
NEW YORK STATE DEPARTMENT OF HEALTH

HEAL NY - PHASE 10

APPLICANTS CONFERENCE

Thursday, April 16, 2009
10:07 a.m.
Empire State Plaza
Meeting Room 6
Albany, New York

PANEL: STEVEN SMITH

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MR. SMITH: Good morning. My name is Steve Smith. And for those I haven't met -- although there's a lot of familiar faces out there -- I'm the director of operations here at the Office of Health Information Technology Transformation, commonly referred to at OHITT.

Before we get started, there are a few people I'd like to introduce who were involved in putting the grant together and that you'll be hearing from. The first is Dr. Pat Hale, who is in our office, as well. She's the deputy director. Keegan Bailey we have armed with the laptop, so if there's any references we need or anything we need to find, he'll be able to find it in a moment's notice.

Tracy Raleigh is here from the Dormitory Authority. As people know,

DASNY is instrumental in securing the funds which brought you all here today, and it is amazing what throwing 60 million dollars out will do to -- to get

people to come to Albany.

Dr. Roberto Martinez is from our office, as well, and is involved in putting things together. And Dr. Foster Gesten from the Office of Health Insurance Program is here and has been very involved from the Health Department's perspective with the patient centered medical home that you'll be hearing more and more about.

The agenda for today. We're going to go over a few ground rules to get things started. We'll then do an overview of the goals and objectives associated with the -- with HEAL 10. We'll talk about allowable costs, because people always want to know what can we spend the money on. The application process is usually a stickler, as well, so we'll spend some time on that. How are you going to make

the decision? What is the awards process going to be? We'll go over that, as well. And then we'll have the infamous and long-lasting question and

answer session, where you'll all get to ask your questions. I'm assuming there are questions. If not, we can just -- you know -- cut that piece off and shut things down at 10:30. There is a job fair going on out in the concourse, so there's that, as well.

So to kick things off. Responses that you received today, information that you got, is considered unofficial. The official way questions will be responded to will be through our question and answer period. The e-mail address is in the RGA, as well as here in your presentation. So we would ask people to submit questions in a formal sort of way. We're starting to assemble questions now. We will be accepting questions through five p.m. on May 11th. And we'll talk a little more about questions a little bit later.

We, as members of the Health Department, are not allowed to -- and -- so don't bother asking us any questions as kind of a sidebar type of thing. All

questions have to be posted in a public sort of way and have to be answered in the same sort of way. So if we're blowing you off, it's just because of that, so don't worry about it.

A transcript of today's conference will be available. We should have that posted on the website in about a week. So if there's something that you missed during the presentation or for people who couldn't make it on short notice, the full transcript of today's presentation, as well as the questions and answers, will be posted on the DOH website, as well as an attendee roster and a copy of the presentation.

And if you didn't already fill it out, we would ask that you fill out the infamous Notice of Appearance. There's some state requirement that says we have to have those, so we're going to get

those.

And with that, we're going to move into the overview and the goals and I'll ask Pat to cover that.

DR. HALE: Let's see if I can handle the technology. I'm so glad everybody's here. This is an exciting time for us, because we've done so much in New York and now we're jumping to the next level.

It was exciting to be actually creating something like this RGA, just talking about direct patient care, bringing caregivers together, coordinating care, all those things that we talk about and having an infrastructure already in New York that we know we can build on to do this.

So that's the goal here, to take the things that we've already started and everybody in this room has been involved in, and build it. If you haven't been involved, there are places and there are people all around you who have. So you don't have to reach seven

people to get to somebody in New York who's involved in these things to move forward.

So -- so this is just an

overview. I mean, the focus and the strategy behind this proposal is coordination of care. It's a continuum of what we've already started in New York, defining it's path, and all of the hard work that you've done with stakeholders and all the other kinds of funding that's gone on in New York to bring it to the next level.

That was our infancy, our childhood, our planning. We're in the implementation stage now. All the way across the state, we've been seeing data exchange where patients have been getting better care and we're bringing this to another level.

So now we're talking about -- you know -- really being able to do coordination of care and looking at patient populations and being able to link those caregivers together and have

a patient say, all my caregivers are sharing my information. It seems like a given, but it's not. Everybody that's been working on this

knows what a struggle that is. So this is to help us do that. It's aligned very carefully with many of the other things that are going on in the state.

In particular, Foster's here to help us answer any questions with the patient centered medical home project. Medicaid has taken a leadership role in trying to promote this. There's others in the state who are working on this, as well. But it's getting the patient centered medical home and primary care to coordinate with all the caregivers and give them the infrastructure to do that, because it's very hard to do when you only have it linked to a paper and fax world or the cellphone world to track things back. So this is to build on that. We already have support structures for that. We have financing structures to help with that, and the

electronic infrastructure, to support that.

And then we're also building on Phase 5. We're building on the

extension of Phase 5 of HEAL in terms of the infrastructure of the SHIN-NY, in terms of statewide services and other things that are going to be built out in this process as this funding moves out.

The funding is actually a total of 100 million. Today we're going to be focusing on 60 million of that. But we want to tell you about the other, as well.

The 60 million of the RGA specifically will be addressing the competitive RGA we will be talking about today. There's another 30 million, though, that is going out as part of this HEAL funding as a single source funding to promote the work that we've already started in building the infrastructure. We've learned a lot over the past few years in

building the infrastructure. There are statewide services under development. There are a bunch of regional health information organizations that have stepped up to the plate to take

leadership roles in these. We need to continue that kind of work. We need to have a connected network that everybody can connect into and have shared technology that is built up of all of the work that everybody does collaboratively to decide how that's rolled out. That work will continue. And 30 million will be going to extend that phase in the statewide services and to building up the SHIN-NY infrastructure.

Another 5 million is going to be going to the collaborative process. The collaborative process, we feel, has been an incredible success. We've had a public/private partnership of members of DOH, working hand-in-hand in workgroups with people from all over the state -- different stakeholders are working on these projects.

Anyone who wanted to can come to the table to develop the recommendations of how we're building this infrastructure. So 5 million is

going to continue to fund that and keep that going.

And then we have to know it works. We have to look at this and evaluate it. And so another 5 million is going to go to that evaluation process that we've looked at before. This time, the 5 million is not being taken out of any RGA funded project. It's directly being funded separately. So when you do your proposal, you don't have to worry about that evaluation money on the side that is what's being done by the state.

You still -- and it's very important -- you really need to look at how much it's going to cost you on your side in terms of data aggregation and personnel to your side of looking and evaluating. So you still need to consider it. You just don't have to

consider it as part of the evaluation that's outside of the project that's done on the state side.

So many of you have seen this

slide before. We're kind of expanding that, adding to it. This is the infrastructure for New York State. This is our statewide infrastructure plan. And it starts out with layers -- three basic layers. The infrastructure layer that allows communication across the state to share data, which is the SHIN-NY. And then the next layer is aggregation and use of that information -- quality measures, sharing data to improve patient care, clinical decision support, and statewide services. All of those will be layered in those two layers. And at the top is reaching out to the end user. This is the clinician. This is the others in patient care. All the stakeholders in patient care who need to be interacting with the system and patients themselves who can interact with the healthcare system and be able to use

information to improve care.

So if you look at what we've done so far in the phases that we've had before in HEAL -- specifically HEAL 5

and 10 -- we've been investing in support of each of those infrastructures.

And HEAL 5 had grants in each of those categories. We're continuing that in HEAL 10 in that this is really working on funding all three of the layers, the 30 million and the collaborative process to build the infrastructure of the SHIN-NY. Also -- we're including some of the collaborative work that will occur for statewide services.

So -- it's like a data stream. we're working on the bottom two layers from the state side to get a collaborative process to build those and have those ready.

And then that top layer that reaches into the second layer is what HEAL 10 is about. It's about us all

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working together to pull together in regions to be able to get the end user the access to information either in electronic health records, a portal, whatever they need to take better care of their patients and be able to interact and share data in the system.

So we're -- the other thing that's great is this is very well aligned with what's going on at the federal level. We're very, very fortunate. Some of it was out of influence and planning, but much of it's out of logical work that everybody has worked on. But we're very, very well aligned with the federal stimulus in that the funding is going to be coming through the state infrastructure that we fulfill.

So Medicaid is part of the Department of Health and we're working

with them. The Medicaid incentives will be coming through the state levels. And so we'll be -- we're working with the Medicaid department to work to make sure

that we align all of that funding with the infrastructure in all of the work we're doing here.

In addition, the ONC funding, that looks toward state or state-designated entities and a lot of other kinds of infrastructures that are collaborative infrastructures that we're also working on through the Governor's office and our office and offices in New York State are well aligned.

And then the Medicare funds are for “meaningful use”. A lot of the work that we're doing is trying to drive towards projects that really show meaningful use. They're doing it. They're not just saying what it should be, but they're looking at it and doing it. And so we see this very,

very carefully aligned.

And if we look, actually, at what meaningful use was in the legislation, it lines up-- it aligns very, very well

with the layers that we have. And that's what's on the right-hand side. Part of it was certified electronic health records with clinical decisions for electronic prescribing, clinical decision support and quality measures -- that's our middle layer -- and then it has to be connected to a meaningful exchange of data for patient care, which is our SHIN-NY level. We're building that and we're continuing to extend that. So we see this as a very good alignment all the way across.

And we feel very fortunate, because all of us working together, we have our hands around both the stimulus and also the state funding and it all can help each other.

The federal money left a lot of gaps though. Less than ten percent of independent physicians can qualify

for Medicaid funding for the upfront cost of their EHR. Whole other populations of caregivers weren't even mentioned and may not even be covered.

So HEAL 10 is a very open architecture. It covers all the caregivers that are really required to take care of patients. We feel that aligns well and helps fill some of those spaces that were left over from the federal funding and then can help us with the whole meaningful use and the infrastructure for support that we'll talk about more, the CHITA infrastructure, to make sure that we're supporting practices, not just today or tomorrow but five years from now or whenever. We're building an infrastructure so that people who are implementing information technology will have an entire infrastructure in the state to make sure that they're moving along and getting what they need, long-term and not just short-term.

So if you look at HEAL 10

specifically, the goal here is to improve coordination and management of care for the full continuum of care for a target patient population. And the

reason we chose a target patient population was to put this in the scope of reality of something you can get your hands around. Some of the diagnoses in those lists are going to be bigger -- a bigger type of project to try and get your hands around. Some of them are smaller. But it varies across the state where everybody is and how they can deal with particular populations and their local infrastructure.

So we have a list of diagnoses that were built off of a number of data sources on whether they are high cost and/or high risk diagnoses within the state. And those are listed in the RGA for you to choose from.

You then pull the caregivers in your region together in a coordinated manner to address that specific that group. We know that when you do

that, it will improve care for other groups. But we want to target a single group so that people are pulling together specific groups and targeting

them and then we can look at the outcomes from that specific group.

So you need to identify a target patient population with a chronic disease from a specific list. If you have a diagnosis that is not on that list, then we're going to need some documentation, validation of why that needs to be considered, other than the ones that are on the list.

And then you need to include a support structure, and that's the CHITA. That's the Community Health Information Technology Adoption support system which we started with the HEAL 5 -- but we're really narrowing this into the whole idea of long-term -- we need to have communities that are supporting the implementation of electronic health records and all of the caregivers in their communities long term. They need

to work together, they need to plan together and they need to support each other. And we as a state have to give them the information and knowledge to

continue that and have an infrastructure across the state to learn from each other and help us guarantee that wherever you are in the state, you're going to be guaranteed that you're not going to see the lack of long term support as you do now.

The target patient population is cared for by the patient centered medical home, which is the primary care medical home.

And the CHITAs are organized in a Care Coordination Zone along with the patient population. I'll show you some graphics to explain it, but what we're looking at is a patient population with a specific diagnosis. And you're looking at the caregivers who are taking care of that patient population with the primary care medical home at the center and then whoever else is really necessary to

coordinate the care for that patient. It will vary according to the diagnosis. Osteoporosis is the example we gave. In your area, maybe an

endocrinologist is the major person who's involved in the care of patients with osteoporosis in addition to the hospital taking care of hip fracture patients and a rehab center and primary care physicians taking care of those patients. There may be others involved -- home health care and others.

That's the idea, to pull that group together to make sure that they're sharing the information that's appropriate for the type of care they're giving and have access to that information.

And then include partnering with the local RHIO -- Regional Health Information Organization. These are all the way across the state now. There's one or more in every region of the state. As I said, they're sharing data, they're maturing, and we want that

infrastructure to continue. That's our statewide infrastructure for data sharing, not only for mobility of patients and clinicians but also because

we, as a state, need to have our Department of Health communicate with everyone in a really useful, bi-directional way.

Now this is a picture to explain this in sort of a graphic form. It may be simplistic, but we will come back to this when we're talking about the percentages.

Again, the idea -- Care Coordination Zones are not built on geography. It's built on more of a referral basis of patient care. That's what we're looking at here. If you want to have a big region, a small region, it just doesn't matter. We want to get past the idea of a specific geography and we want people to look at what is a referral patient pattern for care of a specific patient population. Bring those people together and that's what

the project should be. So that is the Care Coordination Zone.

And the members of that Care Coordination Zone will be the primary

care medical homes key components, because they're the coordinators of the care of those patient populations. The target patient population with the diagnosis that you choose for the project and then this adoption network includes the other clinicians and a support system for implementation of electronic health records for that group.

And that group, the coordinating CHITA group, is the one that's going to be bringing in -- either providing the resources or getting the resources, but they're going to be coordinating the resources to make sure that all of the participants have the electronic systems they need to help take care of patients. It doesn't mean -- like I said before, it doesn't mean everybody has electronic health records, but they -- they need to have some access. It varies from a

portal all the way to a full EHR,

depending on what setting you're in and what will

be appropriate, but everybody needs to

be able to access the right kind of

information and share the right kind of information so that groups of clinicians and others who take care of patients have that information to improve care.

So this is looking at it by narrowing down towards what really is a patient centered medical home. And there is a lot of great resources for this. One really good one is -- the American College of Physicians has entire sections with all kinds of resource materials along with links to others, so if you want to go to acponline.org, it's amazing how much information is available there. I know AFP has a whole lot of information, as well. And some of this -- most of the key stuff is not member required. Some places are. But there's a lot of really good literature on this subject, you can always e-mail us and we can try to

get you links to further information resources.

And then we have resources within

the Deaprtment of Health -- Foster Gesten, as

well, who is here to answer questions on

this topic. And certainly Medicaid has taken a leadership role in this for New York State.

So the idea here for the patient centered medical home is clinicians -- primary care clinicians are coordinating care. This is just an example and is not meant to be inclusive of all stakeholders who may be involved, but examples of the types of care, the coordination, that needs to go on within the patient centered medical home.

And we need to have connectivity of data sharing between these health caregivers to improve patient care. You can do it on paper and fax, but we all know the problems with doing that.

And then the target patient population, the patients themselves are also a key part of this, as well. We would love to see clinicians being able to have more integrated work with patients. We

know there's challenges there and that's why it's not emphasized in the grant. It's not for a lack of interest, but it's because we know that there's a

maturation that has to occur in what we're doing before we can do very sophisticated things in that space. But we certainly are encouraging people to include any kind of communication that can encourage patients to be part of their care as part of their project.

Then if you look at the Care Coordination Zone -- as I said before, this is another way to look at it -- to look at it in relationship to what we've already built as a statewide strategy in New York. So we have the patient centered medical home and the target patient population and that is the cohesive unit of care for taking care of the patients.

Now, in order to implement electronic health systems successfully, we need a system that's going to be able to coordinate that

implementation, and that's what the CHITA is for. You have an electronic health record which is the technical part, but we need the

people part. We need resources. We need people who know how to do this, who are organized within regions, who can go in and support the implementation of electronic systems. So that's with the CHITA is. That's why a CHITA is required. And we look at it as a long term, building towards what's looked at from the national scale for all the way across the state to have this kind of supportive infrastructure all across the state for implementation.

The technical side, on the right-hand side -- like I said before, you have the technical support for the electronic health record, some sort of system for supporting accessing to health information. And then we have the network, the technical network, which is the SHIN-NY. And that's the technical infrastructure built across

the state for data sharing. Data sharing may initially be sharing in your region, but some day we plan to have everything connected together.

On the left-hand side, we're looking at the organizational structure and the building blocks of that are the CHITA, which regional organizations can build in any number of ways. And we look forward to seeing variety of ways, to provide the supportive structure for implementation.

And with that, we see the role of RHIOs. In partnership, a CHITA may be part of the RHIO. The RHIO may be closely collaborating with them. They may only to be associated and not directly part of the RHIO. But there needs to be a very close interaction, aan ctive interaction, because the RHIOs are regional organizations that are also working with us on the state level in order to be collaborative. So you have a structure all the way up through where people collaboratively can learn from each

other, share from each other, and then we as a state can make the best recommendations that everyone can then implement.

And we continue -- we plan to continue this structure ongoing as we move through this and we move through implementation of the stimulus funds, as well.

So what are you as applicants required to do? Well, we need you to pick a diagnosis and a Care Coordination Zone. Again, don't feel like you have to think geography. Think about referral of patients. Think about a disease and who's taking care of the patient with that disease and who needs to be involved. Those are your stakeholders.

The patient centered medical home is the coordination of that. Those clinicians are center and everyone else and all the others that were included in that model. So you need the diagnosis and the Care Coordination Zone and the

patient centered medical home, as we talked about before.

And you'll see specifically in the RGA, specific details in a list

of the types of stakeholders that you should be considering when you're including stakeholders taking care of patients.

So you're going to take a chronic disease or high risk disease. You are going to have the patient centered medical home model with private care physicians at the center of coordinating care with the other caregivers and you're going to be building an electronic system to support that coordination of care.

Then as part of this, because we're coordinating this with all the other things that are going on in the patient centered medical home, and also because it's going to be so much better for your project in terms of getting people on board if you also can participate in the Medicaid program for the patient centered medical home as part of

this.

So the requirements for that are part of this so that there's a reimbursement structure to help support

implementation. And we'll hope to see more and more of that and we're encouraging people to have other health plan involvement, as well. We're not requiring it, because we don't want anybody to have to do it and then have that define their project. But certainly, if you have health plans and reimbursement structures, that is going to help a lot in the implementation and the support of your stakeholders.

And then you need the CHITA, which we talked about before, which is going to insure proper implementation. We'll talk about this a little bit more a little bit later on, but it's there to do soup to nuts, to make sure that the caregivers have the resources they need to choose whatever system they're going to implement or what's the appropriate

type of system, even, to implement and then go through the process of choosing it. Or you may already have caregivers who have systems and now they need to go

to the next step. Because even if you have a system, in order to share information with everybody else, it's going to be a hike and a significant amount of work to move those systems towards the data sharing that we're talking about.

So we want to see that built around this CHITA model and the sharing of best practices and resources and being able to coordinate care through the utilization of the information that's shared.

Applicants are required to demonstrate improved coordination and management of patient care. We gave a few sample recommendations. However, we're looking for people to make suggestions on ways that they're going to be able to measure the improvements in care.

There's literature in this area, again, where you can go out and look at some of the literature for some of the proposed ways to do it that are more defined.

But also feel free to make recommendations, as well, of new types of measures that you could use to look at this to actually identify the coordination of the care.

And you need to explain how the information will be routinely shared with patients. How are going to have the patient involved? Again, we know that this is very early in the maturation of what's going on anywhere across the country. Some places are much further along with this than others, so we want to see how you either are actively doing that or how you plan, going in the future, to be able to include patients and their care and the responsibility of their care.

And then explain the method that will be used to share the information gained from the

evaluation of the project and the project stakeholders in a timely manner. One of the things that's always frustrating is when you are

participating in projects when you don't know how it turned out. So we would like to see people address how they plan to keep those stakeholders that are involved, keep them actively informed about what's going on with their project and what's happening and the successes of their projects.

As I said before, we have an optional section to include payers so that you can include new reimbursement models, things that will support the medical home. We want to encourage that. So that's included, as well.

Now, in terms of the lead applicant. The lead applicant, one of the key features here is the underpinning of what a lead applicant is. This is a very clinical model.

This is a model of clinical coordinating of care. So as a result, we want to have a lead that's part of that clinical picture, part of that medical home

infrastructure. It doesn't mean it has to be the primary care doctor at a medical home. It means somebody who's clinically involved. It could be a hospital. It could be another organization that's a key organization for the region. But we want to be sure that it's a clinically focused model, because that's really the step we need to take. We need to get the technology in, but we have to have this as part of transformation in care and we have to have this buy-in and leadership on the clinical side.

So that's why it's designated -- there's a list -- there's a designation in the RGA about the designated stakeholder participants and also wanting this active role in the clinical care.

And again, the CHITA. I can't

say this enough. I read a study one time that you have to hear things six times. You have to see things three times. And if it makes you sick, it

only takes one time to remember. So you'll see things multiple times in here.

So we want this adoption of service and we think this is, again, going to build on the infrastructure the state has. The stimulus money that comes through the state we'll again be able to build on as we go forward, and this is part of that larger plan.

The required participants are all the appropriate types of providers. So your denominator is going to be everybody that's appropriate for care. Now, we know you can't get every single stakeholder in, and that's why we're going to talk about the fifty and the seventy percent. But the denominator is listing everybody who is involved. And then the numerator becomes any of those involved you're

going to have participating.

So in terms of patients, if you take that patient diagnosis, like I picked osteoporosis, which many of you

know is near and dear to my heart anyway, I would have to have fifty percent -- I would have to be able to document and show that I was including fifty percent of the patients in my chosen zone.

And again, geography is flexible. But in that zone that I picked, I would have to have fifty percent of the patients with osteoporosis or more. We're looking for seventy percent or more. Fifty percent gets you from not being rejected from the scoring pool, but there is definitely significant increases in scoring, a higher score, if you get up above seventy percent, as well.

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The other thing that you're going

to need to have is also the providers. And so the denominators for your providers is all of the stakeholders, as well, and how many of those you have involved.

And then the last part is the primary care medical home. You need to have at least a certain percentage of those. And let me show you a graphic that's going to make that clearer.

So in your Care Coordination Zone that we talked about before, you have the three key components. You have the clinicians that are taking care of the patient centered medical home, you have the target patient population and you have the stakeholders involved. Now the stakeholders involved -- some of them may be part --

MR. SMITH: Pat, excuse me for a second. This was a new slide this

morning, because we knew the question was going to come up. It's not in your handout. It will be posted.

DR. HALE: Sorry about that. So

what's going on is we know in order to really coordinate care, you're going to have to have a significant portion of the patients, you're going to need to have a significant portion of the caregivers and stakeholders and you're going to need to have a significant portion of the primary care medical home -- the primary care physicians. So what we're looking at is a minimum of fifty percent for those.

You're choosing your Care Coordination Zone here. That's very key. So when you're looking at this look at a Care Coordination Zone, not just picking geography and not being able to meet it, but what the referral patterns are so you can meet this requirement. Because when you do, then you're going to have enough

people all connected to have patients really have all their caregivers involved. And that's why the limit. Fifty percent is the bottom. That's to

get in the door, but we're looking for higher. Because in order for any given patient to have most of their caregivers sharing data, it's going to have to be above that.

So that's the goal of the overall proposal. What we're going to talk about now is going to be specifically the allowable costs. And I get to hand that back to Steve.

MR. SMITH: When Pat talks, you learn to listen fast. But we will have time for questions and answers, so if you need to reclarify or go over some of those points or actually bring that slide up again, we can bring the slide up.

So what can we spend the money on? Allowable costs. Eligible project costs are only including those expenses that are directly involved in the

implementation -- in the inter

operability of the electronic health

information exchange systems.

So that would include things such

as the electronic health records -- Pat referenced electronic health records may not be practical in all situations. So if you have to put technology in place to include a portal or that type of thing, although it's not long term where we're hoping to go, that would be an allowable cost, as well.

So that's kind of -- in that three tier diagram that Pat showed, that's kind of the top structure. That's how you're capturing the information. That's how you're assembling it electronically.

We'll also pay for the clinical informatics services, which is that second layer in this diagram. So that's how the information gets analyzed. That's how the information gets used.

And then we're not paying this part of this RGA for the SHIN-NY, per

se. That's part of the 30 million dollar process Pat referenced.

But what we will pay for is your projects for that top layer and second

layer and connectivity to the SHIN-NY.

So we're paying for the top layer, the obtaining of the information through either electronic health record or a portal. We're paying for the second layer, which is the assembling of the information, the analytics, the clinical decisions to support that type of thing. And then we're paying just for the connection to the SHIN-NY as part of this -- part of the HEAL 10.

Allowable costs for electronic health records. Obviously the purchase and implementation of the electronic health records for the providers that are going to be included as part of the patient centered medical home. And that would include not only primary care practices, but also key specialty practices that are involved in your projects. And we will pay up to

twenty-five percent of the cost for electronic health records for small hospitals that you might have involved in your project, as well.

Allowable costs for CHITA services are basically the services necessary to promote the inner -- the implementation and the ongoing care and feeding, if you will -- the ongoing maintenance of the system to make sure that there's successful adoption.

Very often, what you have probably seen from implementation, is somebody comes in, drops in the record, they turn on day one, yup, the physician can see a patient and they say bye-bye. What we're looking for is the ongoing support services to help us move towards meaningful use, which is more than just having a record in place and having the doc know which buttons to press, but to actually make it work and to -- to provide meaningful use to the patient. So that's the adoption and support services.

And other CHITA services to enable improvement in healthcare quality, affordability outcomes, those types of things are also allowable

costs.

Pat talked about the CHITA services, and I don't think I'm going to go over this slide in detail. You can read it. But it basically is reflected in this, which I may not be able to read at all. But it's looking at the whole continuum of implementation services.

So on the left it's looking at the -- and, actually, there's a link in the chain, which we left off here.

In the first link, it's getting the provider, the clinician, the physician to buy-in, that this is something they want to do and it's a good thing. So there really should be a link in this value-oriented project management sheet that's on the left.

It then picks up with vendor selection and contracting, going in and doing the practice workflow analysis,

the practice transformation activities,
the system deployment and
implementation. The system's now up and
running, so you want to take the next

step and start doing some of the decisions supporting performance measurements, ultimately going to -- making the system inter-operable and being able to exchange information and then the ongoing post-implementation support. So everything along that continuum that we refer to as the EHR implementation chain are allowable costs as part of this RGA.

I think we stuck this slide in, again, just as a reminder. We're paying for that top layer, systems via electronic health records of the -- getting ahold of the information, if you will, the second layer, which is the aggregating and analysis of the information, and then just the connectivity to the SHIN-NY. We're not paying for SHIN-NY directly as part of this process.

Allowable costs. Grants will be made for up to fifty percent of total project cost. So yes, there is a fifty percent match, which is a little bit

different than it has been in some of the other HEAL projects. Obviously matching funds would have to be fifty percent.

Applicant allocation of funds. We'll talk more about this, but if you've been involved in these sort of projects before, this is considered a capital project, but we will allow up to forty percent of non-capitalizable expenses. So, said another way, your non-capitalizable expenses cannot exceed forty percent.

And different than some other projects or other grant programs in the past, we're going to do the same thing that we did for HEAL 5 -- and I can see the HEAL 5 people probably running -- is we're going to do it on a milestone or deliverable-based budget. We are not going to pay you to spend money; we are

going to pay you to do work and to show results.

So I'll walk you through in a couple minutes what the budget forms

look like. But very specifically, as you're putting things together, think about milestones, think about deliverables, and that's how we'll be reimbursing and that's how we'll be paying for work that's done.

The application. There's two parts to the application. There's the program application and there's the financial application.

The program application, which is described in section 5.1, is a maximum of thirty pages. We've got a relatively quick turnaround time for this whole project, as you're aware. So the main part of the application is a maximum of thirty pages. And there is a number of forms in section eight of the RGA that you probably saw. Those forms would get included, as well. Those are not counted as part of the thirty pages.

The thirty pages, that's your part.

That's for you to do your sales thing.

There is an application checklist

in section 8.1.1. We would encourage

you to go through that and make sure that everything is included.

And also in the program application, because of the way the state has to do the review and evaluation process, there should be no cost information involved in the program application.

One minor exception to that is in your stakeholder letters. You will be asking your stakeholders and will be demonstrating that your stakeholders have committed specific dollars as either cash or in-kind contributions. Instead of having you do two separate letters, one with the dollars and one without the dollars, we said just put the dollar figures in the stakeholder letters. That is part of the program application. We will be redacting that for purposes of the evaluation for the

program component of the evaluation. But other than that, there should be no cost figures included in the program application.

This is the sixth time. Section 6.15 has a pass/fail checklist. Section 6.15 has a pass/fail checklist. There's a pass/fail checklist in the RGA. It's what we'll be using to decide whether or not you pass or fail. Please use the pass/fail checklist in section 6.15 when you put your application together, because if you don't, you will fail. The financial application -- did you get that part? 6.15.

SPEAKER: Could you go over that again, Steve?

MR. SMITH: We actually will, a little later.

The financial application. The financial application is fairly prescriptive. If you've had a chance to look at the information that was posted on the website, the major component -- or one of the major components is the

budget worksheet, cleverly entitled budgetworksheet.xls. It's an Excel file.

Within that worksheet, there's

various components. There's a project budget, there's a project funding section, there's a revenue and expense projection and also, although it's not directly related to the budget, there's a CHITA services template. And I'll talk more about each of these in just a minute.

In addition to having that worksheet completed -- or those worksheets completed, you also, as part of your financial application, should include a description of the cost-effectiveness of your study -- or your application -- your application -- your applicant financial stability, so that we know you're going to be around when this over, as well as your project financial stability. So those are all important components of the financial application, as well.

You can't see the top spreadsheet, but we'll zoom in on it in a minute -- but this is just to remind me. We talked about the three sections

in the budget worksheet. I talked about milestones and task-oriented. And just a reminder here or to re-emphasize it, those tasks are milestones. They'll be all included on your project work plan. All of that is equal to your scope of work. So as you're putting your tasks and your milestones together, keep in mind the scope of work that you're proposing, and the sum of your tasks or your milestones should be equal to what you're putting in the RGA as your full scope of work. Hint. Hint.

So if we zoom in on it a little bit, the project budget. The first section is basically related to the different cost categories, similar to what was in HEAL 5. We're going to be going with five cost categories, which is including software, hardware, personnel, contractual services and

other non-personnel services. So along the vertical axis is where you're including your milestones, and those milestones can have expenses that would

be -- that would fall into any of these five cost categories.

So for a particular milestone, there might be some hardware that you have to buy to accomplish that milestone. There might be personnel that are involved or associated with it to get that milestone done, or there might be contractual services. So you can have any or all of the cost categories that are shown here included in each of the milestones.

The first three are filled in as being pre-awards. The development of your organizational strategies, the development of your technical strategy and the development of your clinical strategy, those would be milestones -- those would be activities that you obviously would have to go through in order to put the application together.

Those will not be HEAL fund reimbursable, but those activities can be included as part of your cash or in-kind contribution.

And we're getting final determination, but we're shooting to allow you to count costs as of April 1st, 'cause it was an easy day for us to remember, but it was directly in relation to the specific release of the RGA. So costs that are directly associated with the project that would be accumulated post-April 1st would be allowable as cash or in-kind contributions for your project.

And then you would just fill out the rest of the sheet with all of your other milestones, deliverables, etcetera, including the dollar figures that are incorporated in those.

One hint that if you haven't opened the spreadsheet yet, the columns that are grayed out are ones that you will not have access to. They're locked up. There's formulas in there, so

you'll see things kind of build and progress as you're adding dollars into some of the other sites.

In that same worksheet, that next

section will have you designate the capitalizable versus the non-capitalizable expense for each of those milestones. So, for example, if you have a milestone that's equal to a hundred dollars, you might have eighty dollars that's capitalizable and twenty dollars that's non-capitalizable. This is where you plug it in. Because as you'll see in a minute, the spreadsheet will keep track and do the calculation for you so that, at any point, you can look and see where you are capitalizable versus non-capitalizable.

And the last section in that is the cash and in-kind contribution that's coming from your stakeholders. And again, keep in mind, this is all done on a task or a milestone basis. So for each task, you'll have dollars in the HEAL categories. You'll have dollars in

the capitalizable/non-capitalizable categories and you can also have dollars for that milestone coming from cash and in-kind contributions. So it's one row

across. It's one continual -- I just broke it up here to make it a little bit easier to walk us through it.

Project fund source. This is basically where you take the letters of support that are described in section 6.3 and list them out. So what you'll do here is when you have your letters of support from your stakeholders, you'll just list them out here identifying the stakeholder, identifying how much they have committed to from a cash contribution perspective and how much they have committed to from an in-kind perspective.

We did this a little bit different than we did in HEAL 5. We're asking for specific dollars, because what we found in some previous grants is people submitted -- they said stakeholder ABC was going to contribute

-- you know -- so many dollars. And then when the -- the contract got approved, which yes, it's sometimes late, that stakeholder -- you know --

had changed their mind or their commitment wasn't there any longer. So we're trying to get very specific commitments and make the stakeholders really think about whether or not they're going to be involved in this project and -- you know -- be willing to associate dollars with it and not just say, yeah, I'll involve -- I'll be involved and then we try to get them to do something and they're not willing to participate.

These are in the spreadsheets, as well. They're a couple of check tables. The top one gives you your total project expense, and these will calculate for you so it will show the total HEAL 10 dollars that you're requesting and it will also show the matching dollars that you have inserted in that previous sheet that we talked about. And this will sum

up to your total project expense.

The middle will give you what your matching percentage is. And keep in mind, this has to be at least fifty

percent or you will fail.

And the bottom one shows your capitalizable versus non-capitalizable, and that needs to be no more than forty percent non-capitalizable. But these will calculate for you, as you're filling in your individual tasks associated with your application and sum up for you.

The last worksheet also calculates for you, and it just shows you on a quarterly basis and it's really for the state cash projection requirements. It will show you on a quarterly basis across the two-year life of the project how many HEAL 10 dollars are going to be consumed by the project and how many match dollars, which includes both cash and in-kind will be associated with the project.

And the trick on this one is the

bottom right-hand corner. When all is done, it should be zero. So when your project is done, when the eight quarters are over, when the two years has passed,

you will have spent all your HEAL dollars, you will have spent all your match dollars, and you'll sum up to zero in the bottom right corner.

The CHITA services template is in that same file. It's part of the budget application, although you may not look at it as budget, per se. But because HEAL 10 is so much about implementation and it's so much about getting the work done, what we're asking projects to do here is to be very specific on how they're going to get the work done and what kind of resources are going to be associated with that. So although you can't read it real well here, the left-hand column says "service" at the top. The components underneath that represent each of the items in that EHR implementation value chain that we talked about.

So what we'll be asking you to do here is to be very specific for the readiness assessment for your EHR implementation. How much do you plan on

spending? How is that going to be done? Who's going to be doing it? How many FTEs are going to be associated with it? What kind of funding, specifically, are you going to be using to get that particular component done? We want to make sure that we are funding projects which have a legitimate plan that will actually be able to get the EHRs implemented and in the hands of clinicians that need them.

And there is a note at the bottom. The cost that we -- and this is on the spreadsheet, as well. When you're doing this, think about it on a per FTE basis. You know. Physician, DO, NP, PA, whatever it happens to be when you're doing your -- your implementation services -- your CHITA services template.

The application submission is in

section 5.4. It needs to be in two separate and distinct parts. One part is the program application, which none of you will put any cost information in,

and the other is the financial application.

The reason that we're requiring them to be in two separate parts like this is there's two sets of reviewers. When these applications are being reviewed, the people who are reviewing the program component of the application, which is the more heavily weighted of the two, do not have access to the cost information.

We're not looking for the lowest cost project. We're looking for the project that has the best prognosis, that's going to have the best outcome, that's going to actually do what they say they're going to do.

Then there's the financial reviewers, so they have full access to all the numbers. The financial -- the financial reviewers also have access to

the program application, as well. So just to be clear on that.

We don't want a ton of paper. We're supposed to be electronic, but we

are required to have one hard copy, one paper copy that gets signed, and we're then asking for two soft. And I was told we need to put in a definition of what a soft copy is. That's an electronic copy. We're looking for two electronic copies. And in section 8.1, there is a specific file structure that we're looking for, so we ask you to please comply with that file structure.

Also, we ask that each document be submitted in each of those soft copies in two different ways. One is as a searchable PDF. It makes it so much easier for the reviewers to find things, which is to your advantage when it comes to scoring. If a reviewer can't find something easily, they're going to go on to the next one, because there's so many reviews that have to be done. So we're asking people to please include a

searchable PDF.

You don't have to go out and buy a full version of Adobe Professional or whatever it is. We found a freeware

version. And the link to that freeware version for the free PDF thing -- program -- is listed in the RGA. So we're asking for one searchable PDF version, but we're also asking for the native format, as well. So if you're doing it in Word or Excel, please submit that as well, because there are some times we may need to use that and it will be easier for us.

Not adhering to these requirements will result in disqualification, so please, please, please read section 8.1 and make sure you understand what the submission requirements are. And also go over the application form checklist, which is located in section eight.

Applications need to be received by the Department no later than three p.m. on June 15th. The address for

submission is listed here. Applications received after 3:15 -- excuse me -- after three p.m. on June 15th will not be accepted.

Okay. So you got the application in. We've gone through the review process and we're now ready to make awards. There's a couple different parts of the review or the awards process. The first is what we refer to as Phase 1, and that's basically -- did the applicant do technically what they were supposed to.

So this is a completeness review to make sure that all the sections are there. It makes sure that the entity submitting is capable of contracting with the state, that they are a legally existing entity, that their application is complete, that there is at least a fifty percent match.

And guess what else we do? We go through section 6.15, which are the pass/fail criteria. So when you're putting your application together,

please review those criteria. And I'll just stop with going through it twice instead of six times, since you can see it there.

The second phase is the program evaluation -- involves the program evaluation. This is where your thirty page document gets reviewed. And there's a specific structure that we're looking for that's articulated in the RGA section 4.1.4, but it's your organization plan, your technical plan, the clinical plan, leadership, personnel, qualifications, project management, resources, that sort of thing. That's part of the program evaluation, which is in Phase 2.

The Phase 2 evaluation also includes the financial evaluation that I talked about earlier. This is where the project budget, the funding, the revenue projections, cost-effectiveness, sustainability of the project and the applicant gets reviewed as part of Phase 2.

The awards process is done on a regional basis, and I would make a note here to make sure you review the regions because there is a slight difference

than there was in HEAL 5, which was driven by some review work that was done that looked specifically at referral patterns.

So since HEAL 10 is about patient centered medical homes and revolves around referrals and where patients are being taken care of, we had some data within the Health Department and there was a little bit of realignment that went on here.

This part is worth 60 million dollars. We will basically be taking the applications that made it through Phase 1 and Phase 2 and we'll be arraying them from high to low and the scores will be -- or the awards will be made based on high scores.

They will be made in relationship to the regions, however. There will be a minimum of one award per region and a

maximum of two awards per region. The maximum that will be distributed for the awards will be 7 million dollars each.

If, after we have gone through the first

round, if you will, and every region has received a maximum of two awards and a minimum of one, if there are any dollars left, we will then take the remaining applications, again array them from high to low, and start awarding awards based on score. This second round of awards will be regardless of region.

So the first phase of awards, we're doing a minimum of one, a maximum of two per region. After everybody has their two, if there are still dollars left, and if there are dollars to even do two per region, because you can do the math and see there might not be. But if there are still dollars left and every region has two, we'll then take the remaining applications and start awarding based on score regardless of the region where they fall.

We will be doing just fully

fundable projects. There were some issues in the past with previous grants programs where there weren't sufficient -- there weren't dollars to totally fund

a project, but the projects were asked to do the full scope of work anyway and it just became too problematic. So if we can't fully fund the awards, we'll back away from it.

Award letters will be distributed in the late third quarter of this year. New York State, of course, reserves a number of rights. These are just a few of them. They're all listed in section 5.6, but we reserve the right to reject any and all applications, adjust cost figures to where we find minor irregularities in concert with the project, waive or modify minor irregularities and reject any application submitted where the eligible -- where the applicant is not eligible to contract with the state or in compliance with other state and federal requirements.

The contracting process. The way we're having you put the applications together, on the tab and milestone basis will set us up real well for the

contracting process.

We expect the projects start -- backup a second. We will immediately begin the contracting process in the -- after the award letters have gone out. We're anticipating that the project start date will be sometime within the first quarter of 2010 and the contract term will be for two years.

Payment and reporting for those projects that are selected. Payment will be on a milestone deliverable base. Obviously, there needs to be backup to make sure that the dollars were actually spent. The grantees will be asked to submit quarterly vouchers to the Health Department, as well as quarterly reports regarding the progress of the project, as well.

Questions and answers. It's that infamous time. What we're going to do

is we've got two mics here. I'm assuming there might be a couple questions. If not, we can call it a day and go. But in the case people do have

questions, what I'm going to ask you to do is come up to the mic -- and for purposes of the transcript, I'm going to ask people to please slowly, for the stenographer, state their name and the organization that they're representing.

So with that, we'll open up for questions. So just come up to one of the mics and ask a question.

MR. CHECK: Good morning. Thank you for the overview. I'm Tom Check from the Visiting Nurse Service of New York, C-H-E-C-K. And my question is, does the application have to focus on one and only one diagnosis or can it include multiple diagnoses from the list that's in the material?

DR. HALE: The application must choose a single diagnosis. However, we realize that your project may be -- you know -- involved in others. But in

terms of this application, a single diagnosis.

MR. ONG: Good morning. Ken Ong, Catholic Health Services of Long Island.

Last name is spelled O-N-G. I have two questions and I'll ask them sequentially.

The first is, do you have any tools available or any guidance about how we can find out what the population is of patients or providers for any particular given condition?

DR. HALE: We included in the RGA a link to some of the website information that's available at the state. One of the resources that is available is a website that gives discharge diagnoses for specific zip codes and region areas. That is one resource that can use. If we find other resources, we certainly will -- you know -- post them in the Q&A.

If anyone here has suggestions on resources, as well, please let us know and we'll evaluate those.

MR. ONG: So, I have two questions. This is still the first question. So the geographic area that we're talking about coverage --

DR. HALE: Well, that's what that resource is. We're encouraging people to use other resources. I know in many regions, there are specific partners or stakeholders who have a lot of information of their own on specific populations. So we know that in many cases, that may be the data that is used. And with the supporting information showing where that data -- you know -- what was used for that information, that's what we expect to see.

So -- you know -- I think there is a number of types of resources and we're not choosing one that has to be used because of the type of populations that are in that diagnostic list. There isn't a single source that is appropriate for that.

MR. ONG: And my second and last

question. How can we find out who our relevant CHITA is for our particular areas?

DR. HALE: You -- that is what

you will be hopefully answering as a part of this process, because there are areas here that already have strong associations -- CHITA-like or similar types of support organizations already underway.

And -- you know -- I certainly would suggest that people reach out to their Regional Health Information Organizations and others to evaluate that.

But most of the state -- in many areas of the state, we know that this is the type of thing we need to start creating. And so again, we expect to see these new partnerships form. And as part of the process of HEAL 10, we'll see development of CHITA and CHITA support networks.

So we're not expecting everyone to be reaching out to a pre-existing CHITA -- and this is not referring to

the projects of HEAL 5 that were funded. They may or may not be appropriate for this, but that is not necessary. You are encouraged to form an appropriate

combination of resources for your project and not -- you know -- reach out to something that is pre-existing unless it matches.

MR. ONG: Thank you, Pat.

MR. SMITH: One thing I forgot to mention -- one thing I forgot to mention in relationship to questions and answers. We have the cutoff date for questions May 11th, I think it was. As questions get submitted, we will be answering them kind of on an ongoing interim basis, posting responses to the questions on the website. So don't think that you shouldn't look for responses to questions until May 11th. Please, on an ongoing basis, keep checking the website, because it will be constantly updated with questions that were submitted in responses thereto.

MR. DIVER: Good morning.

Excellent program. Joe Diver, CIO

Vice-President of Technology, Bassett

Healthcare, D-I-V as in Victor -E-R.

Two questions. One is from

Bassett Healthcare. We cover a very wide region and we cross counties. Do we submit one application -- that is my assumption -- covering that facility, that cross with that second county?

DR. HALE: Again, I'd like to emphasize that we're not looking for people to feel that they're determined by a geographical location or any specific stakeholders referral network -- complete referral network.

So, for example, if you have a hospital system and you have a referral base that may be several counties, yet for this specific project, you want to choose a subset of that area for the project, then you should be choosing according to the patient population. And it doesn't have to be the patient population for that entire geographic area and the caregivers, the primary

care homes and the supportive stakeholders for that group of patients.

So we're not looking for people to have to do something in their entire

region for -- for any given stakeholder. We're looking for stakeholders to pull together and pull what's the appropriate group according to the diagnosis and the -- the patient centered medical homes of providers. I hope that helps answer that.

MR. DIVER: That's fine.

MR. SMITH: So your patient population is crossing different colors?

MR. DIVER: Correct.

MR. SMITH: You're one of those border entities -- you're one of those border medical homes? Pick the region where the majority of your patients are coming from.

MR. DIVER: Okay. Great. Second question. Being new to the State of New York, just at Bassett for about ninety days now. The CHITA, I certainly understand that. But how -- if there is

anyone in the room, I'd like to get involved in one of the RHIOs -- I think there's HIXNY that kind of covers our area. So --

SPEAKER: (Inaudible.)

COURT REPORTER: I can't hear you. If you're going to speak, please use the microphone.

DR. HALE: I strongly encourage that everyone become involved in the process in New York, not only with your Regional Health Information Organization, but with the New York eHealth Collaborative -- www.nyehealth.org. This organization is open and we have -- you know -- something for everyone. We have a very strong clinical group. We have technical groups. We need the leadership of those who are interested in experiencing all walks of this area to be helping us, because this is where our strategy comes from. This is where our recommendations come from and this is what's going to get this -- you know -- built and working for all of us.

So that's a little speal (sic) on the side, but -- you know -- but please reach out to your regional health information organizations and also

participate in this process, too, because that's how we'll do a better job.

MR. DIVER: Thank you.

MR. KENDALL: Hi. My name is Matt Kendall. I'm with the New York City Department of Health's Primary Care Information Project. And I just have a question about the general scoring.

In terms of the RGA, it looks like you could go two different ways. You could either have one very detailed patient level medical home shared coordination facility where you have a smaller number of providers, smaller number of patients with more extensive services. Or you could try to expand to more providers and maybe not have as many connections but have more patients involved.

In terms of those two scenarios,

which would score more favorably in terms of scenarios like that?

DR. HALE: I don't have an answer for you on that one, that specifically.

I was going to say that anyway.

But to reiterate, what -- what we're looking at is -- you're looking at a patient population. You're going to want to be able to say in your project that a significant number -- and the higher the significant number the better -- of patients in that population can look and see that their caregivers at most -- and I wish it could be all -- but most of their caregivers are sharing information to improve their care.

Now, it's going to come in a lot of varieties and a lot of different ways, and we look forward to that. And we're not giving -- we're not describing this on purpose because you know your regions, you know your patients, you know your patient populations. And depending on where you are, you're going to find a way to meet that.

But the most critical part is that if, in your project, in order to, at the end of the day, say most patients are getting their care coordinated,

you're going to have to be reaching for those higher percentages. Okay.

MR. SMITH: So the short answer, Matt, is both. We're looking for breadth and depth.

MR. KENDALL: Okay. And just a follow-up question. If your CCZ has multiple RHIOs, will you get additional points for partnering multiple RHIOs?

DR. HALE: I'm not going to answer that as a yes or no. But what I'm going to say is that in New York State, there is two infrastructures -- and there's never too many times to try to bring this lesson up. One of them is the technical infrastructure, which is the SHIN-NY. That's the technical infrastructure. No matter where you are, you link in. That is not RHIO specific or RHIO governed.

But the other thing that's really

important is that in every region of the state, there are priorities and there are stakeholder priorities and we have to work together to improve care. And

that's what the RHIOs are.

So when these partnerships are formed, it's not about -- you know -- picking which RHIO for other regions. It's about who is the RHIO that you need to collaborate with for the better care of this patient population. That's what it's about.

So -- and that's as much as I'll say about it. But I think that's -- all the way through this entire RGA, it's about the patient population and getting the people involved who are going to best suit -- you know -- providing care.

MR. KENDALL: Thank you.

DR. CAPPONI: Good morning. Lou Capponi, C-A-P-P-O-N-I, New York City Health and Hospitals Corporation. I have multiple questions.

The first one is in terms of eligible applicants. Does the

definition include public benefit

corporations as public agency -- public

health agencies?

MR. SMITH: The eligible

applicants are listed on page fourteen of the RGA and the type of entity that can be eligible applicants or lead applicants is included in the stakeholder list, which is on page fifteen. So I refer you to that.

DR. CAPPONI: That's what my clarification is about. Public benefit organizations like HHC, are they considered public health agencies, technically?

DR. HALE: That would fall under -- it's the last section of types of agencies.

DR. CAPPONI: Great. You've answered my question already on RHIOs --

DR. HALE: Could you please be sure to submit that one -- you know -- electronically to us?

DR. CAPPONI: Certainly.

DR. HALE: Then we can check,

because that's the type of thing we want to be very specific about.

DR. CAPPONI: Thanks. The -- you mentioned in your presentation EHR

implementations as it relates to small hospitals. Could you clarify that?

DR. HALE: What we're -- what we're looking -- what we're looking for, again, is getting as many of the stakeholders being connected and involved, and we know across the area there is going to be small hospitals that -- you know -- are very key partners and stakeholders in the care of the patient population. We want to help with the implementation of electronic records in those systems.

Obviously, the amount of funding that we have and the amount of funding for your project could be used up -- you know -- tomorrow for a single small hospital. We know that. We know that there's -- again, coordinating with the stimulus funds and other things.

However, we also know that if you

can walk in a door and be able to help support that, that that funding will help. So that's why the amount is twenty-five percent. It isn't intended

to be enough. We know it's not enough. However, it's part of a support structure that can be built on with stimulus -- you know -- stimulus funds that may or may not be appropriate for that place. But it is certainly an amount to intensify and to help you with your project to be able to intensify and get cooperation with the stakeholders that you need.

DR. CAPPONI: So it's not to exclude large hospitals from -- from applying? It's just to focus on --

DR. HALE: Exactly. And it was a funding issue.

MR. SMITH: We figured with a maximum of 7 million per project, you're not going to get much of an HIS for 7 million. So we wanted to give you some opportunity to get the small guys on board, but it's not going to help the

large.

DR. CAPPONI: That's all. Thank you. Next question. Regarding the capital expenses, and it's probably

obvious to some but it's not to me. Is that sixty percent required to be capital -- is that only for the grant-funded portion or does that apply to both grant-funded and in-kind portions?

MR. SMITH: The capitalizable portion that we're concerned with are the funds that are coming from HEAL. So it doesn't -- you don't have to -- and you'll see when you do your spreadsheet. You won't be differentiating your cash and in-kind as to whether that's capitalizable or not. It's strictly the New York State, the HEAL 10 funds that you need to differentiate.

DR. CAPPONI: Okay. Last question. In the RGA, it mentions that existing EHRs must already be certified under either 2008 criteria or other criteria that evolved nationally and

within New York State's requirements.

Is that meant to exclude existing EHR upgrades to a compliant version from grant-funding in this RGA?

DR. HALE: No. It actually -- what we're saying is that in order for grant funds to be used in connecting or improving those existing systems, they have to be -- become compliant. They must be compliant.

So -- so that's the idea, is that we're not going to be paying funds for systems that are not going to be able to connect into the network.

DR. CAPPONI: Thank you very much.

MR. GORMLEY: Hi. My name is Jay Gormley. I'm from Metropolitan Jewish Health Systems, G-O-R-M-L-E-Y. And I have a couple of questions.

My first is when you're talking about defining the patient population by diagnosis, can we parse beyond just geography? You know, when you're talking about, say, diabetes -- you know

what I'm saying -- and you're talking about a small geographic area. Can we say over the age of sixty-five? Or can we focus on juvenile? I mean, can we

parse that population further than just geography and diagnosis?

DR. HALE: I think that's a very good question, but I would prefer -- and actually I'm not answering you at this time. But I think what -- submit that as a question, because I'd like to actually review that one further before I gave you an answer.

MR. GORMLEY: Okay.

DR. HALE: Our tendency would be -- the goal, again, is getting good depth and the coverage of the patient populations.

MR. GORMLEY: The diagnoses are really big. I mean, you know --

DR. HALE: Diabetes especially, and we know some of those are very broad. So -- you know -- again, this is not the absolute rule, what we say today. I would say -- I would say that

sounds like a very good idea, but we definitely want to evaluate it and make sure. I would not --

MR. GORMLEY: I'll put it in

writing.

My next one is that when you talk about fifty percent of the stakeholders, how is that calculated in terms of -- is there a list we're working off? Do you know what I'm saying? Are we talking about article 28? Is it article 28s that are physically in the zip code or article 28s that have a service area in the zip code you choose?

DR. HALE: It's the referral pattern of your diagnostic group in the care of that patient, the CCZ. It's not done by -- you know -- zip code. It's not done by those kinds of criteria.

You're going to be saying -- okay -- this is the patient centered medical home group that I'm working with. These are the stakeholders that are -- that are taking care of patients in that referral pattern, whatever size it is.

And the fifty -- the minimum -- but I think that's seventy. I don't think fifty --

MR. GORMLEY: But I think -- but

my question was in terms of -- like, if there are ten doctors that serve one population, and one doctor serves seventy percent and the rest of the doctors serve the thirty percent, do I get seventy percent by having one doctor that serves seventy percent of patients? Or if I get seven of the doctors that only serve thirty percent of my patients -- I mean, which is it?

DR. HALE: Right. The seventy percent.

MR. GORMLEY: So it's by volume. It's not provider number. It's the people they serve.

DR. HALE: Exactly.

MR. GORMLEY: Okay.

DR. HALE: The patient population.

MR. GORMLEY: And then the last one has to do with the cost piece -- you

know -- the fifty percent of the cost you were talking about. You talked about including payers. What is the role of payer costs into that mix? I

mean, because payers are optional.

So the question is, like, if I get one payer in my region to partner with me, which would be pretty neat, do I have to then try and find one payer so that all the payers make up fifty percent?

DR. HALE: No. There is no percent rules or specifications on the payer mix for the payer participation.

MR. GORMLEY: Okay.

DR. HALE: We just would -- we want to encourage it, and so there will be, in scoring -- you know -- enhancements for -- payers. No fifty percent or none of those other types of requirements.

MR. GORMLEY: But can I use some of the money to pay for payer cost if they are a stakeholder -- you know -- to pay for their EHR?

DR. HALE: They're not providing -- they're not providing care to the patient --

MR. GORMLEY: -- which is part of

the dual diagnosis stakeholder model. Okay. Thanks.

MR. KOSKI: Hi. Andrew Koski, K-O-S-K-I, the Home Care Association of New York State. When you list stakeholders, you list certified home health agencies, licensed home care service agencies. You don't list long term care programs. Any reason why it's not listed? Should I assume it should be part of that mix?

DR. HALE: Long term care providers -- that would be under the long term -- let me make it clear on the chart.

On the right-hand side are examples. They are not restrictive. So those are just examples. So if you're in long term care and you fit the long term care providers, but you aren't specifically listed here, that doesn't

mean that you don't -- it doesn't apply.

What we would like you to do is submit a

question to us so that we could get an

answer specifically addressing your

specific situation so you don't wonder if somehow you didn't -- you didn't meet the criteria.

But these were to be examples so people could see -- you know -- what the examples of each type were.

MR. KOSKI: Right. But the long term healthcare programs, which is a specific funded home care program, is that included on this or not?

DR. HALE: These are -- this is provider-based.

MR. KOSKI: Right. That is one type of provider.

DR. HALE: Certified home health agencies. I guess -- I'm sorry. I don't understand. Why would you not --

MR. KOSKI: There is a separate type of program for the long term healthcare programs. Some of them are CHAs; some of them aren't. So I'm

asking whether or not --

MR. SMITH: Can we ask you to submit that question?

MR. KOSKI: Okay. Fine.

DR. HALE: We'll check -- and make sure we have --

MR. KOSKI: Okay. And also on slide -- on slide twenty-one, it says up to twenty-five percent of the cost of electronic health records for small hospitals or long term care facilities.

When you say "facilities," do you mean home care providers also, or "facilities" meaning nursing homes and other residential facilities?

DR. HALE: That specific requirement was addressing long term care facilities, and it was the same idea that the cost of an electronic healthcare product for a large facility would be greater than the budget for your project. So that's why the twenty-five percent.

However, the stakeholders that are -- that can have financing for

support of electronic health records is all of everyone, so you would be included in the general stakeholders that can have electronic health records

support.

MR. KOSKI: Okay. Thank you.

MR. DEREZNEY: Good morning. Paul Derezney D-E-R-E-Z-N-E-Y, AIDS Community Health Center, Rochester, New York. I have two questions, one in regard to matching funds.

We have been working with the RHIO for some time now, and the date you gave -- we have previous to that date invested a significant amount in the infrastructure leading up to the implementation. We were not aware of HEAL money during that time. So is that date steadfast without --

DR. HALE: Yeah. Let me explain -- we'll explain the date. The good news -- there's good news and bad news. The bad news is the date is rather stringent, and the reason for that is that we can't pay for things that

occurred before the concept of our grant going out. So we can't -- you know -- pay for -- buy systems that somebody bought in the past.

However, the good news is that we're very, very interested in funding the improvement and the expansion and the use of -- the system, etcetera, has limitations. And I really think this is a very important point, because everyone who's in the implementation industry knows that what you get as a vendor product is hardly what you need in order to reconnect and take better care of patients.

So we strongly encourage and we feel this is a big -- a really big opportunity and one of the best situations to be in, is to be in a situation where people have invested and gotten the basic systems. But they really, really need help in the implementation, support, the CHITA and also the cost to get the kind of connectivity that's really left their

system.

So the bad news is no, you can't just get the business paid for, but the good news is you're in an ideal

situation to be able to understand what you really need in terms of cost and funding and support and networking in order to help leverage that with this new funding.

MR. DEREZNEY: So our challenge would be the matching funds, because most of our matching funds were prior to that date. But we really do need what you're saying, the implementation, the work process, the services.

My second question is, since we are a community-based healthcare organization with a targeted population, an underserved population, when I saw the slide that said 1 or 2 million per grant -- 1 or 2 million per region, although we're one of the largest caregivers of that population in the area, are we too small to be --

DR. HALE: Oh, the minimum size

of the grant?

MR. DEREZNEY: Yes.

DR. HALE: No. I suspect --

strongly believe that if you really are

going to build a referral network, when you go back and you contact the organizations and stakeholders, that you're really going to need to take care of your population.

There's going to a lot of people who don't have electronic health records, or even if they do, they are going to have the need to connect in and share data. And that is extensive. That's going to be extensive in terms of fifty -- the qualifications and the expertise, the planning and the implementation.

So -- so -- you know -- not to say -- you know -- we do expect that the minimum really would be for projects, almost no matter how small. And if you're truly going to be connected and sharing data with a referral, physicians and others, that's -- that's the kind of

costs you're going to need.

So I don't -- I really -- I'd be surprised of anyone who was mature enough and far enough along where they

weren't sending me that kind of funding. That's where we are on that.

MR. DEREZNEY: So the funding limitations are not limited to the lead agency; is that what you're saying?

DR. HALE: Exactly. No, the funding is supposed to go to you and your stakeholders.

MR. DEREZNEY: And the stakeholders?

DR. HALE: Yes. Yes. So, for example, you may have -- you, for sure, have pulmonologists and probably endocrinologists. You have infectious disease. You have a number of health professionalists (sic). And really, in your population, probably -- you know -- many -- and you're going to -- you know -- some will have electronic health records. Some may -- some will not. Most, if not all, will have connectivity

issues to share data with you -- with your -- your institution and also your -- each other and the hospital, whoever -- you know -- you're working

with, as well.

So all of those -- everyone -- home healthcare, who's taking care of your patient body, every one of those can leverage the funding to help connect in and use whatever's the appropriate -- again, they're a home health agency. They may be affordable. They may be sophisticated and have electronic health records. Wherever it's the most appropriation communication. This is to pay for all of those stakeholders.

We want a leadership role by organization so they are leading that clinical organization of that group and leading the implementation, which is absolutely required for this model. But the funding is supposed to be for all involved to get data sharing.

MR. DEREZNEY: So, for example, even though we have primary care

physicians and other specialties within our organization, we do refer out, say, to a hospital for emergencies, but our primary care is taking care of what we

call co-morbid. And so those referred out agencies would be part of our stakeholders, as an example?

DR. HALE: Exactly.

MR. DEREZNEY: Okay. Thank you.

DR. HALE: You're welcome.

COURT REPORTER: Could you use this microphone? I'm having a hard time hearing. Thank you.

MS. SHELL: Hi. Good morning. Sasha Shell with Acadia Solutions. Would a for profit technology consulting company qualify as a CHITA?

DR. HALE: What we're looking for in the CHITA organization is implementation and support organization.

MS. SHELL: Okay.

DR. HALE: We see those coming in in a lot of structures, and we're not limiting the -- you know -- the types those would involve. However, I would

qualify it and say that this is just about the technical implementation. It's also the workflow and clinical models, as well.

So we expect to see combinations of groups coming together to provide those services, some of which would be -- you know -- specific vendors of specific implementation services, some who'd be an extra piece in clinical support and other structures.

So we expect to see collaboratives, but we're not restricting it because, obviously, this is an area we all have to learn and develop from.

MS. SHELL: Thank you.

MR. MOLISANI: Good morning. Mark Molisani, that's M-O-L-I-S-A-N-I from the Visiting Nurse Service of New York. I have a few questions.

Do all -- I know you've spoken about RHIOs and this may have been answered, but do all participants in a project need to use the same RHIO or can

different participants use different RHIOs provided the RHIOs exchange data with each other according to the statewide policy guidelines?

MR. SMITH: The thing to keep in mind is -- as Pat said, there's two components to the RHIO. We think of the RHIO as the governance. Everyone will be connecting to the same Statewide Health Information Network. So whatever makes the most sense from you as far as what your goals and objectives are and where you're going with things, you pick the RHIO that's in align with their governance.

DR. HALE: Specifically for the patient population of this project.

MR. MOLISANI: Okay. I had some technical questions. In the submission, you mentioned --

MR. SMITH: None of us are technical, so you're not going to get an answer.

MR. MOLISANI: Just a clarification, then. For the -- for the

hard copy submission, is that a separate submission of the financial and the program application, or how does that work?

MR. SMITH: The financial application and the technical application are separate. They can be in the same envelope.

For the technical application, there needs to be one hard copy and two soft copies, two electronic copies. Ditto for the financial.

DR. HALE: They're going to be going to separate reviewers, so we need --

MR. MOLISANI: But they can all be in the same envelope?

MR. SMITH: Please. Please.

DR. HALE: Yes.

MR. MOLISANI: Okay. And then the other question was another technical one. Sorry. In terms of the searchable PDF on the -- on the letters of support, can they just be scanned and included?

MR. SMITH: As long as it's

searchable. Some scannings are searchable; others are not.

MR. MOLISANI: Okay. Thank you.

MR. SMITH: You're welcome.

MS. EISENSTEIN: Jill Eisenstein from the Rochester RHIO, E-I-S-E-N-S-T-E-I-N. A couple questions.

In the grant, it describes -- it relates a commissioner version of the patient medical home, the requirements. Where can that be found? What are you referring to?

DR. HALE: The -- we're referring to some -- some recommendations that are going to be coming out from the Commissioner's office. And Foster --

MR. SMITH: Foster, do you want to --

DR. HALE: We have the expert in this area to help with questions.

DR. GESTEN: The good news is I don't talk as fast as Pat. The bad news is I don't think as fast as Pat, in answering the questions, any way.

The recently passed legislation two weeks ago talks about the Commissioner establishing requirements for patient centered medical homes by

October 1st. So the dilemma that you all face is having to respond to this -- to this given, if you will, target that you don't know what it's going to be.

My recommendation is two things, because again, we're intuitively involved in -- I'm involved, and so are the people in this room, in the development of this.

There are two documents that I think would be very helpful in looking at definitions. One is the NCQA definitions for patient centered medical homes. It's hard to imagine that one is going to go dramatically wrong in terms of direction.

The second is a document that we should probably post, which is a set of draft primary care standards that were collaborated by the Department last year for Medicaid.

And those two documents, I think, will be useful to you in thinking about what it means to be a patient centered medical home, understanding that there

may be some things that will be changed or modified by October 1st.

And as well, the patient centered medical home criteria that NCQA or any other organization uses are -- are studies in motion. That is, there are iterations to these and the -- they change over time, as well. Does that help?

MS. EISENSTEIN: It adds to the confusion, but yes.

DR. GESTEN: Okay.

DR. HALE: I'm always like the Polly Anna good news part. The reason we did this was that there's very strong movement within the Medicaid department that enhance funding for primary care. It's critical. And -- you know -- your projects are going to need support for those primary care practices that need to be coordinating care.

And so we want to keep this very closely aligned with this so you can take advantage of this and you're talking -- to bring the stakeholders in

and you're talking with primary practices and you say, Listen -- you know -- part of this practice, we're going to get you to the electronic systems to help you take advantage of funding that's coming forward from New York State Department of Health Medicaid program and also funding coming from the stimulus funds, as well. This is for the funding that's coming forward.

So it does mean -- it would be great if everything was physically aligned and timely. It's not. But there is a lot of information that's been reported, and we'll put some links up for the agencies, as well.

There is a lot of information out there that can give you really good guidance on the most important concepts you're going to need.

MS. EISENSTEIN: So on that same

line then, when you look at OB/GYN, would you consider those primary care for this group?

DR. HALE: We're going to answer

that one electronically, because my being an internal medicine doc for a number of years, I should not answer that one.

MS. EISENSTEIN: Okay. It's just that you do list high-risk pregnancy as one of the high-risk factors that we can focus on. So that comes up.

DR. HALE: Yeah. I think -- and it's a very good question. That's why I'm not jumping to answer it. And we have a really good clinical group in that area in the Department of Health, so we'll consult them.

One of the great things about this project is we had a lot of clinical people from very, very good -- from the Department of Health to work with us to construct this, so we have them to ask them these questions.

MS. EISENSTEIN: One or two more.

Can an IPA be a lead applicant?

DR. HALE: The idea of the applicants, the lead applicants, is a clinical model. So again -- you know --

you can submit -- you can submit a question on the specific one, whether they're going to fall into the stakeholder bucket.

But the critical part of this is that you're going to have to be looking at the diagnosis that you're dealing with and the patient care group that's taking care of them. So I don't know all the different ways that an IPA is formed, but it's usually not built around that model.

So I think that we'll -- I would submit that and we'll look into it. Because, immediately, I don't see that being the obvious model for a coordinating care model for this kind of process.

MS. EISENSTEIN: Okay.

MR. BLAIR: John Blair, Taconic IPA. So I'd also be interested in the

answer to that question. I'm with Med Allies in the Hudson Valley and the THINC Project. I'll try not to go with Matt Kendall's approach to try --

COURT REPORTER: Please speak into the microphone.

MR. BLAIR: -- that leads my questions with exposing your scoring criteria. So I'm trying to understand the fifty percent position thing and then the seventy -- up to seventy percent.

DR. HALE: No. Greater than seventy is even better.

MR. BLAIR: Okay. Okay. So the fifty percent to beyond seventy. It sounds like the driver is the diagnosis and then the population that falls under that diagnosis.

So in the Hudson Valley, if we were to pick congestive heart failure, are you saying all of the patients with congestive heart failure that are in the Hudson Valley, or those patients with congestive heart failure that are taken

care of by the group that has been in the patient centered medical home set?

DR. HALE: What you're going to be doing is you're going to be picking

-- you're not -- again, it's not geography. So -- you know -- you just don't pick the Hudson Valley and just do it for the Hudson Valley. What you're going to want to do is look and find a group of physicians who are referring care for a patient population and you can do various sizes. And in that group, it's the referral pattern of that group.

So we're not looking in this case -- and it is different in this case. We're not looking to just -- you know -- fund something for a region -- a region. We're looking for projects within a region that say, These are the primary care physicians in this medical home that are involved in this population. And you're sizing your population.

And -- you know -- some may choose to do large size populations.

Some may choose to do smaller. But -- you know -- you got to pick it according to the coordination of the care of that patient population for that diagnosis.

Not all of them for any given region.

MR. BLAIR: Okay. So it sounds like there's a couple variables as you put this together. The diagnosis and the patients that fit that diagnosis, and then the medical home -- patient centered medical home group. Okay.

DR. HALE: Right.

MR. BLAIR: So -- so does that mean, then, that you -- that under one application, you would only have one patient centered medical home group? Or could you have four or five? So that you have a group of maybe 200 providers in one county, a hospital and physician group of 150 in another county. Could you bring those two or three or four or five together under the application, even though they may not cross-pollenate on the patient population?

DR. HALE: Right. I think --

we're going to look and try and give some more specific detail on some of these -- when you would need to do one application or two applications. But

right now, what we see is that if based off -- you're picking the diagnosis and the patient population. If the caregivers for that patient population don't overlap, then you're going to need to do two projects. Now, if they do overlap -- and we'll publish what that -- you know -- we'll even try to lead into the percentage of something for that. If there's an overlap, then if you consider doing a single project -- but what we don't want too see is one entire referral group here and then another entire referral group here with no overlap in the same culture.

MR. BLAIR: Okay. That's going -- that's going to be tricky with two 7 million and up to two per region and then meeting those criteria. It's going to be tricky. All right.

So then the next thing is

electronic health records and those that are implemented that may or may not meet, be it 2008 or so, and then we'll upgrade -- I mean, I agree with you.

The connectivity is the big deal there. But, do you have any preference one way or the other, whether you're starting from paper and moving on or starting from certified systems and moving them on?

DR. HALE: The preference really here is coordination of care across the populations. So -- you know -- if I was going to say anything, I would say if you could get eighty percent by doing it from an upgrade, I'm much happier with that than I am with -- you know -- fifty percent from paper.

MR. BLAIR: Yeah. 'Cause you're going to spend most of it getting them just up to scope. So even if you had '08 and then connected them and moved on, that's okay?

DR. HALE: Oh, absolutely. This is all about -- you know -- clinical

provision of care supported by --

supported by -- you know -- electronic

systems.

The key here is what is the best

combination you can come up with to get that patient population cared for in your given region. That's really what it's about. That's the big driver for all of the -- you know -- scoring decisions.

MR. BLAIR: Okay. Thank you.

DR. HALE: We will -- I think we will definitely take into consideration the discussion about what you do with projects in various regions. That's an -- that's an issue -- I knew when things came up in the Q & A there would be interesting issues that we ought to consider further and I think that's one.

MR. SMITH: If you could submit that electronically, so we don't forget.

MS. GALLANT: Christina Gallant, Southern Tier Health Plan.

COURT REPORTER: Could you move to this microphone? I'm having trouble

hearing from that one. Sorry.

MS. GALLANT: Christina GallanIS, Southern Tier Health Link. Are you funding PHRs, whether they're an add-on

to an EMR or a -- for example, a small hospital if they wanted to get electronically connected to an exchange?

DR. HALE: If the -- if the -- if the technology is going to be used to connect either patients or clinicians actively -- and it can be shown to be actively used to -- you know -- to be involved in their care --

MS. GALLANT: As part of the zone?

DR. HALE: Yeah. Then -- I'm not going say that we cover PHRs --

MS. GALLANT: Right. But is that a twenty-five --

DR. HALE: But if it -- if it's -- if it's part of the process of actually improving the sharing of data to improve the patient care population, then it's included.

MS. GALLANT: So the concept

would be to include the patient in the project itself using that tool.

And then the followup question.

Would that be fifty percent or

twenty-five?

MR. SMITH: The only funding limitation that we put was on hospital HIE at twenty-five percent.

DR. HALE: And long term --

MR. SMITH: And long term.

MS. GALLANIS: So that would fall under the fifty in lieu of a written question and answer?

I'm curious on the match. You didn't, this time, do any percentages on cash and in-kind. What does that mean? I have to ask. I've been through three of these.

MR. SMITH: It means we didn't do a split between cash and in-kind.

MS. GALLANIS: Just making sure it wasn't an oversight, because I know you've been very busy.

DR. HALE: We love it when you do that.

MS. GALLANIS: And allowable costs on connecting to SHIN-NY. Is there any restriction on just the connection part or can you also include, for example,

the first year of subscription fees for the data source? Or is it just the connection piece that you're going to do allowable on?

DR. HALE: Subscription fees for what?

MS. GALLANIS: Well, generally there are fees -- ongoing fees once you have connected to the exchange that a data partner would experience. So the question is, would that be allowable?

DR. HALE: It's -- again, the key component is going to be showing that whatever that is going to be used for is required in order to share data between the caregivers. But write down that electronically so we can be sure we're addressing it correctly.

MS. GALLANIS: Okay. Thank you.

MR. BIZZARRO: Dominick Bizzarro from the Healthcare Information -- I

want to go mobile here -- Exchange of New York. That's Bizzarro, B like in busy -I-Z-Z-A-R-R-O. Two questions, one more technical.

On page forty-one in the project stakeholder grid, column four and column six look the same where it says, Briefly describe the role in the project, including PCMH and CHITA.

DR. HALE: On the attachment, you mean?

MR. BIZZARRO: Yeah. It's section 6.3. I'm sorry. In the attachments.

DR. HALE: Okay.

MR. BIZZARRO: And column six says, Briefly describe role in project. Is that -- could you help me understand the difference between the two?

MR. SMITH: The difference -- what was the first one? The difference between --

MR. BIZZARRO: Briefly describe roles in projects, including PCMH and CHITA. And then column six, Briefly

describe roles in projects.

MR. SMITH: I think what we're looking for there, Dominick, is if you were bringing stakeholders that weren't

as directly involved in a CHITA, for example, what is your reason for bringing them in? What function are they going to provide?

MR. BIZZARRO: Okay.

MR. SMITH: So there might be some overlap there. There's probably some duplication.

MR. BIZZARRO: Okay. Second question, and I don't know if Dr. Gesten might want to respond to this. But with respect to back in the attachments in section 6.6, model 2.C, we're talking about page fifty-two in 6.6 in the attachments.

We talked about the clinical measures for evaluation and there's a couple listed there. So that's in model 2.C in 6.6.

DR. HALE: Oh, okay. Yeah, yeah, yeah. Okay.

MR. BIZZARRO: So there's a couple measures that are listed there and then there's kind of an accordion and some latitude on defining those

measures. Is that something that you think between now and May 11 or whenever the final set of questions are through is something that you think will evolve more or be shared more, or is it sheer latitude focused on that population for what you think coordination measures should be based on your research and references that you look for?

DR. HALE: At this point in time, I'm expecting it to be the latter. We're expecting that depending on the diagnosis and the experience and the structure of your organizational structure for caregivers of patients, you're going to be having -- you know -- specific measures you may already be looking at or wanting to look at and they need to be supported.

If -- we're always -- you know -- if there is a sharing that can be

done -- if people want to share ideas and thoughts that are referenced, please feel free to send those in and we would gladly post them on Q & A for others to

be able to resource from. We're more than willing to do that.

But when you look in that literature, we decided that it was so broad that there's no way to list possibilities to cover -- we just gave a couple of examples.

So that's what they are. They're not what you have to do. They're examples. We know that depending on the diagnosis and the structure of your model, you're going -- and the structure of things you're already doing, you're going to want to -- you know -- you're going to want to come up with the measures that you're going to want to use.

MR. BIZZARRO: Okay. So beyond that there is nothing in the New York State Department of Health project, primary care project or in the

directives or directions there.

DR. GESTEN: I would look past that.

MR. BIZZARRO: Okay. And then

just to confirm, Steve. 6.15 is important?

MR. SMITH: Yeah.

DR. HALE: It kind of depends on how --

MR. SMITH: It is that whole pass/fail thing.

MS. FERRARI: I didn't know the requirement was you had to be funny. Pam Ferrari from the Open Door Family Medical Center. Ferrari like the car.

I'm seeing that the patient centered medical home is probably the lead organization here. That looks like that's sort of the way we're headed anyway.

And so then we're looking -- then we're talking about a target population of patients within that patient centered medical home. And are we -- and we want fifty to -- fifty to seventy percent of

the --

DR. HALE: More than seventy

percent.

MS. FERRARI: More than seventy

percent. And more than seventy percent of the referral people that you refer to.

Are we looking at a number of patients in the target population? Is there -- are we -- I would imagine you would get more points for more numbers. You probably don't want twenty-five --

DR. HALE: This is going be a breadth and depth balance, so I would not say that necessarily you would. It's really going to depend on how your project is going to be put together on whether -- you know -- you're doing the -- you have that good balance of breadth and depth.

MS. FERRARI: So it would really be possible to submit an application where you have 500 patients in your patient centered medical home with -- with diabetes and coordinate care for

those 500 patients and do a really good job.

DR. HALE: I hope so.

MR. SMITH: You can submit

anything you want.

MS. FERRARI: I hope so.

MR. KAY: And she will. Paul Kay from Hudson River Health Care and CHITA. My question is about capitalizable/ non-capitalizable stuff.

So much of the emphasis is on improving the use -- assistance of improving care coordination, improving referral, improving and insuring the use of systems. That's all labor. I mean, that stuff is almost all people. To what extent can any of those people cost turn out to be capitalizable? So otherwise, you have to buy stuff that you might not actually have to buy.

MR. SMITH: Two comments. One, is I'll ask Tracy if she has anything to add here. But there are specific IRS accounting type of guidelines as to what counts as capitalizable versus

non-capitalizable. So you need to have your accounting-type people review what your proposed expenditures are and make that determination.

DR. HALE: And it's not like -- it isn't a strict -- a absolute line.

MR. SMITH: Well, there is an absolute line, that non-capitalizable cannot be more than forty percent.

DR. HALE: No, but I mean in terms of the evaluation of what is capitalizable and non-capitalizable.

MR. SMITH: Tracy, do you want to --

MS. RALEIGH: There's some pretty good guidance in the RGA. There are accounting standards that govern how you capitalize a project from an accounting perspective. But generally, if it can be included as part of the startup of a project that you ultimately -- that you can capitalize from an accounting perspective.

Let me start again. Sorry. I'll refer you to the RGA, because I do believe there are specific references to

accounting guidelines that can help you govern whether funds are capitalizable or not.

Your point -- one differentiating example I think of is ongoing maintenance, like labor that goes into the ongoing maintenance of a project, would not be a capitalizable expense. But if you have labor that goes into the development of this particular project, then I think it would be capitalizable.

DR. HALE: People labor isn't just automatically categorized one way or the other.

MS. RALEIGH: Right.

MR. KAY: And to the extent that you can provide official kinds of guidelines. We found this in the last application. It's really a gray zone, because it's really not maintenance support. It's development of new users and sometimes that involves purchasing something and learning how to use it. Sometimes it involves new uses of

something you purchased years ago and now you all of a sudden started to use it.

DR. HALE: If you would like to

submit specific -- you know -- specific examples, we will refer to our experts to get answers.

MR. KAY: Thank you.

MR. SMITH: But the primary response -- this was an issue in previous HEAL projects -- was there are specific IRS guidelines and you need to adhere to those.

So I don't think we'll be able to provide a lot of specific -- this is, this isn't -- we're not going to do battle with the IRS. That's up to you.

MR. KAY: Okay. I'm not so sure the guidelines were clear enough on this kind of subject. So maybe you guys actually get to determine some of that for them.

MS. WORDEN: Amy Worden with the Community Healthcare Association of New York State. I have two questions with

two entirely different spins on the project.

And this probably is very similar to what John Blair was asking, but I

think in a different sense in that a collaboration of different primary care medical home providers on a statewide FQHC organization. They're -- obviously -- like-minded providers have been working closely together in technology and primary care medical initiatives. That would make certainly the very broad region and separate RHIO participation. But is that a project that fits?

DR. HALE: Not if it goes out --

MR. SMITH: One of the things you need to keep in mind is you have to define your Care Coordination Zone and after you define your Care Coordination Zone, one of the attachments -- and the number escapes me -- has you articulate the numerator and denominator for all of the three components. So you're going to want to pick your Care Coordination Zone, I would think, very carefully.

MS. WORDEN: Right.

DR. HALE: Are you meaning that you're talking about a statewide project?

MS. WORDEN: It would be broad, yes.

DR. HALE: I mean, it would go over multiple regions?

MS. WORDEN: Yes. And again, it would be primary care medical home providers, different organizations that are all primary care medical providers.

MR. SMITH: Again, keep in mind, if you have a project that traverses multiple -- different colors on the state map, you need to pick the one that the majority of your patients reside.

DR. HALE: Right. So -- you know -- if they are spread over all six or five of the six, that's --

MR. SMITH: You've got to pick one.

DR. HALE: Right. That's not going to work.

MS. WORDEN: And then setting

that aside totally. Can -- forgive me if this was already covered.

Can a stakeholder, a project participant and stakeholder, be named in

multiple project applications? And I'm coming from that from like the RHIO perspective.

I certainly -- just from some of the players here in the room today, there are a lot of projects cooking up from different types of community care providers. I can envision that a RHIO or even an established CHITA possibly would be approached on many different projects? Is it up to the RHIO to choose just the one that they think will be most successful? Can they participate in all of those?

DR. HALE: The only requirement would be that once projects are awarded, we would never be able to pay for duplicative services.

So if you had a particular stakeholder who was in three projects, all in the same region -- you know --

and it was the same -- part of that stakeholder organization that was doing it, if those three were -- three or two, because two in a region -- maybe three

if they got past the other thing, then -- you know -- when they were awarded, they'd only be able to get funds from one of them. That would -- but as far as participating, that is not a problem. It's just that we can't pay for something more than one time for any given service.

MS. WORDEN: Great. Thank you.

MR. SILVER: Alan Silver, IPRO, I-P-R-O. Are there specific categories of government or private foundation grant sources that would not be allowed as matching funds?

MR. SMITH: Dollars that are coming from the State of New York are not allowed to be used as matching funds for these type of projects.

Tracy, is there anything else that would be of mention?

MR. SILVER: That's it? Thank

you.

DR. CAPPONI: Louis Capponi, HHC.

I'm always impressed when I think I

understand something and then after

looking at it for a while I realize I don't.

In this diagram in front of us, I understand -- you know -- clinicians as stakeholders and patients as stakeholders. What is the denominator for stakeholders in that third bucket, and how do you quantify over seventy percent of that?

DR. HALE: So that would be -- stakeholders would be -- for example, if you chose a diagnosis of diabetes, some of the stakeholders in that might be -- you know -- hospitals -- one or more hospitals. It could be one or more home healthcare agencies. It could be -- you know -- any number of supportive agencies that could be involved. And that would be the stakeholders.

DR. CAPPONI: So we would, in our applications, define the places or

services that that patient or that patient population is likely to go to?

DR. HALE: Yes.

DR. CAPPONI: Create that as the

denominator and providing evidence of that. Thank you.

MR. SMITH: And you were probably surprised to see we provided a table for you to do exactly that.

MS. SMITH: Nancy Smith, Health Advancement -- S-M-I-T-H. I never get to spell it. Could you put up the eligibility slide? I have some clarifying questions.

And also, just so that I can make sure I understand it. Is CHITA synonymous with service bureaus synonymous with regional extension centers?

DR. HALE: No. No. I didn't say that at all. We're not saying that they're so much synonymous in that they're all part of an infrastructure that we'll need in New York. I mean -- so, you're going to have an overlapping

statewide infrastructure and within it -- under that -- and it's not necessarily determined by region as much as need. It's going to be a bunch of --

you know -- types of organizations supporting implementation.

MS. SMITH: So the services that each of those three may provide are different or the same?

DR. HALE: Well, what we'll -- what we expect to see happen, and obviously ONC isn't complete with their requirement for what the regional extension centers are going to be, but the expectation and the discussions are -- is that they're going to take a regional approach of not specifically providing services, in most cases, although there may be exceptions.

But be a resource center that's coordinating so that those kinds of needs are provided wherever they're needed within the area. We're looking at the same kind of context in New York State, where we need to all work

together on a collaborative process.

Is that -- you know -- we need to

have a similar kind of approach so that

no matter where you are in New York,

there is some kind of infrastructure that you can reach to that, (A), will tell you what services are available, and then, (B), tell you what services you really need and how can you keep up with what those services are on an ongoing basis. And this is part of building that infrastructure.

MS. SMITH: Okay. That wasn't my question -- but thank you. In the first category of eligible applicants, it's very clear they must have an active role in care -- in patient care.

In the second CHITA, if an applicant -- I assume that also carries. They must, too, have a role in the care of the target population and not simply be --

DR. HALE: Only a service organization --

MS. SMITH: Is that correct then?

So that applies to both?

DR. HALE: I want to make sure that I'm in the same -- I mean --

MR. SMITH: There is a definition

and we're trying to find the section of what a CHITA is. So I would refer you to that definition relative to the --

MS. SMITH: I heard very strongly the importance of having the medical engagement and --

DR. HALE: Well, yeah. I mean, it's -- the trouble is I don't see that as a black and white question, because if you're going to have clinical involvement in the CHITA, whether specifically from a clinical organization or otherwise, depending on the structure.

But you're going to have to have workflow support and clinical support for implementation and planning across these projects. So we expect to see that now. You know.

Does it have to be a specific type of clinical organization -- we have

to specify that. It's more -- it's more of what service does it have to provide that we've addressed --

MS. SMITH: I meant if they are

the lead applicant.

DR. HALE: The lead applicant for the project, yes. We already talked about the CHITAs. The CHITAs are the ones that -- in terms of --

MS. SMITH: In terms of eligible applicant or lead applicant. Specifically, it's the first or the second.

MR. SMITH: And the second is the CHITA.

MS. SMITH: Is a CHITA?

MR. SMITH: Right. And the definition of a CHITA, what a CHITA is and what a CHITA provides is listed --

MS. SMITH: Okay.

MR. BAILEY: 3.2.1 and 3.3.5 are where the definition of what a CHITA should be.

MS. SMITH: And then if the CHITA is not the lead stakeholder, and let's

say you wanted to create a CHITA, again, could that be more of a non-clinical service orientation? Or again, you see the term CHITA saying that --

DR. HALE: We expect people to be creating CHITAs under the definition that we have. You know. If there's specific parts to that definition that are unclear, please ask the question.

MS. SMITH: All right. And if there is a new organization formed, does that put it in a compromised position relative to being a capability question? Is the organization stable? Has it been around --

MR. SMITH: That's something that you're going to have to define as part of your financial application.

But I would also remind you that whoever the lead applicant is has to be able to contract -- to execute the contract for the State of New York. So they have to be a legal entity.

MS. SMITH: And you mentioned that from a technology standpoint that

they need to work through a local health technology --

DR. HALE: A minimum -- either through the SHIN-NY or through the local

hub, but not direct proprietary connection. That's the same as we had in the other ones.

MS. SMITH: Okay.

DR. HALE: It's the same concept.

MR. MITCHELL: Mitch Mitchell with Relay Health. Just a clarifying question on the definitions of the regions relative to specific projects.

The regions will be defined by where the patient population is most heavily concentrated or where the organization is located, if they're close to a border.

DR. HALE: They have to match. Sorry -- oh, okay -- I think he interpreted your question for me.

So the idea is that your patient population is in one region, but some of these main organizations are across the border?

MR. MITCHELL: Correct.

DR. HALE: This is really referred by the patient population.

MR. MITCHELL: Okay. So there

would be a part --

DR. HALE: And it's the referral patterns by the patient population that would be evaluated.

MR. MITCHELL: Okay. And so the application would be for the region in which the higher concentration of patients within that category exist or reside?

DR. HALE: Yes.

MR. MITCHELL: Okay. Is there going to be any restriction on the disease categories by region for the awardees? In other words, would two diabetes programs be awarded in a particular region, or doesn't it vary at all on that?

DR. HALE: We don't see any problem with that. This is really a depth and breadth kind of thing. If you can show that you're going to provide

care --

MR. MITCHELL: You mentioned earlier, as well, that the geographical definition of the regions changed from

prior definitions. Will there be some clarity provided on that?

DR. HALE: You have a map in the RGA.

MR. MITCHELL: The map is there today --

MR. SMITH: In the RGA, there is a map and there is a list of counties that feed into the regions which are being used for HEAL 10.

DR. HALE: It won't be changing from that map. The map in the RGA is --

MR. SMITH: If you're looking for something that happened in the past, I'd suggest consulting those historical documents.

MR. MITCHELL: Okay.

DR. HALE: We won't show you the old one, but that's the one that's --

MR. MITCHELL: Okay. Also, just a point of clarification. Someone had

asked about PHRs. And you mentioned in the -- in the documents that portals would also be considered a viable technology, a fundable technology.

Non-EHR solutions that are not yet -- that don't yet fall under any certification model would qualify?

DR. HALE: Yes. If it's -- if it's a technology that can be shown within the RGA response to be critical and important to the care of the patients and showing that it's involved in that patient care process, then we're not limited what that technology is.

But that's the key. It has to be shown that that is the best methodology to provide improved care for that patient population and coordination between those caregivers.

Because in some cases, clearly, EHR is going to be the preferred one. In other cases, that may clearly not be/ and there are other models that may be better or -- or however it best fits.

MR. MITCHELL: Okay. Regarding

health plan participation, would an example that you're intending to include a health plan sponsored disease management program around a particular

disease state. Is that an example of the type of health plan participation? Because I also saw reference to reimbursement.

DR. HALE: Right. Reimbursement -- reimbursement models are the ones that we would see targeted for enhanced scoring. Certainly others -- you know -- that's great. But the ones that we targeted for enhanced scoring was specifically reimbursement models.

MR. MITCHELL: Okay. Thank you.

MR. DIVER: Joe Diver, D-I-V-E-R, from Bassett Healthcare, new CIO. Question.

If an organization had a development project underway that included ambulatory electronic health record and a portal strategy, but did not meet CHITA certification, do we lose points in that structure or --

DR. HALE: There is no CHITA portals --

MR. DIVER: For EHR?

DR. HALE: Your EHR, in order to

be fundable, it's going to have to either become certified as part of the project or already be certified yearly.

MR. DIVER: Okay. Great. Thank you.

MR. KENDALL: Matt Kendall, New York City Department of Health's Primary Care Information Project.

In the RGA, it talks about CHITAs not being vendor neutral. Can you explain what that means?

DR. HALE: Yes. This -- I miss Lori. If Lori was here, she'd know the answer better. Yeah.

The idea here was that we don't -- we want -- the whole infrastructure for New York is the idea of an open marketplace. And so the concept here is when we build these -- these -- all the things that we're building, the SHIN-NY and everything else, we don't want it to

be tied to specific vendors. We want it to be in a structure as much as possible so that the providers of care are the ones who are in the driver's seat on who

are the best vendors to provide that care.

So that's what that means. That means that we're looking for the project to be designed not around being locked into a certain vendor. That's doesn't mean that -- you know -- we're looking for people to change vendors necessarily. It's just models that don't require it to be locked into certain vendors.

So when people are putting in their proposals how they're going to be looking and evaluating and they haven't chosen a vendor yet, we want to see the model on how they're going to do that and not have people just jumping to assumptions that they have one vendor for something and they're just going to -- you know -- do that and wouldn't even consider others.

Do you want to add anything to that?

MR. SMITH: I would just add that none of these discussions are complete

without the state indicating that it's vendor agnostic in all of these discussions.

MR. KENDALL: Okay. So the CHITA in terms of services that are provided need to be receptive to their target population. They don't have to provide exactly the same sort of services with every vendor that's out there?

MR. SMITH: Yes.

MR. KENDALL: Yes. Thank you.

DR. HALE: You got actually a yes.

MS. PERRY: Hi. Lisa Perry with the Community Healthcare Association of New York State. As you know, I am hung up on this fifty percent issue, trying to figure it out, and I know we've gone over and over it.

But in the RGA, there's no reference to fifty percent of patients

and I think I read that pretty

carefully. So is that a new -- there is

reference to fifty percent of clinicians

and fifty percent of stakeholders. Is

that -- it's a two-part question. Is that a new requirement now?

DR. HALE: It is not a new requirement. If it's not -- we'll have to research it. If it's not listed there, we'll be sure to list it in the Q & A.

MS. PERRY: Okay. And then if it is a requirement, I'm trying to figure out you how do the denominator on that.

DR. HALE: The denominator is the -- whatever you chose as a CCZ, a patient population within that coordinated area, with that diagnosis.

MS. PERRY: But if it's your CCZ, if it's your primary care medical home, why would a patient with that diagnosis not be included? Why wouldn't it --

DR. HALE: I'd love them all to be.

MR. SMITH: Well, the alternative

was to say a hundred percent. If you're doing a diabetes project, the alternative is to say a hundred percent of diabetics.

MS. PERRY: I'm not going to say I'm going to serve that diabetic but not that diabetic.

DR. HALE: No. But see what's going to happen is -- and ideally I would love to see everybody have every member of a primary care medical home in their region and all the providers that are referring in that hundred percent. And hopefully you'll all be able to do that.

Realistically, in trying to get everybody cooperating and joining, we don't have structured models everywhere where there's -- you know -- clinical groups. We have areas where there's multiple -- a multitude of primary care physicians scattered around an area who do or do not coordinate with each other.

MS. PERRY: Right, but --

DR. HALE: You may end up with an

area -- let me finish. You may end up with an area where you're trying to serve a population that is being -- you know -- provided by this group of

primary care physicians, but not all of that group of primary care physicians in that region is participating.

So -- you know -- if patients -- if you're going to have to choose a population and an area of coverage and that's why -- that's why we wrote it that way.

MS. PERRY: But I thought the primary care medical home is defined as a group of primary care physicians?

DR. HALE: It is.

MS. PERRY: Right. So if you're basing your home on that group of physicians, then you would be covering all of that group of physicians' patients in --

DR. HALE: But that's the only way -- if you choose to derive your CCZ that way, then that is true. However, that's not the only way to define a CCZ.

MS. PERRY: All right. Okay.

Thank you.

MR. MATTHEWS: Steve Matthews,

Montefiore Medical Center. Two

unrelated questions -- the questions are not related to each other.

Number one, and I may have missed this in the documentation, but is there a list of CHITAs that have already been established or can you give us a reference?

MR. SMITH: There is no list listed in the RGA. The only reference that we would provide is if you do go to the DOH website, there are CHITAs that were HEAL 5 awardees.

DR. HALE: They were projects -- let me -- let me correct that slightly. Sorry. You can correct me later.

But there were -- in HEAL 5, we funded a number of projects that were around the implementation of electronic record -- electronic record systems and ambulatory care. Those projects were termed CHITA projects. However, those

projects would not all fall under the criteria of what we're saying is necessary for full implementation.

So I would not make any

assumptions. That's a place to go where there are projects that were started, some of which may have reached the full CHITA support structure, some of which may not have.

If you contact the RHIOs, the regional RHIOs, all of those that are listed there, there are other RHIOs that have not been funded by the state money.

So it's a population to look into but there is not -- there is no assumption that any given one listed there meets the criteria of really what's written in the RGA to become a CHITA, because we know that we need better development of this kind of support system.

MR. MATTHEWS: The second question may be appropriate for Dr. Gesten. Is New York State Medicaid open to reimbursement models for PCMH?

DR. GESTEN: Yes. That's part of what the legislation is about. It's the definition standards coupled with enhanced reimbursement for meeting those

standards.

MR. MATTHEWS: So that would be presumably covered in the regulations that will be promulgated in the fall?

DR. GESTEN: The reimbursement may or may not be in regulation, but there will be -- again, the statute speaks to enhanced reimbursement attached to those standards and there will be an articulation. It may not be in regulation -- I don't know if they're going to be putting rates in regulations, necessarily, but it will be an articulation of what those rates will be.

MR. MATTHEWS: Thank you.

MR. ONG: Ken Ong, Catholic Health Services of Long Island. I understand the EHRs for hospitals and that EHRs for ambulatory have to be CCHIT certified. There aren't, as far as I'm

aware, any CCZ certification for long

term care facilities. So would -- would

the funds be restricted to just

hospitals and ambulatory care?

DR. HALE: No. No, no, no. No. If the system that you are going to be implementing and using state funds for has CCHIT certification available on a yearly basis, then that is required. However, if that is not available, then we are not requiring it and we're not restricting to only paying for those systems that you have CCHIT certification.

But what will be necessary, though, is that any system that is implemented is going to need to be able to participate in -- you know -- in the version one requirements and things for the State of New York.

So we are going need that kind of infrastructure. However, CCHIT certification is broad and doesn't cover a lot of the systems that we know are going to be part of this project.

MR. ONG: Thank you.

MR. BLAIR: John Blair, Taconic IPA. Just in followup to the question before on the patient, the fifty percent patient thing, now I'm wondering. How

-- what's the numerator? I know, for example, in the -- in the Medicare or the CMS medical home project that's held up by -- being held up by CBO approval, they are going -- they have -- a patient has to have signed in that they are part of that. Do you anticipate something like that? So how are you going -- how are you going to derive your numerator?

DR. HALE: We're definitely deferring to the projects to define those. You're going be defining your Care Coordination Zone, your patient population within that Care Coordination Zone with supportive information on why that was chosen and what the numerator and denominator are.

MR. BLAIR: But part of the medical home is the patient engagement. And -- and let's say you have 1,000 congestive heart failure patients. How

do you know that those are truly part of the medical -- in the Medicare project, they will have signed that they are part of it?

DR. HALE: Okay. That's a good question. I don't have an answer for that one. We'll have to figure out what we're going to have as requirements for medical home.

DR. GESTEN: But I would say that's sort of the intent. And the funding is different in the two projects in that for the CMS medical home project, as you know, there is a specific dollar amount that goes to specific individuals as part of that medical home incentive.

And I would say that there's some difference here in terms of what this project is about and what it's funding. So -- you know -- I think it's a slightly different intent, but I don't think -- but we can talk about it and get a full answer, what's specifically required for the SHIN-NY to say a person

is going to be capable to be involved in this initiative, which had a lot to do in transforming the practice in ways that may or may not be educational for

the physicians.

MR. BLAIR: Part of getting you there is the patient's involvement. And, I mean, I'm raising the bar for everybody here if we do this, but I'm just saying that how do you know that those patients are truly a numerator?

DR. HALE: Right.

MR. BLAIR: And I understand, Foster, that the piece or part of the reason with Medicare is that they're paying for those patients in their equation. So how do you know? How do you verify that? So that's just my question.

DR. HALE: And we know how we love piles of paperwork. It's hard enough to evaluate which clinicians got their EHR.

MR. BLAIR: I just want to make this possible. So if we do that --

DR. HALE: That means we can chat a lot. I understand.

MS. GREINER: Hi. Laura Greiner from the Primary Care patient model. A

question about the stakeholders and letters of support.

Are you able to add stakeholders at a later date and then -- do you need letters of support from them later or do you have to define all the stakeholders in the beginning and have your letters of support?

DR. HALE: Your -- your RGA will be evaluated and scored on what comes in with the proposal, not what may or may not happen later on.

MS. GREINER: Okay. Thank you.

MR. CHECK: Tom Check, Visiting Nurse Service of New York. This is perhaps a followup to some of the discussions that you had about the Care Coordination Zone. I want to make sure I understand this.

The Care Coordination Zone is largely constructed around referral

patterns, if I understand correctly. If the referral patterns for the patient population in question include stakeholders or clinicians, they're

already part of RHIOs but they're not all part of the same RHIO. Is it correct to assume that it's fine for them to continue their participation in the existing RHIOs because the RHIOs -- as part of this program, the RHIOs work out the data exchange among the RHIOs? That's okay? Okay.

DR. HALE: Well worded. Yes.

MR. CHECK: Thank you.

MS. SUMER: Good morning. Zeynep Sumer, S-U-M-E-R, Greater New York Hospital Association. Just one question. Is there a state defined list of RHIOs?

MR. SMITH: No.

MS. SUMER: No? Thank you.

MR. SHANNON: Trip Shannon, Hudson Midway Health Network. Back to Care Coordination Zones definitions.

If you assume, again, referral

patterns, is there any reason why you

couldn't bring -- and make the

assumption there's probably overlap of

Care Coordination Zones and any given

zone has a hundred percent variation captured there. Can you group that together under one CHITA, three Care Coordination Zones as one that has significant overlap?

DR. HALE: There has to be -- that -- and we're going to try to get some better information on when something would need to be a separate project or a joint project.

But yes, I mean, the clear and important thing would be there needs to be an overlap within those organizations. We are -- you know, initially considering at least a fifty percent overlap of some sort, but we'll try to get more definition on that, because that obviously is an issue that we have to get more refined with.

MR. SMITH: Going once --

MS. HEIMANN: I'm going to ask a

very specific question. Katie Heimann, Jewish Home Life Care.

So, say we have three nursing homes and we want to define our patient

population as diabetics within our three nursing homes. First of all, could we do that?

And then, would you care which of our corporate entities apply in the application? I mean, 'cause we all are different corporations.

DR. HALE: My best answer to that one would be that it's not -- it isn't the nursing home that's necessarily the definition. It's the pattern of care in support of that patient.

So -- you know -- even nursing home patients -- you know -- they move in and out of other care settings. In fact, I've worked in a lot of nursing homes and they move in and out a lot.

MS. HEIMANN: Right.

DR. HALE: And they have consultants and then a variety of caregivers.

So again, what we're looking at is not -- you need to take that patient population and look at the referral patterns of the stakeholders and build

it around that model.

MS. HEIMANN: So that would be one nursing home?

DR. HALE: I don't know. I don't know. Even in just places I've practiced, I can think of a case where it might be and I can think of another case where it cannot be.

So -- you know -- we're not trying to be purposely vague. It's just because there is such a variety in the patterns of which care are given that we want to be open to that. We don't want to be restrictive.

MS. KEMPER: I don't have a question about the Care Coordination Zone.

DR. HALE: Not yet. Apparently this is --

MS. KEMPER: It's early yet.

COURT REPORTER: Can I get your

name?

MS. KEMPER: My name is Garland Kemper. I'm from --

COURT REPORTER: Could you say it

again?

MS. KEMPER: Garland Kemper from Unisys. I'm one of those agnostic vendors.

And my question is related to being a vendor and your vision about the timeframes for projects to identify their vendor partners and their technology solutions that they're going to propose, whereas you have your chart of allowable costs.

And you talked briefly in an answer to another question about choosing -- describing in your proposal and your response to the grant application -- describing how you were going to choose your vendor. And it's -- I would envision it virtually impossible for somebody to have complete cost information if they hadn't already chosen their technical solution.

So I'm just sort of looking for a little clarification on how you expect projects to choose vendor partners.

DR. HALE: Our experience has

actually been that -- that people are able to get -- you know, what people do is they do evaluations and they do research and they do background information.

And our experience with previous funding is that it's not necessary to have chosen a vendor by any means in order to construct good proposals and good budgets. We've seen many good ones that have not and they've included their methodology on how they will do that and they've done the research ahead of time to get some numbers to use either with collaboration with others within the state that they know -- you know -- to talk to or even with a combination of vendors to get suggested costs.

MS. KEMPER: Okay.

MR. SMITH: The other piece that I would add to that is the HEAL dollars

need to be allocated into one of the five cost categories. The matching dollars do not.

MS. KEMPER: Okay.

MR. RAB: My name is Shamiq, S-H-A-M-I-Q, last name is R-A-B. I'm the vice-president and chief information officer of -- medical center.

COURT REPORTER: What's the name of the medical center?

MR. RAB: Orange Regional Medical Center. We have Orange in New York, too, but --

DR. HALE: We don't grow oranges up here, so --

MR. RAB: I know. I know. But I had to stand up because everybody here asked questions and I felt left out.

So first of all, I want to thank all of you and acknowledge you for doing this so that the patients who live in New York can communicate better and there will be better healthcare.

I just want to ask you a question. What do you envision by

spending 60 million dollars will happen to the healthcare in New York? A little bit -- because everybody is trying to get the money. I want to find out

what's going to happen. One day, I will be a patient and so will my children. That's all I wanted to say. Thank you.

DR. GESTEN: His application gets funded. I don't care what it is.

MR. SMITH: I'd just like to say, Foster's views do not represent --

DR. HALE: Personally, I just look forward -- I've always looked forward to the day where I can look at something that is a little bit on the concrete side and instead of giving patients -- information technology was used to coordinate the care of patients in a real way. I think that's a very hard place to get to and we need to know so much more.

So this is a good thing. That's at the end of the day what we'd like to see, but we know that we have so much to learn to get there and we have a lot of

infrastructure across the state we've got to build, and HEAL 10 is just a part of that discussion.

So the biggest part of this

project is also the discovery, the working together that -- we've enjoyed some days better than others with HEAL 5, the learning that's taken place, the collaborative process so that we all can get better at doing this, because we're all on an early road and the only way we're going to learn how to do this the right way is by diving in and -- you know -- doing the hard stuff to try to do it and learning along the way and trying to apply that to the next level.

And that's what's being -- each of these have been. What do we learn from what we've done, what do we know we need to get to and how do we try to fund to learn to get to the next level? That's my personal opinion.

MR. RAB: Thank you so much.

MR. SMITH: I guess with that, I'll do one last call for questions.

And as people are or are not coming up for questions, just a reminder that we'll be accepting electronic questions until May 11th at five p.m. We will be

posting interim responses. As questions come in, we'll be trying to turn them around as quickly as possible, so check the website for that.

And I guess with that, we'll adjourn. I thank you all for participating.

(Whereupon, the Conference concluded at 12:28 p.m.)

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C E R T I F I C A T E

I, Nora B. Lamica, a Shorthand Reporter and Notary Public in and for the State of New York, do hereby certify that the foregoing record taken by me is a true and accurate transcript of the same, to the best of my ability and belief.

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Nora B. Lamica

DATE: April 20, 2009

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