well do you fulfill the role of quality leader?	*Poor* *Outstanding* 1 2 3 4 5 6
h. How well do you fulfill the role of education leader?	*Poor* *Outstanding* 1 2 3 4 5 6

ATTENDING PRACTITIONER ASSESSMENT

(This assessment is to be completed by the facility)

Name: _____ Facility: _____ Date: _____

ITEM	RATING
1. To what extent do attending physicians lead the clinical decision-making for patients under their care? *The attending physician guidelines as a whole describe a leadership role for each resident's physician.*	*Not at all* 1 2 3 4 5 6 *Always*
2. To what extent does your facility collaborate with the medical director to create an environment conducive to the delivery of appropriate medical practice? *Section B. General Facility Responsibilities.*	*No Collaboration* 1 2 3 4 5 6 *Strong Collaboration*
3. To what extent does your facility provide attending physicians with the support they need to fulfill responsibilities, including ensuring that the adequate personnel, resources, supplies and ancillary services are available? *Section B. General Facility Responsibilities.*	*Not at all* 1 2 3 4 5 6 *Always*
4. Please rate attending physicians' understanding of the principles and practice of geriatric medicine. *Section C. Physician Training, Qualifications and Medical Director Oversight.*	*Poor* 1 2 3 4 5 6 *Excellent*
5. To what extent do attending physicians review the resident's total program of care, including medications and treatments and the reasons for each, at each regularly scheduled visit? *Section D.a.i. Physician Responsibilities.*	*Never* 1 2 3 4 5 6 *Always*
6. To what extent do attending physicians, in consultation with the facility's staff, determine appropriate services and programs for a patient, consistent with diagnoses, conditions, prognosis, and patient and family goals and wishes? *Section D.a.i. Physician Responsibilities.*	*Never* 1 2 3 4 5 6 *Always*
7. To what extent do attending physicians explain and document the medical rationale for their interventions or decisions not to intervene? *D.a.i. Physician Responsibilities* .	*Never* 1 2 3 4 5 6 *Always*
8. To what extent do attending physicians respond adequately to issues requiring a physician's expertise? *Section D.b. Acute Illness Visits.*	*Never* 1 2 3 4 5 6 *Always*
9. To what extent do attending physicians make appropriate and timely acute illness visits? *Section D.b. Acute Illness Visits.*	*Never* 1 2 3 4 5 6 *Always*
10. To what extent does your facility have appropriate notification protocols to ensure that pertinent information concerning a resident's status is relayed to her/his physician in a timely and complete manner? *Section D. b. Acute Illness Visits and Section G.b. Facility Responsibilities.*	*No Protocols* 1 2 3 4 5 6 *Effective Protocols*

ATTENDING PRACTITIONER ASSESSMENT

(This assessment is to be completed by the facility)

Name: _____ Facility: _____ Date: _____

ITEM	RATING
11. To what extent does your facility obtain and provide appropriate medical records in a timely manner? *Section E.b. Facility Responsibilities.*	*Never* 1 2 3 4 5 6 *Always*
12. To what extent do attending physicians and facility staff adequately review the transfer information for readmissions? *Section E.b. Facility Responsibilities.*	*Never* 1 2 3 4 5 6 *Always*
13. How reliable is the physician coverage in your facility? *Section G. Physician Notification/Ongoing Coverage.*	*Unsatisfactory* 1 2 3 4 5 6 *Satisfactory*
14. To what extent do attending physicians respond in an appropriate time frame to routine notifications regarding their patients when they are not present in the facility? *Section G. Physician Notification/Ongoing Coverage.*	*Never* 1 2 3 4 5 6 *Always*
15. To what extent do attending physicians receive the support that they need to fulfill their responsibilities at times when they are not present in the facility? *Section G. Physician Notification/Ongoing Coverage.*	*Never* 1 2 3 4 5 6 *Always*
16. To what extent are attending physicians responsive to contact from nursing staff with updates on the condition of anyone who received an order for new or additional medications and treatments during the previous evening or overnight shifts? *Section G. Physician Notification/Ongoing Coverage.*	*Never* 1 2 3 4 5 6 *Always*
17. To what extent do attending physicians communicate effectively with residents and their representatives regarding medical care? *Section J. Relationship With Residents and Families.*	*Never* 1 2 3 4 5 6 *Always*
18. To what extent do attending physicians abide by pertinent facility and medical policies and procedures? *Section K. Professional Conduct.*	*Never* 1 2 3 4 5 6 *Always*
19. To what extent do attending physicians identify prognosis and the potential for functional improvement of the residents under their care? *Section L. General.*	*Never* 1 2 3 4 5 6 *Always*
20. To what extent are attending physicians committed to fostering and strengthening collaboration with non-physician providers, if applicable? *Section M. Non-physician Providers.*	*Not at all* 1 2 3 4 5 6 *Highly Committed*

ATTENDING PRACTITIONER ASSESSMENT

(This assessment is to be completed by the attending physician)

Name: _____ Facility: _____ Date: _____

ITEM	RATING
1. To what extent do you, as attending physician, lead the clinical decision-making for patients under their care? *The attending physician guidelines as a whole describe a leadership role for each resident's physician.*	*Not at all* 1 2 3 4 5 6 *Always*
2. To what extent does your facility collaborate with the medical director to create an environment conducive to the delivery of appropriate medical practice? *Section B. General Facility Responsibilities.*	*No Collaboration* 1 2 3 4 5 6 *Strong Collaboration*
3. To what extent does your facility provide you with the support you need to fulfill responsibilities, including ensuring that the adequate personnel, resources, supplies and ancillary services are available? *Section B. General Facility Responsibilities.*	*Not at all* 1 2 3 4 5 6 *Always*
4. Please rate your understanding of the principles and practice of geriatric medicine. *Section C. Physician Training, Qualifications and Medical Director Oversight.*	*Poor* 1 2 3 4 5 6 *Excellent*
5. To what extent do you review the resident's total program of care, including medications and treatments and the reasons for each, at each regularly scheduled visit? *Section D.a.i. Physician Responsibilities.*	*Never* 1 2 3 4 5 6 *Always*
6. To what extent do you, in consultation with the facility's staff, determine appropriate services and programs for a patient, consistent with diagnoses, conditions, prognosis, and patient and family goals and wishes? *Section D.a.i. Physician Responsibilities.*	*Never* 1 2 3 4 5 6 *Always*
7. To what extent do you explain and document the medical rationale for your interventions or decisions not to intervene? *Section D.a.i. Physician Responsibilities*	*Never* 1 2 3 4 5 6 *Always*
8. To what extent do you respond adequately to issues requiring a physician's expertise? *Section D.b. Acute Illness Visits.*	*Never* 1 2 3 4 5 6 *Always*
9. To what extent do you make appropriate and timely acute illness visits? *Section D.b. Acute Illness Visits.*	*Never* 1 2 3 4 5 6 *Always*
10. To what extent does your facility have appropriate notification protocols to ensure that pertinent information concerning a resident's status is relayed to you in a timely and complete manner? *Section D. b. Acute Illness Visits and Section G.b. Facility Responsibilities.*	*No Protocols* 1 2 3 4 5 6 *Effective Protocols*

ATTENDING PRACTITIONER ASSESSMENT

(This assessment is to be completed by the attending physician)

Name: _____ Facility: _____ Date: _____

ITEM	RATING
11. To what extent does your facility obtain and provide appropriate medical records in a timely manner? *Section E.b. Facility Responsibilities.*	*Never* 1 2 3 4 5 6 *Always*
12. To what extent do you and facility staff adequately review the transfer information for readmissions? *Section E.b. Facility Responsibilities.*	*Never* 1 2 3 4 5 6 *Always*
13. How reliable is the physician coverage in your facility? *Section G. Physician Notification/Ongoing Coverage.*	*Unsatisfactory* 1 2 3 4 5 6 *Satisfactory*
14. To what extent do you respond in an appropriate time frame to routine notifications regarding your patients when you are not present in the facility? *Section G. Physician Notification/Ongoing Coverage.*	*Never* 1 2 3 4 5 6 *Always*
15. To what extent do you receive the support that you need to fulfill your responsibilities at times when you are not present in the facility? *Section G. Physician Notification/Ongoing Coverage.*	*Never* 1 2 3 4 5 6 *Always*
16. To what extent are you responsive to contact from nursing staff with updates on the condition of anyone who received an order for new or additional medications and treatments during the previous evening or overnight shifts? *Section G. Physician Notification/Ongoing Coverage.*	*Never* 1 2 3 4 5 6 *Always*
17. To what extent do you communicate effectively with residents and their representatives regarding medical care? *Section J. Relationship With Residents and Families.*	*Never* 1 2 3 4 5 6 *Always*
18. To what extent do you abide by pertinent facility and medical policies and procedures? *Section K. Professional Conduct.*	*Never* 1 2 3 4 5 6 *Always*
19. To what extent do you identify prognosis and the potential for functional improvement of the residents under their care? *Section L. General.*	*Never* 1 2 3 4 5 6 *Always*
20. To what extent are you committed to fostering and strengthening collaboration with non-physician providers, if applicable? *Section M. Non-physician Providers.*	*Not at all* 1 2 3 4 5 6 *Highly Committed*

Attachment 6

Vendor Responsibility Attestation

To comply with the Vendor Responsibility Requirements outlined in Section IV, Administrative Requirements, K. Vendor Responsibility Questionnaire, I hereby certify:

Choose one:

☐ An on-line Vender Responsibility Questionnaire has been updated or created at OSC's website: https://portal.osc.state.ny.us within the last six months.

☐ A hard copy Vendor Responsibility Questionnaire is included with this application and is dated within the last six months.

☐ A Vendor Responsibility Questionnaire is not required due to an exempt status. Exemptions include governmental entities, public authorities, public colleges and universities, public benefit corporations, and Indian Nations.

Signature of Organization Official: _____

Print/type Name: _____

Title: _____

Organization: _____

Date Signed: _____

Attachment 7

APPLICATION TABLE OF CONTENTS

Page Number

I. Cover Sheet

II. Table of Contents

III. Statement of Understanding

IV. Organizational Qualifications

- A. Overview of organization
- B. Providing education, training and/or technical assistance (ETTA) to New York nursing homes
- C. Designing and conducting research in New York nursing homes
- D. Interviewing or otherwise collecting information from nursing home staff
- E. Designing and conducting program evaluation research in any health or health-related setting other than a nursing home subject to 42 CFR 483

V. Staff Qualifications

- A. Providing education, training and/or technical assistance (ETTA) to New York nursing homes
- B. Designing and conducting research in New York nursing homes
- C. Interviewing or otherwise collecting information from nursing home staff
- D. Designing and conducting program evaluation research in any health or health-related setting other than a nursing home subject to 42 CFR 483
- E. Experience with MDS, SPARCS, RHCF-4, Medicare and Medicaid claims and any other databases proposed to be used in this project
- F. Database development and processing
- G. Data analysis using SAS, SPSS and other data processing and analysis software
- H. Resumes

VII. Work Plan

VIII. Managerial and Supervisory Plan

IX. Subcontractors and Consultants

X. Evaluation Research Design

XI. Letters of Reference

In a separate sealed envelope:

XII. Budget

Attachment 8

Application Cover Sheet

Applicant's name, operating certificate number and address must be identical to that on its operating certificate.

RFA Title: _____

RFA FAU Number: _____

Applicant's name: _____

If applicant is a nursing home, Operating Certificate Number:

_____

If applicant is a nursing home, PFI:

_____

Applicant's address: _____

_____

Applicant's phone number: _____

Individual with signatory authority for applicant: _____
(Print Name and Title)

_____
(Signature)

Contact individual if different from signatory authority: _____
(Print Name and Title)

ATTACHMENT 9

WORK PLAN
SUMMARY

All deliverables specified in the RFA must be included in the work plan. Deliverables are specified in Section III.C. of the RFA. Applicants may also identify milestones if they wish.

PROJECT NAME: _____

CONTRACTOR SFS PAYEE NAME: _____

CONTRACT PERIOD: From: _____

To: _____

Provide an overview of the project including goals, tasks, desired outcomes and performance measures:

ATTACHMENT 9 (CONT'D)
WORK PLAN
DETAIL

OBJECTIVE	BUDGET CATEGORY/ DELIVERABLE (if applicable)	TASKS	PERFORMANCE MEASURES
1:		a.	i.
			ii.
			iii.
		b.	i.
			ii.
			iii.
		c.	i.
			ii.
			iii.

ATTACHMENT 9 (CONT'D)
WORK PLAN
DETAIL

OBJECTIVE	BUDGET CATEGORY/ DELIVERABLE (if applicable)	TASKS	PERFORMANCE MEASURES
2:		a.	i.
			ii.
			iii.
		b.	i.
			ii.
			iii.
		c.	i.
			ii.
			iii.

ATTACHMENT 9 (CONT'D)
WORK PLAN
DETAIL

OBJECTIVE	BUDGET CATEGORY/ DELIVERABLE (if applicable)	TASKS	PERFORMANCE MEASURES
3:		a.	i.
			ii.
			iii.
		b.	i.
			ii.
			iii.
		c.	i.
			ii.
			iii.

Attachment 10

Expenditure Based Budget

(See file labeled – **Expenditure Based Budget Template** - posted along with this RFA.)

IMPORTANT: Total 5-year budgets cannot exceed $840,000.
Indirect expense or overhead includes space/property and utilities and operating expense. The sum of these two budget lines cannot exceed 10% of the sum of salaries and fringe benefits. Fixed capital expense is not allowed.

Attachment 11

GUIDE TO NEW YORK STATE DOH M/WBE RFP/RFA REQUIRED FORMS

All DOH procurements have a section entitled **"MINORITY AND WOMEN OWNED BUSINESS ENTERPRISE REQUIREMENTS."** This section of procurement sets forth the established DOH goal for that particular procurement and also describes the forms that must be completed with their proposal or application. Below is a summary of the forms used in the DOH MWBE Participation Program by a grantee.

Form #1: Grantee MWBE Utilization Plan - This document must be completed by all grantees responding to RFAs with an MWBE goal greater than zero. The grantee must demonstrate how it plans to meet the stated MWBE goal. In completing this form, the grantee should describe the steps taken to establish communication with MWBE firms and identify current or future relationships with certified MWBE firms. The second page of the form should list the MWBE certified firms that the vendor plans to engage with on the project and the amount that each certified firm is projected to be paid. Plans to work with uncertified firms or women and minority owned firms do not meet the criteria for participation. If the plan is not submitted or is deemed deficient**,** the grantee may be sent a notice of deficiency. It is mandatory that all awards with goals have a utilization plan on file.

Form #2: MWBE Utilization Waiver Request - This document must be filled out by the grantee if the utilization plan (Form #1) indicates less than the stated participation goal for the procurement. In this instance, Form #2 must accompany Form #1 with the proposal. When completing Form #2, it is important that the grantee thoroughly document the steps that were taken to meet the goal and provide evidence in the form of attachments to the document. The required attachments are listed on Form #2 and will document the good-faith efforts taken to meet the desired goal. A grantee can also attach additional evidence outside of those referenced attachments. Without evidence of good-faith efforts, in the form of attachments or other documentation, the Department of Health may not approve the waiver and the grantee may be deemed non-responsive.

New MWBE firms are being certified daily and new MWBE firms may now be available to provide products or services that were historically unavailable. If Form #2 is found by DOH to be deficient, the grantee will be sent a deficiency letter asking for a revised form to be returned within 7 business days of receipt.

Any questions regarding completion of these forms can be sent to jae11@health.state.ny.us.

MWBE Form #1
New York State Department of Health
GRANTEE/CONTRACTOR MWBE UTILIZATION PLAN

Grantee/Contractor Name:	
Vendor ID:	**Telephone No.**
RFA/Contract Title:	**RFA/Contract No.**

Description of Plan to Meet MWBE Goals (Use pages 2-3 to provide specific M and W subcontractor information)

PROJECTED MWBE USAGE

	%	Amount
1. Total Dollar Value of Eligible Costs on Budget	**100**	**$**
2. MBE Goal Applied to Eligible Costs		**$**
3. WBE Goal Applied to Eligible Costs		**$**
4. MWBE Combined Totals*		**$**

*If less than the stated goal in RFA, Form #2 is required.

GRANTEE/CONTRACTOR PROPOSED MWBE UTILIZATION PLAN
MINORITY OWNED BUSINESS ENTERPRISE (MBE) INFORMATION

In order to achieve the MBE Goals, grantee expects to subcontract with New York State certified MINORITY-OWNED entities as follows: (add additional pages as needed)

MBE Firm (Exactly as Registered)	Description of Work (Products/Services) [MBE]	Projected MBE Dollar Amount
Name **Address** **City, State, ZIP** **Employer I.D.** **Telephone Number** **( ) -**		**$** _____
Name **Address** **City, State, ZIP** **Employer I.D.** **Telephone Number** **( ) -**		**$** _____
Name **Address** **City, State, ZIP** **Employer I.D.** **Telephone Number** **( ) -**		**$** _____

GRANTEE/CONTRACTOR PROPOSED MWBE UTILIZATION PLAN
WOMEN OWNED BUSINESS ENTERPRISE (WBE) INFORMATION

In order to achieve the MBE Goals, grantee expects to subcontract with New York State certified WOMEN-OWNED entities as follows: (add additional pages as needed)

WBE Firm (Exactly as Registered)	**Description of Work (Products/Services) [WBE]**	**Projected WBE Dollar Amount**
Name **Address** **City, State, ZIP** **Employer I.D.** **Telephone Number** **( ) -**		**$** _____
Name **Address** **City, State, ZIP** **Employer I.D.** **Telephone Number** **( ) -**		**$** _____
Name **Address** **City, State, ZIP** **Employer I.D.** **Telephone Number** **( ) -**		**$** _____

MWBE Form #2

MWBE UTILIZATION WAIVER REQUEST

Grantee/Contractor Name:	
Vendor ID:	**Telephone No.**
RFA/Contract Title:	**RFA/Contract No.**

Explanation why Grantee is unable to meet MWBE goals for this project:

Include attachments below to evidence good faith efforts:

- ☐ Attachment A. List of the general circulation, trade and MWBE-oriented publications and dates of publications soliciting for certified MWBE participation as a subcontractor/supplier and copies of such solicitation.
- ☐ Attachment B. List of the certified MWBEs appearing in the Empire State Development MWBE directory that were solicited for this contract. Provide proof of dates or copies of the solicitations and copies of the responses made by the certified MWBEs. Describe specific reasons that responding certified MWBEs were not selected.
- ☐ Attachment C. Descriptions of the contract documents/plans/specifications made available to certified MWBEs by the contractor when soliciting their participation and steps taken to structure the scope of work for the purpose of subcontracting with or obtaining supplies from certified MWBEs.
- ☐ Attachment D. Description of the negotiations between the contractor and certified MWBEs for the purposes of complying with the MWBE goals of this contract.
- ☐ Attachment E. Identify dates of any pre-proposal, pre-award or other meetings attended by contractor, if any, scheduled by OGS with certified MWBEs whom OGS determined were capable of fulfilling the MWBE goals set in the contract.
- ☐ Attachment F. Other information deemed relevant to the request.

Section 4: Signature and Contact Information

By signing and submitting this form, the contractor certifies that a good faith effort has been made to promote MWBE participation pursuant to the MWBE requirements set forth under the contract. Failure to submit complete and accurate information may result in a finding of noncompliance, non-responsibility, and a suspension or termination of the contract.

Submitted by: _____ Title: _____

_____

(Signature) / (Date)

Attachment 12

NYS Master Grant Contract

STATE OF NEW YORK MASTER CONTRACT FOR GRANTS FACE PAGE

STATE AGENCY (Name & Address):	BUSINESS UNIT/DEPT. ID: CONTRACT NUMBER: CONTRACT TYPE: ☐ Multi-Year Agreement ☐ Simplified Renewal Agreement ☐ Fixed Term Agreement
CONTRACTOR SFS PAYEE NAME:	TRANSACTION TYPE: ☐ New ☐ Renewal ☐ Amendment
CONTRACTOR DOS INCORPORATED NAME:	PROJECT NAME:
CONTRACTOR IDENTIFICATION NUMBERS: NYS Vendor ID Number: Federal Tax ID Number: DUNS Number (if applicable):	AGENCY IDENTIFIER: CFDA NUMBER (Federally Funded Grants Only):
CONTRACTOR PRIMARY MAILING ADDRESS: CONTRACTOR PAYMENT ADDRESS: ☐ Check if same as primary mailing address CONTRACT MAILING ADDRESS: ☐ Check if same as primary mailing address	CONTRACTOR STATUS: ☐ For Profit ☐ Municipality, Code: ☐ Tribal Nation ☐ Individual ☐ Not-for-Profit Charities Registration Number: Exemption Status/Code: ☐ Sectarian Entity

STATE OF NEW YORK MASTER CONTRACT FOR GRANTS FACE PAGE

CURRENT CONTRACT TERM:

From: To:

CURRENT CONTRACT PERIOD:

From: To:

AMENDED TERM:

From: To:

AMENDED PERIOD:

From: To:

CONTRACT FUNDING AMOUNT
(*Multi-year* - enter total projected amount of the contract; *Fixed Term/Simplified Renewal* - enter current period amount):

CURRENT:

AMENDED:

FUNDING SOURCE(S)

- ☐ State
- ☐ Federal
- ☐ Other

FOR MULTI-YEAR AGREEMENTS ONLY - CONTRACT PERIOD AND FUNDING AMOUNT:
(Out years represent projected funding amounts)

#	CURRENT PERIOD	CURRENT AMOUNT	AMENDED PERIOD	AMENDED AMOUNT
1				
2				
3				
4				
5				

ATTACHMENTS PART OF THIS AGREEMENT:

☐ Attachment A:
- ☐ A-1 Program Specific Terms and Conditions
- ☐ A-2 Federally Funded Grants

☐ Attachment B:
- ☐ B-1 Expenditure Based Budget
- ☐ B-2 Performance Based Budget
- ☐ B-3 Capital Budget
- ☐ B-1(A) Expenditure Based Budget (Amendment)
- ☐ B-2(A) Performance Based Budget (Amendment)
- ☐ B-3(A) Capital Budget (Amendment)

☐ Attachment C: Work Plan
☐ Attachment D: Payment and Reporting Schedule
☐ Other:

IN WITNESS THEREOF, the parties hereto have executed or approved this Master Contract on the dates below their signatures.

CONTRACTOR:	STATE AGENCY:
_____	_____
_____	_____
By:_____	By:_____
_____ Printed Name	_____ Printed Name
Title:_____	Title:_____
Date:_____	Date:_____

STATE OF NEW YORK

County of_____

On the ___ day of _____, ____, before me personally appeared_____, to me known, who being by me duly sworn, did depose and say that he/she resides at _____, that he/she is the _____ of the _____, the contractor described herein which executed the foregoing instrument; and that he/she signed his/her name thereto as authorized by the contractor named on the face page of this Master Contract.

(Notary)_____

ATTORNEY GENERAL'S SIGNATURE	STATE COMPTROLLER'S SIGNATURE
_____	_____
_____ Printed Name	_____ Printed Name
Title:_____	Title:_____
Date:_____	Date:_____

STATE OF NEW YORK
MASTER CONTRACT FOR GRANTS

This State of New York Master Contract for Grants (Master Contract) is hereby made by and between the State of New York acting by and through the applicable State Agency (State) and the public or private entity (Contractor) identified on the face page hereof (Face Page).

WITNESSETH:

WHEREAS, the State has the authority to regulate and provide funding for the establishment and operation of program services, design or the execution and performance of construction projects, as applicable and desires to contract with skilled parties possessing the necessary resources to provide such services or work, as applicable; and

WHEREAS, the Contractor is ready, willing and able to provide such program services or the execution and performance of construction projects and possesses or can make available all necessary qualified personnel, licenses, facilities and expertise to perform or have performed the services or work, as applicable, required pursuant to the terms of the Master Contract;

NOW THEREFORE, in consideration of the promises, responsibilities, and covenants herein, the State and the Contractor agree as follows:

STANDARD TERMS AND CONDITIONS

I. GENERAL PROVISIONS

A. Executory Clause: In accordance with Section 41 of the State Finance Law, the State shall have no liability under the Master Contract to the Contractor, or to anyone else, beyond funds appropriated and available for the Master Contract.

B. Required Approvals: In accordance with Section 112 of the State Finance Law (or, if the Master Contract is with the State University of New York (SUNY) or City University of New York (CUNY), Section 355 or Section 6218 of the Education Law), if the Master Contract exceeds $50,000 (or $85,000 for contracts let by the Office of General Services, or the minimum thresholds agreed to by the Office of the State Comptroller (OSC) for certain SUNY and CUNY contracts), or if this is an amendment for any amount to a contract which, as so amended, exceeds said statutory amount including, but not limited to, changes in amount, consideration, scope or contract term identified on the Face Page (Contract Term), it shall not be valid, effective or binding upon the State until it has been approved by, and filed with, the New York Attorney General Contract Approval Unit (AG) and OSC. If, by the Master Contract, the State agrees to give something other than money when the value or reasonably estimated value of such consideration exceeds $10,000, it shall not be valid, effective or binding upon the State until it has been approved by, and filed with, the AG and OSC.

***Budget Changes*:** An amendment that would result in a transfer of funds among program activities or budget cost categories that does not affect the amount, consideration, scope or other terms of such contract may be subject to the approval of the AG and OSC where the amount of such modification is, as a portion of the total value of the contract, equal to or greater than ten percent for contracts of less than five million dollars, or five percent for contracts of more than

five million dollars; and, in addition, such amendment may be subject to prior approval by the applicable State Agency as detailed in Attachment D (Payment and Reporting Schedule).

C. Order of Precedence:

In the event of a conflict among (i) the terms of the Master Contract (including any and all attachments and amendments) or (ii) between the terms of the Master Contract and the original request for proposal, the program application or other attachment that was completed and executed by the Contractor in connection with the Master Contract, the order of precedence is as follows:

1. Standard Terms and Conditions

2. Modifications to the Face Page

3. Modifications to Attachment A-2[1], Attachment B, Attachment C and Attachment D

4. The Face Page

5. Attachment A-2[2], Attachment B, Attachment C and Attachment D

6. Modification to Attachment A-1

7. Attachment A-1

8. Other attachments, including, but not limited to, the request for proposal or program application

D. Funding: Funding for the term of the Master Contract shall not exceed the amount specified as "Contract Funding Amount" on the Face Page or as subsequently revised to reflect an approved renewal or cost amendment. Funding for the initial and subsequent periods of the Master Contract shall not exceed the applicable amounts specified in the applicable Attachment B form (Budget).

E. Contract Performance: The Contractor shall perform all services or work, as applicable, and comply with all provisions of the Master Contract to the satisfaction of the State. The Contractor shall provide services or work, as applicable, and meet the program objectives summarized in Attachment C (Work Plan) in accordance with the provisions of the Master Contract, relevant laws, rules and regulations, administrative, program and fiscal guidelines, and where applicable, operating certificate for facilities or licenses for an activity or program.

F. Modifications: To modify the Attachments or Face Page, the parties mutually agree to record, in writing, the terms of such modification and to revise or complete the Face Page and all the appropriate attachments in conjunction therewith. In addition, to the extent that such modification meets the criteria set forth in Section I.B herein, it shall be subject to the approval of the AG and

[1] To the extent that the modifications to Attachment A-2 are required by federal requirements and conflict with other provisions of the Master Contract, the modifications to Attachment A-2 shall supersede all other provisions of this Master Contract. See Section I(V).

[2] To the extent that the terms of Attachment A-2 are required by federal requirements and conflict with other provisions of the Master Contract, the federal requirements of Attachment A-2 shall supersede all other provisions of this Master Contract. See Section I(V).

OSC before it shall become valid, effective and binding upon the State. Modifications that are not subject to the AG and OSC approval shall be processed in accordance with the guidelines stated in the Master Contract.

G. Governing Law: The Master Contract shall be governed by the laws of the State of New York except where the Federal Supremacy Clause requires otherwise.

H. Severability: Any provision of the Master Contract that is held to be invalid, illegal or unenforceable in any respect by a court of competent jurisdiction, shall be ineffective only to the extent of such invalidity, illegality or unenforceability, without affecting in any way the remaining provisions hereof; provided, however, that the parties to the Master Contract shall attempt in good faith to reform the Master Contract in a manner consistent with the intent of any such ineffective provision for the purpose of carrying out such intent. If any provision is held void, invalid or unenforceable with respect to particular circumstances, it shall nevertheless remain in full force and effect in all other circumstances.

I. Interpretation: The headings in the Master Contract are inserted for convenience and reference only and do not modify or restrict any of the provisions herein. All personal pronouns used herein shall be considered to be gender neutral. The Master Contract has been made under the laws of the State of New York, and the venue for resolving any disputes hereunder shall be in a court of competent jurisdiction of the State of New York.

J. Notice:

1. All notices, except for notices of termination, shall be in writing and shall be transmitted either:

   a) by certified or registered United States mail, return receipt requested;

   b) by facsimile transmission;

   c) by personal delivery;

   d) by expedited delivery service; or

   e) by e-mail.

2. Notices to the State shall be addressed to the Program Office designated in Attachment A-1 (Program Specific Terms and Conditions).

3. Notices to the Contractor shall be addressed to the Contractor's designee as designated in Attachment A-1 (Program Specific Terms and Conditions).

4. Any such notice shall be deemed to have been given either at the time of personal delivery or, in the case of expedited delivery service or certified or registered United States mail, as of the date of first attempted delivery at the address and in the manner provided herein, or in the case of facsimile transmission or e-mail, upon receipt.

5. The parties may, from time to time, specify any new or different e-mail address, facsimile

number or address in the United States as their address for purpose of receiving notice under the Master Contract by giving fifteen (15) calendar days prior written notice to the other party sent in accordance herewith. The parties agree to mutually designate individuals as their respective representatives for the purposes of receiving notices under the Master Contract. Additional individuals may be designated in writing by the parties for purposes of implementation, administration, billing and resolving issues and/or disputes.

K. Service of Process: In addition to the methods of service allowed by the State Civil Practice Law & Rules (CPLR), Contractor hereby consents to service of process upon it by registered or certified mail, return receipt requested. Service hereunder shall be complete upon Contractor's actual receipt of process or upon the State's receipt of the return thereof by the United States Postal Service as refused or undeliverable. Contractor must promptly notify the State, in writing, of each and every change of address to which service of process can be made. Service by the State to the last known address shall be sufficient. The Contractor shall have thirty (30) calendar days after service hereunder is complete in which to respond.

L. Set-Off Rights: The State shall have all of its common law, equitable, and statutory rights of set-off. These rights shall include, but not be limited to, the State's option to withhold, for the purposes of set-off, any moneys due to the Contractor under the Master Contract up to any amounts due and owing to the State with regard to the Master Contract, any other contract with any State department or agency, including any contract for a term commencing prior to the term of the Master Contract, plus any amounts due and owing to the State for any other reason including, without limitation, tax delinquencies, fee delinquencies, or monetary penalties relative thereto. The State shall exercise its set-off rights in accordance with normal State practices including, in cases of set-off pursuant to an audit, the finalization of such audit by the State Agency, its representatives, or OSC.

M. Indemnification: The Contractor shall be solely responsible and answerable in damages for any and all accidents and/or injuries to persons (including death) or property arising out of or related to the services to be rendered by the Contractor or its subcontractors pursuant to this Master Contract. The Contractor shall indemnify and hold harmless the State and its officers and employees from claims, suits, actions, damages and cost of every nature arising out of the provision of services pursuant to the Master Contract.

N. Non-Assignment Clause: In accordance with Section 138 of the State Finance Law, the Master Contract may not be assigned by the Contractor or its right, title or interest therein assigned, transferred, conveyed, sublet, or otherwise disposed of without the State's previous written consent, and attempts to do so shall be considered to be null and void. Notwithstanding the foregoing, such prior written consent of an assignment of a contract, let pursuant to Article XI of the State Finance Law, may be waived at the discretion of the State Agency and with the concurrence of OSC, where the original contract was subject to OSC's approval, where the assignment is due to a reorganization, merger, or consolidation of the Contractor's business entity or enterprise. The State retains its right to approve an assignment and to require that the merged contractor demonstrate its responsibility to do business with the State. The Contractor may, however, assign its right to receive payments without the State's prior written consent unless the Master Contract concerns Certificates of Participation pursuant to Article 5-A of the State Finance Law.

O. Legal Action: No litigation or regulatory action shall be brought against the State of New York, the State Agency, or against any county or other local government entity with funds provided under

the Master Contract. The term "litigation" shall include commencing or threatening to commence a lawsuit, joining or threatening to join as a party to ongoing litigation, or requesting any relief from any of the State of New York, the State Agency, or any county, or other local government entity. The term "regulatory action" shall include commencing or threatening to commence a regulatory proceeding, or requesting any regulatory relief from any of the State of New York, the State Agency, or any county, or other local government entity.

P. No Arbitration: Disputes involving the Master Contract, including the breach or alleged breach thereof, may not be submitted to binding arbitration (except where statutorily authorized), but must, instead, be heard in a court of competent jurisdiction of the State of New York.

Q. Secular Purpose: Services performed pursuant to the Master Contract are secular in nature and shall be performed in a manner that does not discriminate on the basis of religious belief, or promote or discourage adherence to religion in general or particular religious beliefs.

R. Partisan Political Activity and Lobbying: Funds provided pursuant to the Master Contract shall not be used for any partisan political activity, or for activities that attempt to influence legislation or election or defeat of any candidate for public office.

S. Reciprocity and Sanctions Provisions: The Contractor is hereby notified that if its principal place of business is located in a country, nation, province, state, or political subdivision that penalizes New York State vendors, and if the goods or services it offers shall be substantially produced or performed outside New York State, the Omnibus Procurement Act 1994 and 2000 amendments (Chapter 684 and Chapter 383, respectively) require that it be denied contracts which it would otherwise obtain.[3]

T. Reporting Fraud and Abuse: Contractor acknowledges that it has reviewed information on how to prevent, detect, and report fraud, waste and abuse of public funds, including information about the Federal False Claims Act, the New York State False Claims Act, and whistleblower protections.

U. Non-Collusive Bidding: By submission of this bid, the Contractor and each person signing on behalf of the Contractor certifies, and in the case of a joint bid each party thereto certifies as to its own organization, under penalty of perjury, that to the best of his or her knowledge and belief that its bid was arrived at independently and without collusion aimed at restricting competition. The Contractor further affirms that, at the time the Contractor submitted its bid, an authorized and responsible person executed and delivered to the State a non-collusive binding certification on the Contractor's behalf.

V. Federally Funded Grants: All of the Specific federal requirements that are applicable to the Master Contract are identified in Attachment A-2 (Federally Funded Grants) hereto. To the extent that the Master Contract is funded in whole or part with federal funds, (i) the provisions of the Master Contract that conflict with federal rules, federal regulations, or federal program specific requirements shall not apply and (ii) the Contractor agrees to comply with all applicable federal

[3]As of October 9, 2012, the list of discriminatory jurisdictions subject to this provision includes the states of Alaska, Hawaii, Louisiana, South Carolina, West Virginia and Wyoming. Contact NYS Department of Economic Development for the most current list of jurisdictions subject to this provision.

rules, regulations and program specific requirements including, but not limited to, those provisions that are set forth in Attachment A-2 (Federally Funded Grants) hereto.

II. TERM, TERMINATION AND SUSPENSION

A. Term: The term of the Master Contract shall be as specified on the Face Page, unless terminated sooner as provided herein.

B. Renewal:

1. *General Renewal*: The Master Contract may consist of successive periods on the same terms and conditions, as specified within the Master Contract (a "Simplified Renewal Contract"). Each additional or superseding period shall be on the forms specified by the State and shall be incorporated in the Master Contract.

2. *Renewal Notice to Not-for-Profit Contractors*:

a) Pursuant to State Finance Law §179-t, if the Master Contract is with a not-for-profit Contractor and provides for a renewal option, the State shall notify the Contractor of the State's intent to renew or not to renew the Master Contract no later than ninety (90) calendar days prior to the end of the term of the Master Contract, unless funding for the renewal is contingent upon enactment of an appropriation. If funding for the renewal is contingent upon enactment of an appropriation, the State shall notify the Contractor of the State's intent to renew or not to renew the Master Contract the later of: (1) ninety (90) calendar days prior to the end of the term of the Master Contract, and (2) thirty (30) calendar days after the necessary appropriation becomes law. Notwithstanding the foregoing, in the event that the State is unable to comply with the time frames set forth in this paragraph due to unusual circumstances beyond the control of the State ("Unusual Circumstances"), no payment of interest shall be due to the not-for-profit Contractor. For purposes of State Finance Law §179-t, "Unusual Circumstances" shall not mean the failure by the State to (i) plan for implementation of a program, (ii) assign sufficient staff resources to implement a program, (iii) establish a schedule for the implementation of a program or (iv) anticipate any other reasonably foreseeable circumstance.

b) Notification to the not-for-profit Contractor of the State's intent to not renew the Master Contract must be in writing in the form of a letter, with the reason(s) for the non-renewal included. If the State does not provide notice to the not-for-profit Contractor of its intent not to renew the Master Contract as required in this Section and State Finance Law §179-t, the Master Contract shall be deemed continued until the date the State provides the necessary notice to the Contractor, in accordance with State Finance Law §179-t. Expenses incurred by the not-for-profit Contractor during such extension shall be reimbursable under the terms of the Master Contract.

C. Termination:

1. *Grounds*:

a) Mutual Consent: The Master Contract may be terminated at any time upon mutual written consent of the State and the Contractor.

b) Cause: The State may terminate the Master Contract immediately, upon written notice of termination to the Contractor, if the Contractor fails to comply with any of the terms and conditions of the Master Contract and/or with any laws, rules, regulations, policies, or procedures that are applicable to the Master Contract.

c) Non-Responsibility: In accordance with the provisions of Sections IV(N)(6) and (7) herein, the State may make a final determination that the Contractor is non-responsible (Determination of Non-Responsibility). In such event, the State may terminate the Master Contract at the Contractor's expense, complete the contractual requirements in any manner the State deems advisable and pursue available legal or equitable remedies for breach.

d) Convenience: The State may terminate the Master Contract in its sole discretion upon thirty (30) calendar days prior written notice.

e) Lack of Funds: If for any reason the State or the Federal government terminates or reduces its appropriation to the applicable State Agency entering into the Master Contract or fails to pay the full amount of the allocation for the operation of one or more programs funded under this Master Contract, the Master Contract may be terminated or reduced at the State Agency's discretion, provided that no such reduction or termination shall apply to allowable costs already incurred by the Contractor where funds are available to the State Agency for payment of such costs. Upon termination or reduction of the Master Contract, all remaining funds paid to the Contractor that are not subject to allowable costs already incurred by the Contractor shall be returned to the State Agency. In any event, no liability shall be incurred by the State (including the State Agency) beyond monies available for the purposes of the Master Contract. The Contractor acknowledges that any funds due to the State Agency or the State of New York because of disallowed expenditures after audit shall be the Contractor's responsibility.

f) Force Majeure: The State may terminate or suspend its performance under the Master Contract immediately upon the occurrence of a "force majeure." For purposes of the Master Contract, "Force majeure" shall include, but not be limited to, natural disasters, war, rebellion, insurrection, riot, strikes, lockout and any unforeseen circumstances and acts beyond the control of the State which render the performance of its obligations impossible.

2. *Notice of Termination*:

a) Service of notice: Written notice of termination shall be sent by:

(i) personal messenger service; or

(ii) certified mail, return receipt requested and first class mail.

b) Effective date of termination: The effective date of the termination shall be the later of (i) the date indicated in the notice and (ii) the date the notice is received by the Contractor, and shall be established as follows:

(i) if the notice is delivered by hand, the date of receipt shall be established by the receipt given to the Contractor or by affidavit of the individual making such hand delivery attesting to the date of delivery; or

(ii) if the notice is delivered by registered or certified mail, by the receipt returned from the United States Postal Service, or if no receipt is returned, five (5) business days from the date of mailing of the first class letter, postage prepaid, in a depository under the care and control of the United States Postal Service.

3. ***Effect of Notice and Termination on State's Payment Obligations*:**

a) Upon receipt of notice of termination, the Contractor agrees to cancel, prior to the effective date of any prospective termination, as many outstanding obligations as possible, and agrees not to incur any new obligations after receipt of the notice without approval by the State.

b) The State shall be responsible for payment on claims for services or work provided and costs incurred pursuant to the terms of the Master Contract. In no event shall the State be liable for expenses and obligations arising from the requirements of the Master Contract after its termination date.

4. *Effect of Termination Based on Misuse or Conversion of State or Federal Property*:

Where the Master Contract is terminated for cause based on Contractor's failure to use some or all of the real property or equipment purchased pursuant to the Master Contract for the purposes set forth herein, the State may, at its option, require:

a) the repayment to the State of any monies previously paid to the Contractor; or

b) the return of any real property or equipment purchased under the terms of the Master Contract; or

c) an appropriate combination of clauses (a) and (b) of Section II(C)(4) herein.

Nothing herein shall be intended to limit the State's ability to pursue such other legal or equitable remedies as may be available.

D. Suspension: The State may, in its discretion, order the Contractor to suspend performance for a reasonable period of time. In the event of such suspension, the Contractor shall be given a formal written notice outlining the particulars of such suspension. Upon issuance of such notice, the Contractor shall comply with the particulars of the notice. The State shall have no obligation to reimburse Contractor's expenses during such suspension period. Activities may resume at such time

as the State issues a formal written notice authorizing a resumption of performance under the Master Contract.

III. PAYMENT AND REPORTING

A. Terms and Conditions:

1. In full consideration of contract services to be performed, the State Agency agrees to pay and the Contractor agrees to accept a sum not to exceed the amount noted on the Face Page.

2. The State has no obligation to make payment until all required approvals, including the approval of the AG and OSC, if required, have been obtained. Contractor obligations or expenditures that precede the start date of the Master Contract shall not be reimbursed.

3. Contractor must provide complete and accurate billing invoices to the State in order to receive payment. Provided, however, the State may, at its discretion, automatically generate a voucher in accordance with an approved contract payment schedule. Billing invoices submitted to the State must contain all information and supporting documentation required by Attachment D (Payment and Reporting Schedule) and Section III(C) herein. The State may require the Contractor to submit billing invoices electronically.

4. Payment for invoices submitted by the Contractor shall only be rendered electronically unless payment by paper check is expressly authorized by the head of the State Agency, in the sole discretion of the head of such State Agency, due to extenuating circumstances. Such electronic payment shall be made in accordance with OSC's procedures and practices to authorize electronic payments.

5. If travel expenses are an approved expenditure under the Master Contract, travel expenses shall be reimbursed at the lesser of the rates set forth in the written standard travel policy of the Contractor, the OSC guidelines, or United States General Services Administration rates. No out-of-state travel costs shall be permitted unless specifically detailed and pre-approved by the State.

6. Timeliness of advance payments or other claims for reimbursement, and any interest to be paid to Contractor for late payment, shall be governed by Article 11-A of the State Finance Law to the extent required by law.

7. Article 11-B of the State Finance Law sets forth certain time frames for the Full Execution of contracts or renewal contracts with not-for-profit organizations and the implementation of any program plan associated with such contract. For purposes of this section, “Full Execution” shall mean that the contract has been signed by all parties thereto and has obtained the approval of the AG and OSC. Any interest to be paid on a missed payment to the Contractor based on a delay in the Full Execution of the Master Contract shall be governed by Article 11-B of the State Finance Law.

B. Advance Payment and Recoupment:

1. Advance payments, which the State in its sole discretion may make to not-for-profit grant recipients, shall be made and recouped in accordance with State Finance Law Section 179(u), this Section and the provisions of Attachment D (Payment and Reporting Schedule).

2. Advance payments made by the State to not-for-profit grant recipients shall be due no later than thirty (30) calendar days, excluding legal holidays, after the first day of the Contract Term or, if renewed, in the period identified on the Face Page.

3. For subsequent contract years in multi-year contracts, Contractor will be notified of the scheduled advance payments for the upcoming contract year no later than 90 days prior to the commencement of the contract year. For simplified renewals, the payment schedule (Attachment D) will be modified as part of the renewal process.

4. Recoupment of any advance payment(s) shall be recovered by crediting the percentage of subsequent claims listed in Attachment D (Payment and Reporting Schedule) and Section III(C) herein and such claims shall be reduced until the advance is fully recovered within the Contract Term. Any unexpended advance balance at the end of the Contract Term shall be refunded by the Contractor to the State.

5. If for any reason the amount of any claim is not sufficient to cover the proportionate advance amount to be recovered, then subsequent claims may be reduced until the advance is fully recovered.

C. Claims for Reimbursement:

1. The Contractor shall submit claims for the reimbursement of expenses incurred on behalf of the State under the Master Contract in accordance with this Section and the applicable claiming schedule in Attachment D (Payment and Reporting Schedule).

Vouchers submitted for payment shall be deemed to be a certification that the payments requested are for project expenditures made in accordance with the items as contained in the applicable Attachment B form (Budget) and during the Contract Term. When submitting a voucher, such voucher shall also be deemed to certify that: (i) the payments requested do not duplicate reimbursement from other sources of funding; and (ii) the funds provided herein do not replace funds that, in the absence of this grant, would have been made available by the Contractor for this program. Requirement (ii) does not apply to grants funded pursuant to a Community Projects Fund appropriation.

2. Consistent with the selected reimbursement claiming schedule in Attachment D (Payment and Reporting Schedule), the Contractor shall comply with the appropriate following provisions:

a) <u>Quarterly Reimbursement:</u> The Contractor shall be entitled to receive payments for work, projects, and services rendered as detailed and described in Attachment C (Work Plan).

The Contractor shall submit to the State Agency quarterly voucher claims and supporting documentation. The Contractor shall submit vouchers to the State Agency in accordance with the procedures set forth in Section III(A)(3) herein.

b) Monthly Reimbursement: The Contractor shall be entitled to receive payments for work, projects, and services rendered as detailed and described in Attachment C (Work Plan).

The Contractor shall submit to the State Agency monthly voucher claims and supporting documentation. The Contractor shall submit vouchers to the State Agency in accordance with the procedures set forth in Section III(A)(3) herein.

c) Biannual Reimbursement: The Contractor shall be entitled to receive payments for work, projects, and services rendered as detailed and described in Attachment C (Work Plan).

The Contractor shall submit to the State Agency biannually voucher claims and supporting documentation. The Contractor shall submit vouchers to the State Agency in accordance with the procedures set forth in Section III(A)(3) herein.

d) Milestone/Performance Reimbursement:[4] Requests for payment based upon an event or milestone may be either severable or cumulative. A severable event/milestone is independent of accomplishment of any other event. If the event is cumulative, the successful completion of an event or milestone is dependent on the previous completion of another event.

Milestone payments shall be made to the Contractor when requested in a form approved by the State, and at frequencies and in amounts stated in Attachment D (Payment and Reporting Schedule). The State Agency shall make milestone payments subject to the Contractor's satisfactory performance.

e) Fee for Service Reimbursement:[5] Payment shall be limited to only those fees specifically agreed upon in the Master Contract and shall be payable no more frequently than monthly upon submission of a voucher by the contractor.

f) Rate Based Reimbursement:[6] Payment shall be limited to rate(s) established in the Master Contract. Payment may be requested no more frequently than monthly.

g) Scheduled Reimbursement:[7] The State Agency shall generate vouchers at the frequencies and amounts as set forth in Attachment D (Payment and Reporting Schedule),

[4] A milestone/ performance payment schedule identifies mutually agreed-to payment amounts based on meeting contract events or milestones. Events or milestones must represent integral and meaningful aspects of contract performance and should signify true progress in completing the Master Contract effort.
[5] Fee for Service is a rate established by the Contractor for a service or services rendered.
[6] Rate based agreements are those agreements in which payment is premised upon a specific established rate per unit.
[7] Scheduled Reimbursement agreements provide for payments that occur at defined and regular intervals that provide for a specified dollar amount to be paid to the Contractor at the beginning of each payment period (i.e. quarterly, monthly or bi-annually). While these payments are related to the particular services and outcomes defined in the Master Contract, they are not dependent upon particular services or expenses in any one payment period and provide the Contractor with a defined and regular payment over the life of the contract.

and service reports shall be used to determine funding levels appropriate to the next annual contract period.

h) Fifth Quarter Payments:[8] Fifth quarter payment shall be paid to the Contractor at the conclusion of the final scheduled payment period of the preceding contract period. The State Agency shall use a written directive for fifth quarter financing. The State Agency shall generate a voucher in the fourth quarter of the current contract year to pay the scheduled payment for the next contract year.

3. The Contractor shall also submit supporting fiscal documentation for the expenses claimed.

4. The State reserves the right to withhold up to fifteen percent (15%) of the total amount of the Master Contract as security for the faithful completion of services or work, as applicable, under the Master Contract. This amount may be withheld in whole or in part from any single payment or combination of payments otherwise due under the Master Contract. In the event that such withheld funds are insufficient to satisfy Contractor's obligations to the State, the State may pursue all available remedies, including the right of setoff and recoupment.

5. The State shall not be liable for payments on the Master Contract if it is made pursuant to a Community Projects Fund appropriation if insufficient monies are available pursuant to Section 99-d of the State Finance Law.

6. All vouchers submitted by the Contractor pursuant to the Master Contract shall be submitted to the State Agency no later than thirty (30) calendar days after the end date of the period for which reimbursement is claimed. In no event shall the amount received by the Contractor exceed the budget amount approved by the State Agency, and, if actual expenditures by the Contractor are less than such sum, the amount payable by the State Agency to the Contractor shall not exceed the amount of actual expenditures.

7. All obligations must be incurred prior to the end date of the contract. Notwithstanding the provisions of Section III(C)(6) above, with respect to the final period for which reimbursement is claimed, so long as the obligations were incurred prior to the end date of the contract, the Contractor shall have up to ninety (90) calendar days after the contract end date to make expenditures; provided, however, that if the Master Contract is funded in whole or in part with federal funds, the Contractor shall have up to sixty (60) calendar days after the contract end date to make expenditures.

D. Identifying Information and Privacy Notification:

1. Every voucher or New York State Claim for Payment submitted to a State Agency by the Contractor, for payment for the sale of goods or services or for transactions (e.g., leases, easements, licenses, etc.) related to real or personal property, must include the Contractor's Vendor Identification Number assigned by the Statewide Financial System, and any or all of the following identification numbers: (i) the Contractor's Federal employer identification number, (ii) the Contractor's Federal social security number, and/or (iii) DUNS number. Failure to

[8] Fifth Quarter Payments occurs where there are scheduled payments and where there is an expectation that services will be continued through renewals or subsequent contracts. Fifth Quarter Payments allow for the continuation of scheduled payments to a Contractor for the first payment period quarter of an anticipated renewal or new contract.

include such identification number or numbers may delay payment by the State to the Contractor. Where the Contractor does not have such number or numbers, the Contractor, on its voucher or Claim for Payment, must provide the reason or reasons for why the Contractor does not have such number or numbers.

2. The authority to request the above personal information from a seller of goods or services or a lessor of real or personal property, and the authority to maintain such information, is found in Section 5 of the State Tax Law. Disclosure of this information by the seller or lessor to the State is mandatory. The principle purpose for which the information is collected is to enable the State to identify individuals, businesses and others who have been delinquent in filing tax returns or may have understated their tax liabilities and to generally identify persons affected by the taxes administered by the Commissioner of Taxation and Finance. The information will be used for tax administration purposes and for any other purpose authorized by law. The personal information is requested by the purchasing unit of the State Agency contracting to purchase the goods or services or lease the real or personal property covered by the Master Contract. This information is maintained in the Statewide Financial System by the Vendor Management Unit within the Bureau of State Expenditures, Office of the State Comptroller, 110 State Street, Albany, New York, 12236.

E. Refunds:

1. In the event that the Contractor must make a refund to the State for Master Contract-related activities, including repayment of an advance or an audit disallowance, payment must be made payable as set forth in Attachment A-1 (Program Specific Terms and Conditions). The Contractor must reference the contract number with its payment and include a brief explanation of why the refund is being made. Refund payments must be submitted to the Designated Refund Office at the address specified in Attachment A-1 (Program Specific Terms and Conditions).

2. If at the end or termination of the Master Contract, there remains any unexpended balance of the monies advanced under the Master Contract in the possession of the Contractor, the Contractor shall make payment within forty-five (45) calendar days of the end or termination of the Master Contract. In the event that the Contractor fails to refund such balance the State may pursue all available remedies.

F. Outstanding Amounts Owed to the State: Prior period overpayments (including, but not limited to, contract advances in excess of actual expenditures) and/or audit recoveries associated with the Contractor may be recouped against future payments made under this Master Contract to Contractor. The recoupment generally begins with the first payment made to the Contractor following identification of the overpayment and/or audit recovery amount. In the event that there are no payments to apply recoveries against, the Contractor shall make payment as provided in Section III(E) (Refunds) herein.

G. Program and Fiscal Reporting Requirements:

1. The Contractor shall submit required periodic reports in accordance with the applicable schedule provided in Attachment D (Payment and Reporting Schedule). All required reports or other work products developed pursuant to the Master Contract must be completed as provided by the agreed upon work schedule in a manner satisfactory and acceptable to the State Agency in order for the Contractor to be eligible for payment.

2. Consistent with the selected reporting options in Attachment D (Payment and Reporting Schedule), the Contractor shall comply with the following applicable provisions:

a) If the Expenditure Based Reports option is indicated in Attachment D (Payment and Reporting Schedule), the Contractor shall provide the State Agency with one or more of the following reports as required by the following provisions and Attachment D (Payment and Reporting Schedule) as applicable:

(i) *Narrative/Qualitative Report*: The Contractor shall submit, on a quarterly basis, not later than the time period listed in Attachment D (Payment and Reporting Schedule), a report, in narrative form, summarizing the services rendered during the quarter. This report shall detail how the Contractor has progressed toward attaining the qualitative goals enumerated in Attachment C (Work Plan). This report should address all goals and objectives of the project and include a discussion of problems encountered and steps taken to solve them.

(ii) *Statistical/Quantitative Report*: The Contractor shall submit, on a quarterly basis, not later than the time period listed in Attachment D (Payment and Reporting Schedule), a detailed report analyzing the quantitative aspects of the program plan, as appropriate (e.g., number of meals served, clients transported, patient/client encounters, procedures performed, training sessions conducted, etc.)

(iii) *Expenditure Report*: The Contractor shall submit, on a quarterly basis, not later than the time period listed in Attachment D (Payment and Reporting Schedule), a detailed expenditure report, by object of expense. This report shall accompany the voucher submitted for such period.

(iv) *Final Report*: The Contractor shall submit a final report as required by the Master Contract, not later than the time period listed in Attachment D (Payment and Reporting Schedule) which reports on all aspects of the program and detailing how the use of funds were utilized in achieving the goals set forth in Attachment C (Work Plan).

(v) *Consolidated Fiscal Report* (CFR): The Contractor shall submit a CFR, which includes a year-end cost report and final claim not later than the time period listed in Attachment D (Payment and Reporting Schedule).

b) If the Performance-Based Reports option is indicated in Attachment D (Payment and Reporting Schedule), the Contractor shall provide the State Agency with the following reports as required by the following provisions and Attachment D (Payment and Reporting Schedule) as applicable:

(i) *Progress Report*: The Contractor shall provide the State Agency with a written progress report using the forms and formats as provided by the State Agency, summarizing the work performed during the period. These reports shall detail the Contractor's progress toward attaining the specific goals enumerated in Attachment C (Work Plan). Progress reports shall be submitted in a format prescribed in the Master Contract.

(ii) *Final Progress Report*: Final scheduled payment is due during the time period set forth in Attachment D (Payment and Reporting Schedule). The deadline for submission of the final report shall be the date set forth in Attachment D (Payment and Reporting Schedule). The State Agency shall complete its audit and notify the Contractor of the results no later than the date set forth in Attachment D (Payment and Reporting Schedule). Payment shall be adjusted by the State Agency to reflect only those services/expenditures that were made in accordance with the Master Contract. The Contractor shall submit a detailed comprehensive final progress report not later than the date set forth in Attachment D (Payment and Reporting Schedule), summarizing the work performed during the entire Contract Term (i.e., a cumulative report), in the forms and formats required.

3. In addition to the periodic reports stated above, the Contractor may be required (a) to submit such other reports as are required in Table 1 of Attachment D (Payment and Reporting Schedule), and (b) prior to receipt of final payment under the Master Contract, to submit one or more final reports in accordance with the form, content, and schedule stated in Table 1 of Attachment D (Payment and Reporting Schedule).

H. Notification of Significant Occurrences:

1. If any specific event or conjunction of circumstances threatens the successful completion of this project, in whole or in part, including where relevant, timely completion of milestones or other program requirements, the Contractor agrees to submit to the State Agency within three (3) calendar days of becoming aware of the occurrence or of such problem, a written description thereof together with a recommended solution thereto.

2. The Contractor shall immediately notify in writing the program manager assigned to the Master Contract of any unusual incident, occurrence, or event that involves the staff, volunteers, directors or officers of the Contractor, any subcontractor or program participant funded through the Master Contract, including but not limited to the following: death or serious injury; an arrest or possible criminal activity that could impact the successful completion of this project; any destruction of property; significant damage to the physical plant of the Contractor; or other matters of a similarly serious nature.

IV. ADDITIONAL CONTRACTOR OBLIGATIONS, REPRESENTATIONS AND WARRANTIES

A. Contractor as an Independent Contractor/Employees:

1. The State and the Contractor agree that the Contractor is an independent contractor, and not an employee of the State and may neither hold itself out nor claim to be an officer, employee, or subdivision of the State nor make any claim, demand, or application to or for any right based upon any different status. The Contractor shall be solely responsible for the recruitment, hiring, provision of employment benefits, payment of salaries and management of its project personnel. These functions shall be carried out in accordance with the provisions of the Master Contract, and all applicable Federal and State laws and regulations.

2. The Contractor warrants that it, its staff, and any and all subcontractors have all the necessary licenses, approvals, and certifications currently required by the laws of any applicable local, state, or Federal government to perform the services or work, as applicable, pursuant to the

Master Contract and/or any subcontract entered into under the Master Contract. The Contractor further agrees that such required licenses, approvals, and certificates shall be kept in full force and effect during the term of the Master Contract, or any extension thereof, and to secure any new licenses, approvals, or certificates within the required time frames and/or to require its staff and subcontractors to obtain the requisite licenses, approvals, or certificates. In the event the Contractor, its staff, and/or subcontractors are notified of a denial or revocation of any license, approval, or certification to perform the services or work, as applicable, under the Master Contract, Contractor shall immediately notify the State.

B. Subcontractors:

1. If the Contractor enters into subcontracts for the performance of work pursuant to the Master Contract, the Contractor shall take full responsibility for the acts and omissions of its subcontractors. Nothing in the subcontract shall impair the rights of the State under the Master Contract. No contractual relationship shall be deemed to exist between the subcontractor and the State.

2. The Contractor agrees not to enter into any subcontracts, or revisions to subcontracts, that are in excess of $100,000 for the performance of the obligations contained herein until it has received the prior written permission of the State, which shall have the right to review and approve each and every subcontract in excess of $100,000 prior to giving written permission to the Contractor to enter into the subcontract. All agreements between the Contractor and subcontractors shall be by written contract, signed by individuals authorized to bind the parties. All such subcontracts shall contain provisions for specifying (1) that the work performed by the subcontractor must be in accordance with the terms of the Master Contract, (2) that nothing contained in the subcontract shall impair the rights of the State under the Master Contract, and (3) that nothing contained in the subcontract, nor under the Master Contract, shall be deemed to create any contractual relationship between the subcontractor and the State. In addition, subcontracts shall contain any other provisions which are required to be included in subcontracts pursuant to the terms herein.

3. Prior to executing a subcontract, the Contractor agrees to require the subcontractor to provide to the State the information the State needs to determine whether a proposed subcontractor is a responsible vendor.

4. When a subcontract equals or exceeds $100,000, the subcontractor must submit a Vendor Responsibility Questionnaire (Questionnaire).

5. When a subcontract is executed, the Contractor must provide detailed subcontract information (a copy of subcontract will suffice) to the State within fifteen (15) calendar days after execution. The State may request from the Contractor copies of subcontracts between a subcontractor and its subcontractor.

6. The Contractor shall require any and all subcontractors to submit to the Contractor all financial claims for Services or work to the State agency, as applicable, rendered and required supporting documentation and reports as necessary to permit Contractor to meet claim deadlines and documentation requirements as established in Attachment D (Payment and Reporting Schedule) and Section III. Subcontractors shall be paid by the Contractor on a timely basis after submitting the required reports and vouchers for reimbursement of services or work, as

applicable. Subcontractors shall be informed by the Contractor of the possibility of non-payment or rejection by the Contractor of claims that do not contain the required information, and/or are not received by the Contractor by said due date.

C. Use Of Material, Equipment, Or Personnel:

1. The Contractor shall not use materials, equipment, or personnel paid for under the Master Contract for any activity other than those provided for under the Master Contract, except with the State's prior written permission.

2. Any interest accrued on funds paid to the Contractor by the State shall be deemed to be the property of the State and shall either be credited to the State at the close-out of the Master Contract or, upon the written permission of the State, shall be expended on additional services or work, as applicable, provided for under the Master Contract.

D. Property:

1. Property is real property, equipment, or tangible personal property having a useful life of more than one year and an acquisition cost of $1,000 or more per unit.

a) If an item of Property required by the Contractor is available as surplus to the State, the State at its sole discretion, may arrange to provide such Property to the Contractor in lieu of the purchase of such Property.

b) If the State consents in writing, the Contractor may retain possession of Property owned by the State, as provided herein, after the termination of the Master Contract to use for similar purposes. Otherwise, the Contractor shall return such Property to the State at the Contractor's cost and expense upon the expiration of the Master Contract.

c) In addition, the Contractor agrees to permit the State to inspect the Property and to monitor its use at reasonable intervals during the Contractor's regular business hours.

d) The Contractor shall be responsible for maintaining and repairing Property purchased or procured under the Master Contract at its own cost and expense. The Contractor shall procure and maintain insurance at its own cost and expense in an amount satisfactory to the State Agency, naming the State Agency as an additional insured, covering the loss, theft or destruction of such equipment.

e) A rental charge to the Master Contract for a piece of Property owned by the Contractor shall not be allowed.

f) The State has the right to review and approve in writing any new contract for the purchase of or lease for rental of Property (Purchase/Lease Contract) operated in connection with the provision of the services or work, as applicable, as specified in the Master Contract, if applicable, and any modifications, amendments, or extensions of an existing lease or purchase prior to its execution. If, in its discretion, the State disapproves of any Purchase/Lease Contract, then the State shall not be obligated to make any payments for such Property.

g) No member, officer, director or employee of the Contractor shall retain or acquire any interest, direct or indirect, in any Property, paid for with funds under the Master Contract, nor retain any interest, direct or indirect, in such, without full and complete prior disclosure of such interest and the date of acquisition thereof, in writing to the Contractor and the State.

2. For non-Federally-funded contracts, unless otherwise provided herein, the State shall have the following rights to Property purchased with funds provided under the Master Contract:

a) For cost-reimbursable contracts, all right, title and interest in such Property shall belong to the State.

b) For performance-based contracts, all right, title and interest in such Property shall belong to the Contractor.

3. For Federally funded contracts, title to Property whose requisition cost is borne in whole or in part by monies provided under the Master Contract shall be governed by the terms and conditions of Attachment A-2 (Federally Funded Grants).

4. Upon written direction by the State, the Contractor shall maintain an inventory of all Property that is owned by the State as provided herein.

5. The Contractor shall execute any documents which the State may reasonably require to effectuate the provisions of this section.

E. Records and Audits:

1. *General*:

a) The Contractor shall establish and maintain, in paper or electronic format, complete and accurate books, records, documents, receipts, accounts, and other evidence directly pertinent to its performance under the Master Contract (collectively, Records).

b) The Contractor agrees to produce and retain for the balance of the term of the Master Contract, and for a period of six years from the later of the date of (i) the Master Contract and (ii) the most recent renewal of the Master Contract, any and all Records necessary to substantiate upon audit, the proper deposit and expenditure of funds received under the Master Contract. Such Records may include, but not be limited to, original books of entry (e.g., cash disbursements and cash receipts journal), and the following specific records (as applicable) to substantiate the types of expenditures noted:

(i) personal service expenditures: cancelled checks and the related bank statements, time and attendance records, payroll journals, cash and check disbursement records including copies of money orders and the like, vouchers and invoices, records of contract labor, any and all records listing payroll and the money value of non-cash advantages provided to employees, time cards, work schedules and logs, employee personal history folders, detailed and general ledgers, sales records, miscellaneous reports and returns (tax and otherwise), and cost allocation plans, if applicable.

(ii) payroll taxes and fringe benefits: cancelled checks, copies of related bank statements, cash and check disbursement records including copies of money orders and the like, invoices for fringe benefit expenses, miscellaneous reports and returns (tax and otherwise), and cost allocation plans, if applicable.

(iii) non-personal services expenditures: original invoices/receipts, cancelled checks and related bank statements, consultant agreements, leases, and cost allocation plans, if applicable.

(iv) receipt and deposit of advance and reimbursements: itemized bank stamped deposit slips, and a copy of the related bank statements.

c) The OSC, AG and any other person or entity authorized to conduct an examination, as well as the State Agency or State Agencies involved in the Master Contract that provided funding, shall have access to the Records during the hours of 9:00 a.m. until 5:00 p.m., Monday through Friday (excluding State recognized holidays), at an office of the Contractor within the State of New York or, if no such office is available, at a mutually agreeable and reasonable venue within the State, for the term specified above for the purposes of inspection, auditing and copying.

d) The State shall protect from public disclosure any of the Records which are exempt from disclosure under Section 87 of the Public Officers Law provided that: (i) the Contractor shall timely inform an appropriate State official, in writing, that said records should not be disclosed; and (ii) said records shall be sufficiently identified; and (iii) designation of said records, as exempt under Section 87 of the Public Officers Law, is reasonable.

e) Nothing contained herein shall diminish, or in any way adversely affect, the State's rights in connection with its audit and investigatory authority or the State's rights in connection with discovery in any pending or future litigation.

2. *Cost Allocation*:

a) For non-performance based contracts, the proper allocation of the Contractor's costs must be made according to a cost allocation plan that meets the requirements of OMB Circulars A-87, A-122, and/or A-21. Methods used to determine and assign costs shall conform to generally accepted accounting practices and shall be consistent with the method(s) used by the Contractor to determine costs for other operations or programs. Such accounting standards and practices shall be subject to approval of the State.

b) For performance based milestone contracts, or for the portion of the contract amount paid on a performance basis, the Contractor shall maintain documentation demonstrating that milestones were attained.

3. *Federal Funds*: For records and audit provisions governing Federal funds, please see Attachment A-2 (Federally Funded Grants).

F. Confidentiality: The Contractor agrees that it shall use and maintain information relating to individuals who may receive services, and their families pursuant to the Master Contract, or any other information, data or records deemed confidential by the State (Confidential Information) only

for the limited purposes of the Master Contract and in conformity with applicable provisions of State and Federal law. The Contractor (i) has an affirmative obligation to safeguard any such Confidential Information from unnecessary or unauthorized disclosure and (ii) must comply with the provisions of the New York State Information Security Breach and Notification Act (General Business Law Section 899-aa; State Technology Law Section 208).

G. Publicity:

1. Publicity includes, but is not limited to: news conferences; news releases; public announcements; advertising; brochures; reports; discussions or presentations at conferences or meetings; and/or the inclusion of State materials, the State's name or other such references to the State in any document or forum. Publicity regarding this project may not be released without prior written approval from the State.

2. Any publications, presentations or announcements of conferences, meetings or trainings which are funded in whole or in part through any activity supported under the Master Contract may not be published, presented or announced without prior approval of the State. Any such publication, presentation or announcement shall:

a) Acknowledge the support of the State of New York and, if funded with Federal funds, the applicable Federal funding agency; and

b) State that the opinions, results, findings and/or interpretations of data contained therein are the responsibility of the Contractor and do not necessarily represent the opinions, interpretations or policy of the State or if funded with Federal funds, the applicable Federal funding agency.

3. Notwithstanding the above, the Contractor may submit for publication, scholarly or academic publications that derive from activity under the Master Contract (but are not deliverable under the Master Contract), provided that the Contractor first submits such manuscripts to the State forty-five (45) calendar days prior to submission for consideration by a publisher in order for the State to review the manuscript for compliance with confidentiality requirements and restrictions and to make such other comments as the State deems appropriate. All derivative publications shall follow the same acknowledgments and disclaimer as described in Section V(G)(2) (Publicity) hereof.

H. Web-Based Applications-Accessibility: Any web-based intranet and Internet information and applications development, or programming delivered pursuant to the Master Contract or procurement shall comply with New York State Enterprise IT Policy NYS-P08-005, Accessibility Web-Based Information and Applications, and New York State Enterprise IT Standard NYS-S08-005, Accessibility of Web-Based Information Applications, as such policy or standard may be amended, modified or superseded, which requires that State Agency web-based intranet and Internet information and applications are accessible to person with disabilities. Web content must conform to New York State Enterprise IT Standards NYS-S08-005, as determined by quality assurance testing. Such quality assurance testing shall be conducted by the State Agency and the results of such testing must be satisfactory to the State Agency before web content shall be considered a qualified deliverable under the Master Contract or procurement.

I. Non-Discrimination Requirements: Pursuant to Article 15 of the Executive Law (also known as the Human Rights Law) and all other State and Federal statutory and constitutional non-discrimination provisions, the Contractor and sub-contractors will not discriminate against any employee or applicant for employment because of race, creed (religion), color, sex (including gender expression), national origin, sexual orientation, military status, age, disability, predisposing genetic characteristic, marital status or domestic violence victim status, and shall also follow the requirements of the Human Rights Law with regard to non-discrimination on the basis of prior criminal conviction and prior arrest. Furthermore, in accordance with Section 220-e of the Labor Law, if this is a contract for the construction, alteration or repair of any public building or public work or for the manufacture, sale or distribution of materials, equipment or supplies, and to the extent that the Master Contract shall be performed within the State of New York, the Contractor agrees that neither it nor its subcontractors shall, by reason of race, creed, color, disability, sex, or national origin: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under the Master Contract. If this is a building service contract as defined in Section 230 of the Labor Law, then, in accordance with Section 239 thereof, the Contractor agrees that neither it nor its subcontractors shall by reason of race, creed, color, national origin, age, sex or disability: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under the Master Contract. The Contractor shall be subject to fines of $50.00 per person per day for any violation of Section 220-e or Section 239 of the Labor Law.

J. Equal Opportunities for Minorities and Women; Minority and Women Owned Business Enterprises: In accordance with Section 312 of the Executive Law and 5 NYCRR 143, if the Master Contract is: (i) a written agreement or purchase order instrument, providing for a total expenditure in excess of $25,000.00, whereby a contracting State Agency is committed to expend or does expend funds in return for labor, services, supplies, equipment, materials or any combination of the foregoing, to be performed for, or rendered or furnished to the contracting State Agency; or (ii) a written agreement in excess of $100,000.00 whereby a contracting State Agency is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon; or (iii) a written agreement in excess of $100,000.00 whereby the owner of a State assisted housing project is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon for such project, then the Contractor certifies and affirms that (i) it is subject to Article 15-A of the Executive Law which includes, but is not limited to, those provisions concerning the maximizing of opportunities for the participation of minority and women-owned business enterprises and (ii) the following provisions shall apply and it is Contractor's equal employment opportunity policy that:

1. The Contractor shall not discriminate against employees or applicants for employment because of race, creed, color, national origin, sex, age, disability or marital status;

2. The Contractor shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its work force on State contracts;

3. The Contractor shall undertake or continue existing programs of affirmative action to ensure that minority group members and women are afforded equal employment opportunities without discrimination. Affirmative action shall mean recruitment, employment, job assignment,

promotion, upgrading, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation;

4. At the request of the State, the Contractor shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union or representative shall not discriminate on the basis of race, creed, color, national origin, sex, age, disability or marital status and that such union or representative shall affirmatively cooperate in the implementation of the Contractor's obligations herein; and

5. The Contractor shall state, in all solicitations or advertisements for employees, that, in the performance of the State contract, all qualified applicants shall be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status.

The Contractor shall include the provisions of subclauses 1 – 5 of this Section (IV)(J), in every subcontract over $25,000.00 for the construction, demolition, replacement, major repair, renovation, planning or design of real property and improvements thereon (Work) except where the Work is for the beneficial use of the Contractor. Section 312 of the Executive Law does not apply to: (i) work, goods or services unrelated to the Master Contract; or (ii) employment outside New York State. The State shall consider compliance by the Contractor or a subcontractor with the requirements of any Federal law concerning equal employment opportunity which effectuates the purpose of this section. The State shall determine whether the imposition of the requirements of the provisions hereof duplicate or conflict with any such Federal law and if such duplication or conflict exists, the State shall waive the applicability of Section 312 of the Executive Law to the extent of such duplication or conflict. The Contractor shall comply with all duly promulgated and lawful rules and regulations of the Department of Economic Development's Division of Minority and Women's Business Development pertaining hereto.

K. Omnibus Procurement Act of 1992: It is the policy of New York State to maximize opportunities for the participation of New York State business enterprises, including minority and women-owned business enterprises, as bidders, subcontractors and suppliers on its procurement contracts.

1. If the total dollar amount of the Master Contract is greater than $1 million, the Omnibus Procurement Act of 1992 requires that by signing the Master Contract, the Contractor certifies the following:

a) The Contractor has made reasonable efforts to encourage the participation of State business enterprises as suppliers and subcontractors, including certified minority and women-owned business enterprises, on this project, and has retained the documentation of these efforts to be provided upon request to the State;

b) The Contractor has complied with the Federal Equal Opportunity Act of 1972 (P.L. 92-261), as amended;

c) The Contractor agrees to make reasonable efforts to provide notification to State residents of employment opportunities on this project through listing any such positions with the Job Service Division of the New York State Department of Labor, or providing such notification

in such manner as is consistent with existing collective bargaining contracts or agreements. The Contractor agrees to document these efforts and to provide said documentation to the State upon request; and

d) The Contractor acknowledges notice that the State may seek to obtain offset credits from foreign countries as a result of the Master Contract and agrees to cooperate with the State in these efforts.

L. Workers' Compensation Benefits:

1. In accordance with Section 142 of the State Finance Law, the Master Contract shall be void and of no force and effect unless the Contractor shall provide and maintain coverage during the life of the Master Contract for the benefit of such employees as are required to be covered by the provisions of the Workers' Compensation Law.

2. If a Contractor believes they are exempt from the Workers Compensation insurance requirement they must apply for an exemption.

M. Unemployment Insurance Compliance: The Contractor shall remain current in both its quarterly reporting and payment of contributions or payments in lieu of contributions, as applicable, to the State Unemployment Insurance system as a condition of maintaining this grant.

The Contractor hereby authorizes the State Department of Labor to disclose to the State Agency staff only such information as is necessary to determine the Contractor's compliance with the State Unemployment Insurance Law. This includes, but is not limited to, the following:

1. any records of unemployment insurance (UI) contributions, interest, and/or penalty payment arrears or reporting delinquency;

2. any debts owed for UI contributions, interest, and/or penalties;

3. the history and results of any audit or investigation; and

4. copies of wage reporting information.

Such disclosures are protected under Section 537 of the State Labor Law, which makes it a misdemeanor for the recipient of such information to use or disclose the information for any purpose other than the performing due diligence as a part of the approval process for the Master Contract.

N. Vendor Responsibility:

1. If a Contractor is required to complete a Questionnaire, the Contractor covenants and represents that it has, to the best of its knowledge, truthfully, accurately and thoroughly completed such Questionnaire. Although electronic filing is preferred, the Contractor may obtain a paper form from the OSC prior to execution of the Master Contract. The Contractor further covenants and represents that as of the date of execution of the Master Contract, there are no material events, omissions, changes or corrections to such document requiring an amendment to the Questionnaire.

2. The Contractor shall provide to the State updates to the Questionnaire if any material event(s) occurs requiring an amendment or as new information material to such Questionnaire becomes available.

3. The Contractor shall, in addition, promptly report to the State the initiation of any investigation or audit by a governmental entity with enforcement authority with respect to any alleged violation of Federal or state law by the Contractor, its employees, its officers and/or directors in connection with matters involving, relating to or arising out of the Contractor's business. Such report shall be made within five (5) business days following the Contractor becoming aware of such event, investigation, or audit. Such report may be considered by the State in making a Determination of Vendor Non-Responsibility pursuant to this section.

4. The State reserves the right, in its sole discretion, at any time during the term of the Master Contract:

a) to require updates or clarifications to the Questionnaire upon written request;

b) to inquire about information included in or required information omitted from the Questionnaire;

c) to require the Contractor to provide such information to the State within a reasonable timeframe; and

d) to require as a condition precedent to entering into the Master Contract that the Contractor agree to such additional conditions as shall be necessary to satisfy the State that the Contractor is, and shall remain, a responsible vendor; and

e) to require the Contractor to present evidence of its continuing legal authority to do business in New York State, integrity, experience, ability, prior performance, and organizational and financial capacity. By signing the Master Contract, the Contractor agrees to comply with any such additional conditions that have been made a part of the Master Contract.

5. The State, in its sole discretion, reserves the right to suspend any or all activities under the Master Contract, at any time, when it discovers information that calls into question the responsibility of the Contractor. In the event of such suspension, the Contractor shall be given written notice outlining the particulars of such suspension. Upon issuance of such notice, the Contractor must comply with the terms of the suspension order. Contract activity may resume at such time as the State issues a written notice authorizing a resumption of performance under the Master Contract.

6. The State, in its sole discretion, reserves the right to make a final Determination of Non-Responsibility at any time during the term of the Master Contract based on:

a) any information provided in the Questionnaire and/or in any updates, clarifications or amendments thereof; or

b) the State's discovery of any material information which pertains to the Contractor's responsibility.

7. Prior to making a final Determination of Non-Responsibility, the State shall provide written notice to the Contractor that it has made a preliminary determination of non- responsibility. The State shall detail the reason(s) for the preliminary determination, and shall provide the Contractor with an opportunity to be heard.

O. Charities Registration: If applicable, the Contractor agrees to (i) obtain not-for-profit status, a Federal identification number, and a charitable registration number (or a declaration of exemption) and to furnish the State Agency with this information as soon as it is available, (ii) be in compliance with the OAG charities registration requirements at the time of the awarding of this Master Contract by the State and (iii) remain in compliance with the OAG charities registration requirements throughout the term of the Master Contract.

P. Consultant Disclosure Law:[9] If this is a contract for consulting services, defined for purposes of this requirement to include analysis, evaluation, research, training, data processing, computer programming, engineering, environmental, health, and mental health services, accounting, auditing, paralegal, legal, or similar services, then in accordance with Section 163 (4-g) of the State Finance Law (as amended by Chapter 10 of the Laws of 2006), the Contractor shall timely, accurately and properly comply with the requirement to submit an annual employment report for the contract to the agency that awarded the contract, the Department of Civil Service and the State Comptroller.

Q. Wage and Hours Provisions: If this is a public work contract covered by Article 8 of the Labor Law or a building service contract covered by Article 9 thereof, neither Contractor's employees nor the employees of its subcontractors may be required or permitted to work more than the number of hours or days stated in said statutes, except as otherwise provided in the Labor Law and as set forth in prevailing wage and supplement schedules issued by the State Labor Department. Furthermore, Contractor and its subcontractors must pay at least the prevailing wage rate and pay or provide the prevailing supplements, including the premium rates for overtime pay, as determined by the State Labor Department in accordance with the Labor Law. Additionally, effective April 28, 2008, if this is a public work contract covered by Article 8 of the Labor Law, the Contractor understands and agrees that the filing of payrolls in a manner consistent with Subdivision 3-a of Section 220 of the Labor Law shall be condition precedent to payment by the State of any State approved sums due and owing for work done upon the project.

[9] Not applicable to not-for-profit entities.

ATTACHMENT A-1
AGENCY AND PROGRAM SPECIFIC CLAUSES
Part A. Agency Specific Clauses

The parties to the attached contract, license, lease, amendment or other agreement of any kind (hereinafter, "the contract" or "this contract") agree to be bound by the following clauses which are hereby made a part of the contract (the word "Contractor" herein refers to any party other than the State, whether a contractor, licenser, licensee, lessor, lessee or any other party):

A. International Boycott Prohibition: In accordance with Section 220-f of the Labor Law and Section 139-h of the State Finance Law, if this contract exceeds $5,000, the Contractor agrees, as a material condition of the contract, that neither the Contractor nor any substantially owned or affiliated person, firm, partnership or corporation has participated, is participating, or shall participate in an international boycott in violation of the federal Export Administration Act of 1979 (50 USC App. Sections 2401 et seq.) or regulations thereunder. If such Contractor, or any of the aforesaid affiliates of Contractor, is convicted or is otherwise found to have violated said laws or regulations upon the final determination of the United States Commerce Department or any other appropriate agency of the United States subsequent to the contract's execution, such contract, amendment or modification thereto shall be rendered forfeit and void. The Contractor shall so notify the State Comptroller within five (5) business days of such conviction, determination or disposition of appeal (2NYCRR 105.4).

B. Prohibition on Purchase of Tropical Hardwoods:

1. The Contractor certifies and warrants that all wood products to be used under this contract award will be in accordance with, but not limited to, the specifications and provisions of Section 165 of the State Finance Law, (Use of Tropical Hardwoods) which prohibits purchase and use of tropical hardwoods, unless specifically exempted, by the State or any governmental agency or political subdivision or public benefit corporation. Qualification for an exemption under this law will be the responsibility of the contractor to establish to meet with the approval of the State.

2. In addition, when any portion of this contract involving the use of woods, whether supply or installation, is to be performed by any subcontractor, the prime Contractor will indicate and certify in the submitted bid proposal that the subcontractor has been informed and is in compliance with specifications and provisions regarding use of tropical hardwoods as detailed in §165 State Finance Law. Any such use must meet with the approval of the State; otherwise, the bid may not be considered responsive. Under bidder certifications, proof of qualification for exemption will be the responsibility of the Contractor to meet with the approval of the State.

C. MacBride Fair Employment Principles: In accordance with the MacBride Fair Employment Principles (Chapter 807 of the Laws of 1992), the Contractor hereby stipulates that the Contractor either (a) has no business operations in Northern Ireland, or (b) shall take lawful steps in good faith to conduct any business operations in Northern Ireland in accordance with the

MacBride Fair Employment Principles (as described in Section 165 of the New York State Finance Law), and shall permit independent monitoring of compliance with such principles.

D. Omnibus Procurement Act of 1992: It is the policy of New York State to maximize opportunities for the participation of New York State business enterprises, including minority and women-owned business enterprises as bidders, subcontractors and suppliers on its procurement contracts.

Information on the availability of New York State subcontractors and suppliers is available from:

NYS Department of Economic Development
Division for Small Business
Albany, New York 12245
Telephone: 518-292-5100
Fax: 518-292-5884
email: opa@esd.ny.gov

A directory of certified minority and women-owned business enterprises is available from:

NYS Department of Economic Development
Division of Minority and Women's Business Development

633 Third Avenue
New York, NY 10017
212-803-2414
email: mwbecertification@esd.ny.gov
http://esd.ny.gov/MWBE/directorySearch.html

E. Procurement Lobbying: To the extent this agreement is a "procurement contract" as defined by State Finance Law Sections 139-j and 139-k, by signing this agreement the contractor certifies and affirms that all disclosures made in accordance with State Finance Law Sections 139-j and 139-k are complete, true and accurate. In the event such certification is found to be intentionally false or intentionally incomplete, the State may terminate the agreement by providing written notification to the Contractor in accordance with the terms of the agreement.

F. Certification of Registration to Collect Sales and Compensating Use Tax by Certain State Contractors, Affiliates, and Subcontractors: To the extent this agreement is a contract as defined by Tax Law Section 5-a, if the contractor fails to make the certification required by Tax Law Section 5-a or if during the term of the contract, the Department of Taxation and Finance or the covered agency, as defined by Tax Law 5-a, discovers that the certification, made under penalty of perjury, is false, then such failure to file or false certification shall be a material breach of this contract and this contract may be terminated, by providing written notification to the Contractor in accordance with the terms of the agreement, if the covered agency determines that such action is in the best interest of the State.

G. The CONTRACTOR certifies that all revenue earned during the budget period as a result of services and related activities performed pursuant to this contract shall be used either to expand those program services funded by this AGREEMENT or to offset expenditures submitted to the STATE for reimbursement.

H. Administrative Rules and Audits:

1. If this contract is funded in whole or in part from federal funds, the CONTRACTOR shall comply with the following federal grant requirements regarding administration and allowable costs:

a) For a local or Indian tribal government, use the principles in the common rule, "Uniform Administrative Requirements for Grants and Cooperative Agreements to State and Local Governments," and Office of Management and Budget (OMB) Circular A-87, "Cost Principles for State, Local and Indian Tribal Governments".

b) For a nonprofit organization other than
   (i) an institution of higher education,
   (ii) a hospital, or
   (iii) an organization named in OMB Circular A-122, “Cost Principles for Non-profit Organizations”, as not subject to that circular,

use the principles in OMB Circular A-110, "Uniform Administrative Requirements for Grants and Agreements with Institutions of Higher Education, Hospitals and Other Non-profit Organizations," and OMB Circular A-122.

c) For an Educational Institution, use the principles in OMB Circular A-110 and OMB Circular A-21, "Cost Principles for Educational Institutions".

d) For a hospital, use the principles in OMB Circular A-110, Department of Health and Human Services, 45 CFR 74, Appendix E, "Principles for Determining Costs Applicable to Research and Development Under Grants and Contracts with Hospitals" and, if not covered for audit purposes by OMB Circular A-133, “Audits of States Local Governments and Non-profit Organizations”, then subject to program specific audit requirements following Government Auditing Standards for financial audits.

2. If this contract is funded entirely from STATE funds, and if there are no specific administration and allowable costs requirements applicable, CONTRACTOR shall adhere to the applicable principles in “1” above.

3. The CONTRACTOR shall comply with the following grant requirements regarding audits.

a) If the contract is funded from federal funds, and the CONTRACTOR spends more than $500,000 in federal funds in their fiscal year, an audit report must be submitted in accordance with OMB Circular A-133.

b) If this contract is funded from other than federal funds or if the contract is funded from a combination of STATE and federal funds but federal funds are less than $500,000, and if the CONTRACTOR receives $300,000 or more in total annual payments from the STATE, the CONTRACTOR shall submit to the STATE after the end of the CONTRACTOR's fiscal year an audit report. The audit report shall be submitted to the STATE within thirty days after its completion but no later than nine months after the end of the audit period. The audit report shall summarize the business and financial transactions of the CONTRACTOR. The report shall be prepared and certified by an independent accounting firm or other accounting entity, which is demonstrably independent of the administration of the program being audited. Audits performed of the CONTRACTOR's records shall be conducted in accordance with Government Auditing Standards issued by the Comptroller General of the United States covering financial audits. This audit requirement may be met through entity-wide audits, coincident with the CONTRACTOR's fiscal year, as described in OMB Circular A-133. Reports, disclosures, comments and opinions required under these publications should be so noted in the audit report.

4. For audit reports due on or after April 1, 2003, that are not received by the dates due, the following steps shall be taken:

a) If the audit report is one or more days late, voucher payments shall be held until a compliant audit report is received.

b) If the audit report is 91 or more days late, the STATE shall recover payments for all STATE funded contracts for periods for which compliant audit reports are not received.

c) If the audit report is 180 days or more late, the STATE shall terminate all active contracts, prohibit renewal of those contracts and prohibit the execution of future contracts until all outstanding compliant audit reports have been submitted.

I. The CONTRACTOR shall accept responsibility for compensating the STATE for any exceptions which are revealed on an audit and sustained after completion of the normal audit procedure.

J. The STATE, its employees, representatives and designees, shall have the right at any time during normal business hours to inspect the sites where services are performed and observe the services being performed by the CONTRACTOR. The CONTRACTOR shall render all assistance and cooperation to the STATE in making such inspections. The surveyors shall have the responsibility for determining contract compliance as well as the quality of service being rendered.

K. The CONTRACTOR has an affirmative duty to take prompt, effective, investigative and remedial action where it has actual or constructive notice of discrimination in the terms, conditions or privileges of employment against (including harassment of) any of its employees by any of its other employees, including managerial personnel, based on race, creed, color, sex, national origin, age, disability, sexual orientation or marital status.

L. The CONTRACTOR shall not discriminate on the basis of race, creed, color, sex, national origin, age, disability, sexual orientation or marital status against any person seeking services for which the CONTRACTOR may receive reimbursement or payment under this AGREEMENT

M. The CONTRACTOR shall comply with all applicable federal, State and local civil rights and human rights laws with reference to equal employment opportunities and the provision of services.

N. Unless the CONTRACTOR is a political sub-division of New York State, the CONTRACTOR shall provide proof, completed by the CONTRACTOR's insurance carrier and/or the Workers' Compensation Board, of coverage for:

1. Workers' Compensation, for which one of the following is incorporated into this contract as **Attachment E-1**:

   a) **CE-200 --** Certificate of Attestation For New York Entities With No Employees And Certain Out Of State Entities, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage Is Not Required; OR

   b) **C-105.2** -- Certificate of Workers' Compensation Insurance. PLEASE NOTE: The State Insurance Fund provides its own version of this form, the **U-26.3;** OR

   c) **SI-12** -- Certificate of Workers' Compensation Self-Insurance, OR **GSI-105.2** -- Certificate of Participation in Workers' Compensation Group Self-Insurance

2. Disability Benefits coverage, for which one of the following is incorporated into this contract as **Attachment E-2:**

   a) **CE-200**, Certificate of Attestation For New York Entities With No Employees And Certain Out Of State Entities, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage Is Not Required; OR

   b) **DB-120.1 --** Certificate of Disability Benefits Insurance OR

   c) **DB-155** -- Certificate of Disability Benefits Self-Insurance

O. Contractor shall comply with the provisions of the New York State Information Security Breach and Notification Act (General Business Law Section 899-aa; State Technology Law Section 208). Contractor shall be liable for the costs associated with any breach if caused by Contractor's negligent or willful acts or omissions, or the negligent or willful acts or omissions of Contractor's agents, officers, employees or subcontractors.

P. All products supplied pursuant to this agreement shall meet local, state and federal regulations, guidelines and action levels for lead as they exist at the time of the State's acceptance of this contract.

Q. All bidders/contractors agree that all state funds dispersed under this bid/contract will be bound by the terms, conditions, obligations and regulations promulgated or to be promulgated by the Department in accordance with E.O. 38, signed in 2012, governing restrictions on executive compensation.

R. The CONTRACTOR shall submit to the STATE ***(monthly or quarterly)*** voucher claims and reports of expenditures on such forms and in such detail as the STATE shall require. The CONTRACTOR shall submit vouchers to the State's designated payment office located in the:

<< Insert Address>>

S. If the CONTRACTOR is eligible for an annual cost of living adjustment (COLA), enacted in New York State Law, that is associated with this grant AGREEMENT, payment of such COLA shall be made separate from payments under this AGREEMENT and shall not be applied toward or amend amounts payable under Attachment B of this Agreement.

Before payment of a COLA can be made, the STATE shall notify the CONTRACTOR, in writing, of eligibility for any COLA. The CONTRACTOR shall be required to submit a written certification attesting that all COLA funding will be used to promote the recruitment and retention of staff or respond to other critical non-personal service costs during the State fiscal year for which the cost of living adjustment was allocated, or provide any other such certification as may be required in the enacted legislation authorizing the COLA.

T. Certification Regarding Environmental Tobacco Smoke: Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through State or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to $1000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this AGREEMENT, the CONTRACTOR certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The CONTRACTOR agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

U. Pursuant to the Master Contract's Standard Terms and Conditions, I. (General Provisions); J. (Notices), such notices shall be addressed as follows or to such different addresses as the parties may from time to time designate:

State of New York Department of Health
Name:
Title:
Address:
Telephone Number:
Facsimile Number:
E-Mail Address:

Insert Vendor/Grantee Name Here
Name:
Title:
Address:
Telephone Number:
Facsimile Number:
E-Mail Address:

Part B. Program Specific Clauses

Additional Department of Health program specific clauses follow in Attachment A-1 Part B.

<< **OR** >>

Attachment A-1 Part B intentionally omitted.

ATTACHMENT B-1 - EXPENDITURE BASED BUDGET
SUMMARY

PROJECT NAME: _____

CONTRACTOR SFS PAYEE NAME: _____

CONTRACT PERIOD: From: _____

To: _____

CATEGORY OF EXPENSE	GRANT FUNDS	MATCH FUNDS	MATCH %	OTHER FUNDS	TOTAL
1. Personal Services					
a) Salary					
b) Fringe					
Subtotal					
2. Non Personal Services					
a) Contractual Services					
b) Travel					
c) Equipment					
d) Space/Property & Utilities					
e) Operating Expenses					
f) Other					
Subtotal					
TOTAL					

ATTACHMENT B-1 - EXPENDITURE BASED BUDGET
PERSONAL SERVICES DETAIL

SALARY					
POSITION TITLE	ANNUALIZED SALARY PER POSITION	STANDARD WORK WEEK (HOURS)	PERCENT OF EFFORT FUNDED	NUMBER OF MONTHS FUNDED	TOTAL
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
				Subtotal	
FRINGE - TYPE/DESCRIPTION					
				PERSONAL SERVICES TOTAL	

ATTACHMENT B-1 - EXPENDITURE BASED BUDGET
NON-PERSONAL SERVICES DETAIL

CONTRACTUAL SERVICES - TYPE/DESCRIPTION	TOTAL
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
TOTAL	

TRAVEL - TYPE/DESCRIPTION	TOTAL
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
TOTAL	

EQUIPMENT - TYPE/DESCRIPTION	TOTAL
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
TOTAL	

SPACE/PROPERTY EXPENSES: RENT - TYPE/DESCRIPTION	TOTAL
1.	
2.	
3.	
SPACE/PROPERTY EXPENSES: OWN - TYPE/DESCRIPTION	TOTAL
1.	
2.	
3.	
TYPE/DESCRIPTION OF UTILITY EXPENSES	TOTAL
1.	
2.	
3.	
TOTAL	

OPERATING EXPENSES - TYPE/DESCRIPTION	TOTAL
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
TOTAL	

OTHER - TYPE/DESCRIPTION	TOTAL
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
TOTAL	

ATTACHMENT C – WORK PLAN
SUMMARY

PROJECT NAME: _____

CONTRACTOR SFS PAYEE NAME: _____

CONTRACT PERIOD: From: _____

To: _____

Provide an overview of the project including goals, tasks, desired outcomes and performance measures:

ATTACHMENT C – WORK PLAN
DETAIL

OBJECTIVE	BUDGET CATEGORY/ DELIVERABLE (if applicable)	TASKS	PERFORMANCE MEASURES
1:		a.	i.
			ii.
			iii.
		b.	i.
			ii.
			iii.
		c.	i.
			ii.
			iii.

OBJECTIVE	BUDGET CATEGORY/ DELIVERABLE (if applicable)	TASKS	PERFORMANCE MEASURES
2:		a.	i.
			ii.
			iii.
		b.	i.
			ii.
			iii.
		c.	i.
			ii.
			iii.

ATTACHMENT D
PAYMENT AND REPORTING SCHEDULE

I. PAYMENT PROVISIONS

In full consideration of contract services to be performed the State Agency agrees to pay and the contractor agrees to accept a sum not to exceed the amount noted on the face page hereof. All payments shall be in accordance with the budget contained in the applicable Attachment B form (Budget), which is attached hereto.

A. Advance Payment and Recoupment Language (if applicable):

1. The State agency will make an advance payment to the Contractor, during the initial period, in the amount of _____ percent (__%) the budget as set forth in the most recently approved applicable Attachment B form (Budget).

2. Recoupment of any advance payment(s) shall be recovered by crediting (___%) of subsequent claims and such claims will be reduced until the advance is fully recovered within the contract period.

3. Scheduled advance payments shall be due in accordance with an approved payment schedule as follows:

   Period: _____ Amount: _____ Due Date: _____

   Period: _____ Amount: _____ Due Date: _____

   Period: _____ Amount: _____ Due Date: _____

   Period: _____ Amount: _____ Due Date: _____

B. Interim and/or Final Claims for Reimbursement

Claiming Schedule (*select applicable frequency*):

- ☐ Quarterly Reimbursement
  Due date _____
- ☐ Monthly Reimbursement
  Due date _____
- ☐ Biannual Reimbursement
  Due date _____
- ☐ Fee for Service Reimbursement
  Due date _____

☐ Rate Based Reimbursement
Due date _____

☐ Fifth Quarter Reimbursement
Due date _____

☐ Milestone/Performance Reimbursement
Due date/Frequency _____

☐ Scheduled Reimbursement
Due date/Frequency _____

II. REPORTING PROVISIONS

A. Expenditure-Based Reports (*select the applicable report type*):

☐ Narrative/Qualitative Report

The Contractor will submit, on a quarterly basis, not later than _____ days from the end of the quarter, the report described in Section III(G)(2)(a)(i) of the Master Contract

☐ Statistical/Quantitative Report

The Contractor will submit, on a quarterly basis, not later than ____ days from the end of the quarter, the report described in Section III(G)(2)(a)(ii) of the Master Contract.

☐ Expenditure Report

The Contractor will submit, on a quarterly basis, not later than ____ days after the end date for which reimbursement is being claimed, the report described in Section III(G)(2)(a)(iii) of the Master Contract.

☐ Final Report

The Contractor will submit the final report as described in Section III(G)(2)(a)(iv) of the Master Contract, no later than _____ days after the end of the contract period.

☐ Consolidated Fiscal Report (CFR)[1]

The Contractor will submit the CFR on an annual basis, in accordance with the time frames designated in the CFR manual. For New York City contractors, the due date shall be May 1 of each year; for Upstate and Long Island contractors, the due date shall be November 1 of each year.

[1] The Consolidated Fiscal Reporting System is a standardized electronic reporting method accepted by Office of Alcoholism & Substance Services, Office of Mental Health, Office of Persons with Developmental Disabilities and the State Education Department, consisting of schedules which, in different combinations, capture financial information for budgets, quarterly and/or mid-year claims, an annual cost report, and a final claim. The CFR, which must be submitted annually, is both a year-end cost report and a year-end claiming document.

B. Progress-Based Reports

1. Progress Reports

The Contractor shall provide the report described in Section III(G)(2)(b)(i) of the Master Contract in accordance with the forms and in the format provided by the State Agency, summarizing the work performed during the contract period (see Table 1 below for the annual schedule).

2. Final Progress Report

Final scheduled payment will not be due until ____ days after completion of agency's audit of the final expenditures report/documentation showing total grant expenses submitted by vendor with its final invoice. Deadline for submission of the final report is _____. The agency shall complete its audit and notify vendor of the results no later than _____. The Contractor shall submit the report not later than ____days from the end of the contract.

C. Other Reports

The Contractor shall provide reports in accordance with the form, content and schedule as set forth in Table 1.

TABLE I – REPORTING SCHEDULE

PROGRESS REPORT #	PERIOD COVERED	DUE DATE

VII. ENDNOTES & REFERENCES

[1] Katz, P.R., Karuza, J., Intrator, O., and Mor, V. (2009). Nursing Home Physician Specialists: A Response to the Workforce Crisis in Long-Term Care. *Annals of Internal Medicine,* 150(6).

[2] Harrison, J.P. and Curran, L. (2009). The Hospitalist Model: Does It Enhance Health Care Quality? *Journal of Health Care Finance*.

[3] These guidelines were developed by The Medical Direction and Medical Care Work Group, a group of non-government stakeholders convened by the NYS Department of Health. The Work Group developed the guidelines over the course of a year from June, 2010 to May, 2011, relying heavily on (and in some cases quoting directly from) resources and publications of the American Medical Directors Association (AMDA), including those listed below. The Executive Directors of both AMDA and its New York affiliate, New York Medical Directors Association (NYMDA), were members of the Work Group. Dr. Jacob Dimant was a member of and Dr. Steven Levenson was a special advisor to the Work Group.

American Medical Directors Association (AMDA) (1991, rev. 2002). *Role of the Attending Physician in the Nursing Facility*. Columbia, MD.

American Medical Directors Association (AMDA). *Medical Director Role and Responsibilities: AMDA Core Curriculum*. Columbia, MD.

Dimant, J. (2002). Responsibilities of Attending Physicians in Long-Term Care Facilities. *Journal of the American Medical Directors Association*. 254-258.

Dimant, J. (2003). Roles and Responsibilities of Attending Physicians in Skilled Nursing Facilities. *Journal of the American Medical Directors Association.* 4(4), 231-243.

Levenson, S.A. (2009). The Basis for Improving and Reforming Long-Term Care. Part 1: The Foundation. *Journal of the American Medical Directors Association.* 10, 459-465.

Levenson, S.A. (2009). The Basis for Improving and Reforming Long-Term Care. Part 2: Clinical Problem Solving and Evidence-Based Care. *Journal of the American Medical Directors Association.* 10, 520-529.

Levenson, S.A. (2009). The Basis for Improving and Reforming Long-Term Care. Part 3: Essential Elements for Quality Care. *Journal of the American Medical Directors Association.* 10, 597-606.

Levenson, S.A. (2010). The Basis for Improving and Reforming Long-Term Care. Part 4: Identifying Meaning Improvement Approaches (Segment 1). *Journal of the American Medical Directors Association.* 11, 84-91.

Levenson, S.A. (2010). The Basis for Improving and Reforming Long-Term Care. Part 4: Identifying Meaningful Improvement Approaches (Segment 2). *Journal of the American Medical Directors Association.* 11, 161-170.