1

2 NEW YORK STATE

DEPARTMENT OF HEALTH

3

4 HEAL-17 PRESENTATION

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DATE: July 15, 2010

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TIME: 12:10 p.m. to 1:48 p.m.

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1 Heal-17 Presentation - 7-15-2010

2 FOR THE DEPARTMENT:

3 Rachel Block, Deputy Commissioner, OHITT

4 Steven Smith

Patricia L. Hale, M.D.

5

ALSO PRESENT:

6

Christina Glanis

7 Jennifer Romanowski

Nancy Smith

8 Cynthia Fryden-Warsh

Valla

9 Cheryl King

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1 Heal-17 Presentation - 7-15-2010

2 (The presentation commenced at 12:10 p.m.)

3 (The proceeding commenced before the reporter

4 connected)

5 MS. BLOCK: -- did a request for grant applications for

6 HEAL-17, and Steve and Pat are going to be walking you through

7 the presentation, and Steve will, I think, again give folks

8 instructions. If you're having any difficulty accessing the --

9 the Web-Ex, there is a PowerPoint available.

10 And -- and maybe Steve, you can just go back over those

11 instructions one more time for anybody who might have just

12 missed your tutorial a moment ago.

13 We really appreciate your joining us today and we're

14 just thrilled that we are able to offer what we think is going

15 to be the last round of HEAL funding opportunity for health

16 information technology activities here in New York State.

17 Obviously I think you all recognize that New York State has been

18 a real pioneer both in terms of policy activities to support

19 health information technology, but also through the HEAL New

20 York grant program, and as a result we've been able to advance

21 the development of infrastructure to support health information

22 exchange and advance a broader adoption of health information

23 technology across the healthcare system with the use of the HEAL

24 New York dollars. And so we're very proud of that legacy, but

25 we did have an opportunity, under the terms of the HEAL New York

2 program, and the federal waiver which helps to support our
3 funding of that program, to authorize this one additional round
4 of funding. So, we'll be talking a little bit more about the
5 different purposes that we've outlined for this program, and
6 then of course, the specifics for the competitive R.G.A.
7 Because this is a part of the HEAL New York program,
8 and I made reference to this federal waiver which provides
9 federal matching funds for this program, that requires -- and
10 any of you who have been through this before will know, that the
11 awards for -- under this program, must be made by September
12 30th, which is the end of the federal fiscal year.
13 And so, the first thing I would like to say, in
14 addition to welcoming you and telling you how proud and excited
15 we are, is to apologize a little bit for the tight turnaround
16 time that we are required to impose for this particular round of
17 funding. We've done some things to try to help to ameliorate
18 the impact of that, in terms of reusing many documents that we
19 used for the Heal-10 process, and so anybody who -- who used
20 those documents before, and -- and -- or even just looked at
21 them before, you'll see that hopefully we'll make it a little
22 bit easier to respond to this as a result.
23 But anyway we have a very tight turnaround time to
24 complete all of the steps for a competitive procurement right
25 through to the award stage, and so we apologize a little bit for

2 that tight turnaround, but obviously we think there are enormous
3 benefits that can accrue to the communities and providers and
4 consumers for participating in these programs. So, we think
5 it's worth your while to explore this further, and the purpose
6 of today's call is to go into a bit more depth, and then also
7 talk a little bit more specifically about the -- the -- some of
8 the deadlines associated with the program.
9 So, Steve, unless you thought there was something else
10 that I should address in my opening remarks, I'm going to turn
11 it over to you and Pat to walk through the slides.
12 MR. SMITH: No, that's great. Thank you.
13 To introduce myself, my name is Steve Smith. I'm the
14 director of operations. I work in Rachel's office, and I'm
15 pleased to provide information today related to HEAL phase
16 seventeen.
17 The first thing I want to do is let people know there
18 was a question that was raised on the Web-Ex. Are we going to
19 be addressing Heal-20? We're not going to be addressing Heal-20
20 in this conference, so if you're here for Heal-20, you're on the
21 wrong plane, so you can hang up now and -- and save yourself
22 some time.
23 For those people that have not been able to get into
24 the Web-Ex for whatever reason, the PowerPoint presentation that
25 we're going to be walking through today is available on the DOH

2 Web site. It's the same U.R.L., the same location where you
3 found the R.G.A. Specifically if you go to nyehealth.gov, in
4 the bottom right-hand corner there's a link for help information
5 technology. That takes you to health I.T. page that talks about
6 a new funding opportunity. If you click on that new funding
7 opportunity, you get taken to the HEAL-17 page, and on the
8 bottom of that page, under request for grant applications,
9 there's a series of documents which include the request for
10 grant application, the attachments, the budget worksheets, et
11 cetera, et cetera. The very bottom bullet there -- the very
12 bottom document, is the PowerPoint presentation that we'll be
13 walking through today, and I'll try to remember, and -- and Pat
14 will as well, to indicate what page we're on as we move through
15 it.
16 So, if we turn to page two of the PowerPoint
17 presentation, the agenda items that we're going to talk about
18 today. We'll go over some basic ground rules as they relate to
19 today's call and to the HEAL-17 process. We'll be doing an
20 overview, talking about the goals that are associated with
21 HEAL-17, describing allowable costs. We'll describe the
22 application process, as well as the -- as well as the awards
23 process, and then we'll open things up for questions and
24 answers.
25 We are scheduled to go to two o'clock today, and we do

2 have a hard stop at two o'clock, so we'll address as many
3 issues, answer as many questions as we can, during that time
4 period.
5 Moving on to page three, we'll be starting with the
6 ground rules. The first ground rule that I need to make clear
7 is that the responses to questions that we provide today should
8 be considered unofficial. We will be asking people whether they
9 are submitting questions via the Web-Ex and getting answers, or
10 if they're just submitting questions on their own. So please
11 submit all questions in writing to the U.R.L., to the e-mail
12 address that's listed on this page. The question and answer
13 period ends at five p.m. on July 16th. We will have responses
14 posted on or about July 23rd, and those responses will be posted
15 on the same Web site, the same U.R.L. where you found the grant
16 application.
17 We will also be posting a transcript of today's
18 teleconference, so if there were some points that were made that
19 you want to review, you'll be able to go back over the
20 transcript. Again that transcript will be posted on the D.O.H.
21 Web site.
22 As Rachel mentioned - and I figured I would address
23 this right up front, because I know the question is going to be
24 asked and probably asked repeatedly - the dates, the time lines,
25 et cetera, that have been published, and that we'll be talking

2 about today, unfortunately have absolutely no flexibility at
3 all. They are hard dates. Basically what we've done with
4 HEAL-17 is taken a process that typically takes ten to eleven
5 months and we've compressed it down into about a
6 three-and-a-half-month time frame. So every portion of the
7 process, from the development of the R.G.A., through the writing
8 of the responses through the R.G.A., through the various
9 evaluation and approval steps that have to take place, have all
10 been significantly compressed, so we're all on a compressed time
11 frame.
12 If we move on to slide number five, the next area that
13 we'll be discussing today is -- or are the -- the goals and
14 objectives. The overview associated with HEAL-17, and for that
15 I'll turn things over to Dr. Patricia Hale.
16 Pat? Who will use star six to unmute her line. Pat,
17 are you there?
18 (No audible response)
19 MR. SMITH: Okay. I'm going to assume that Pat will
20 jump in eventually, and to keep things moving I'll start through
21 this. This is to discuss the strategic focus of HEAL-17.
22 The goals, the objectives of HEAL-17 are basically to
23 continue to advance to New York's health IT infrastructure,
24 based on clinical and programmatic priorities that have been
25 established by the Department, that have been established by the

2 state, with the specific goals of improving quality,
3 affordability, and outcomes of care.
4 HEAL-17 is --.
5 DR. HALE: Hello?
6 MR. SMITH: Pat, you there?
7 DR. HALE: Yes.
8 MR. SMITH: Okay. You want to --
9 DR. HALE: Can you hear me now?
10 MR. SMITH: -- pick up on -- yeah, slide number six?
11 DR. HALE: Yeah. I -- I'm very sorry. My phone
12 didn't -- didn't work on the normal numbers.
13 Yes. This is Pat Hale. I'm deputy director of the
14 Office of Health Information Technology Transformation, and as
15 Steve was saying, the idea here is to pick up on the framework
16 that was already built for previous HEAL projects, in order to
17 leverage the infrastructure that already exists, in terms of
18 causative processes, different kinds of support networks, the --
19 the RHIO networks and the SHINNY infrastructure, to connect with
20 providers, to be able to share information to help in patient
21 care.
22 And what we're really looking for here is to further
23 the ability to use information systems to share information
24 across providers for improvement of care of chronic diseases,
25 where the particular focus, in this case on reaching out to more

2 providers in the care of mental health illnesses, and also in
3 chronic diseases that are associated with mental health
4 diseases.
5 As we did in Heal-10, we're -- we're focusing on
6 patient-centered medical home models, which is a key
7 underpinning in New York State for improving care across the
8 state, and improving the coordination of care across the state.
9 So, as we did in Heal-10, we are focusing on paying for the
10 information systems to support the patients that are in medical
11 home, not only for the primary care providers, but the other
12 providers who are sharing data with primary care in order to
13 improve the patient care for these populations.
14 In addition, the communication between providers to
15 share data, and also to be able to do other kinds of things,
16 like clinical decisions before, and for other value-added
17 services to patient populations.
18 HEAL-17 is reaching out particularly to mental health
19 providers, and also bringing in long-term care and home
20 healthcare providers, to share data in the patient-centered
21 medical home model.
22 So if we go on to slide seven, the -- the five key
23 components of HEAL-17 are this -- what we're talking about right
24 now, which is a hundred and twenty million specifically in
25 competitive R.G.A. for this improvement in care coordination in

the patients that are medical home, extending out to mental health, long-term care, and home care. We're also continuing our support to try and build the infrastructure to improve this collaborative care through information technology, by twelve million to advance the operations of the state health information network of New York, which is the infrastructure that's been expanding across the state, that allows providers to share data with each other in standardized ways through their regions and then eventually across the state.

In addition, we'll be supporting four million dollars for collaborative process work. And through HEAL-5 and Heal-10, there's been a lot of work done to try to develop specific guidance in New York State, on the implementation of information system in a consistent way, and built on consistent standards. And all projects will be brought into that process, so that all stakeholders can continue to work to make consistent policies and consistent leverage the -- the -- the federal work, and also the state work, on standards and policies, so that we can share data in a uniform way.

There will also be two million dollars to develop the framework for RHIO accreditation. And as I said earlier, through the work of previous HEAL grants we've developed a number of REOs across the state that have been linking in providers, and now we're going to work towards accrediting

2 the -- the REOs so that there will be a framework where there
3 will be consistency across the state in how the -- the REOs are
4 functioning. And providers will be guaranteed that there will
5 be certain qualifications and abilities by REOs to connect to
6 providers, such as Medicaid and others, who require certain
7 types of framework and types of structures within REOs, in order
8 to connect to them.
9 And finally, there will be two million to support the
10 evaluation of the projects, and as we have done in the past, we
11 have worked with a collaborative in New York State called High
12 Tech, which has a number of universities working together with
13 significant experience in the area, specifically with health
14 I.T., to evaluate the projects, and also evaluate the work that
15 we're doing in building the SHINNY infrastructure across the
16 state.
17 If you go on to slide eight. Slide eight shows how
18 we're working our HEAL programs to support several levels --
19 important levels of health information technology, and also how
20 this matches up well with what's going on with -- at the federal
21 level, with A.A.R.A. (sic) and meaningful use, so at the base of
22 this strategy is the building of the SHINNY network which is
23 standards and policies that allow us to share data in uniform
24 ways across the state. And all of our HEAL programs have been
25 supporting the building out of this infrastructure, supporting

2 the RHIO infrastructure, but also very importantly, the
3 collaborative process that's developed, the policy guidance by
4 which everyone can comply in the state to share data in a
5 uniform way.
6 And this matches really well with meaningful use. One
7 of the important considerations of meaningful use is that there
8 needs to be promotion of electronic exchange of health
9 information across providers in a standardized way. So, this --
10 the SHINNY infrastructure is pushing that initiative forward in
11 New York State by developing policy guidance and also working
12 closely with the federal government guidelines for the entrance
13 structure.
14 The middle layer is the aggregation of data,
15 measurement and reporting, and services that can be provided to
16 improve data exchange and also care of patients. And again,
17 we've been supporting, through our previous HEAL projects, and
18 we'll continue through HEAL-17, to build services that are --
19 are of use to everyone across the state for data exchange. This
20 is another major area of focus for the federal government in
21 promotion of clinical decision support, collection of quality
22 metrics, and also in the ability to share important data with
23 the Department of Health, in terms of immunization data and also
24 by surveillance data.
25 And at the top level is the interaction with the

2 clinicians, patients, and the community. And this is the
3 implementation level for electronic health records themselves,
4 and also the ability of those records to be able to share key
5 clinical data between providers. And -- and again, we're --
6 we're supporting this through all of our efforts in -- in
7 HEAL-5, 10 and 17, and this aligns again with the A.A.R.A.
8 (sic), particularly currently electronic prescribing is one of
9 the key focuses. There's also a share of the clinical care
10 document and these -- these capabilities within the electronic
11 health records are being promoted on the federal level with
12 certifications, which will help us to promote the communication
13 between providers at the state level as well.
14 If we go to the next slide, slide nine. In terms of
15 HEAL-17 R.G.A. requirements, again, as we've said before, it's
16 building on the patient-centered medical home model that was
17 initiated in our grant support in Heal-10, and has been a major
18 focus for many programs in New York State and elsewhere. In
19 order to promote this continuation of the patient-centered
20 medical home model, applicants must provide a minimum of
21 evidence of -- of a completed and accepted application for
22 review by N.C.Q.A. And the reason we're doing this is that we
23 want applicants to be able to have already had some preparation
24 in the area of patient medical home, but we aren't requiring, at
25 the start of this project, for everyone to already be certified.

2 So, what we are requiring for applicants is that
3 they've already begun the process, and that they have put
4 together the information for the application for N.C.Q.A., which
5 does involve evaluation of your practices. And then move on to
6 the certification levels of level two and three during the
7 course of the project itself. If projects already are certified
8 at level two or level three, then they are also encouraged to --
9 to apply.
10 So we're really looking for projects that are moving
11 forward with the patient-centered medical home model, and are
12 ready to take these next steps in expanding their
13 patient-centered medical home by supporting health I.T.
14 communication between the providers for -- for the care of the
15 patients in that medical home.
16 Eighty percent of the P.C.P.s included in -- in the
17 project must achieve the N.C.Q.A. patient-centered medical home
18 level two by the beginning of next year, which is at the
19 contract stage beginning of the project. And they need to reach
20 level three certification by the end of the project. So we're
21 really looking, again, for projects that are already beginning,
22 or for projects that include providers that are already working
23 on the patient-centered medical home model, either at the very
24 early ages of application, or have already achieved these levels
25 and are moving forward, so that they can now take advantage of

2 the electronic system to -- to implement more and more of the
3 requirements for the medical home model.
4 In addition, we think it's critically important that
5 there is a mechanism within the community to support
6 implementation of electronic health records. This is a
7 community effort. In order to take care of patients, you know,
8 a community needs to work together. It's a very complex process
9 in coordinating care across multiple providers and services
10 within a community. And we think it's in on -- ongoing,
11 long-term process, so people to work together and plan as they
12 move forward. So again, we're promoting that the community
13 health information technology as action-collaborative, as we
14 have in HEAL-5 and Heal-10.
15 And this, the -- we call them Cheetahs. And what
16 Cheetahs do is they coordinate the supporting services for
17 implementation. And there -- there is a list specifically in
18 the R.G.A. and there's rules and information about what's really
19 required to support implementation of electronic health records
20 across not only primary care providers, but the other providers
21 in -- in the medical home, and the coordinated zone that the
22 project is going to cover. And the idea is to really pull a
23 group of people together who will support each other with the
24 implementation tools, not only for the short term of starting
25 the project, but for -- for the long term, as we move forward

2 and the levels of meaningful -- meaningful use start going
3 higher and higher, and the needs in the community for
4 coordination of care extend.
5 Go to slide ten. Collectively the target zone that
6 we're talking about for projects are the patient-centered
7 medical homes, coordinated around the specific diagnosis that
8 the project chooses. So, the first thing the project would do
9 is chose the -- the diagnosis for which they're -- they're going
10 to do their project. And then around that diagnosis they need
11 to organize the patient-centered medical home, which will be the
12 primary care providers, and the other providers within that zone
13 of care, that will be the referral base for the care of that --
14 that patient population. And this -- this group, together with
15 the -- the -- those who will be helping in the implementation of
16 the services for the information systems and the connectivities
17 of the information systems, makes up the C.C.Z., along with the
18 patient population that's targeted by this project.
19 So the patient -- the patient diagnosis will determine
20 the target patient population, and the caregivers that are
21 included with those primary care physicians in the care of that
22 patient population for the C.C.Z. The C.C.Z., or the
23 care-coordination zone, is not determined by a specific
24 geography. It may be appropriate for a geography to be used in
25 the determination, however it is totally acceptable for this to

2 be chosen outside of a specific geography, but really based on
3 referral patterns for the patients that are cared for by the
4 project. So, don't feel that it's necessary that it be -- you
5 know, to specify a particular geography for your project. Think
6 more in terms of the diagnosis and the patient population, and
7 the caregivers that are necessary to provide care for that
8 patient population.
9 The projects also need to include a partnership with a
10 RHIO. And we really feel strongly that it's important for our
11 projects to take a strong role in informing, moving forward, the
12 policies and the requirements in New York State for health
13 information technology. We want this -- a bottom-up approach
14 where projects are helping us determine what sort of things we
15 can do in support of information technology in New York, and the
16 REOs are a key component of that. They're very active in the
17 regions of New York State, in pulling providers together,
18 discussing what are the priorities and the important areas for
19 connectivity, and what are the issues and collaborative
20 opportunities that we can determine across the state for things
21 like statewide services and other thing -- and policies and --
22 and -- and technical requirements that will support information
23 technology. So, one of the requirements is to participate in
24 partnership with a RHIO, to discuss how their projects will
25 coordinate with the -- with the RHIO, in terms of activities

2 within the region.

3 If you go to slide eleven, slide eleven is a diagram

4 that's basically an overall picture, to try and tie these

5 concepts together. So, if you look in the center, there's a

6 purple section that says the patient-centered medical home.

7 Then you'll see an arrow that goes across to a blue section that

8 says the target patient population. So the most important key

9 component is picking the patient population with a specific

10 diagnosis, and we'll talk about those in a second -- about

11 targeting the diagnosis. And once that diagnosis and that

12 patient population is --is chosen, then tying that to the

13 patient medical home, and the primary care providers who will be

14 caring for that patient population.

15 Then the -- the next important part of the project is

16 to consider who are the important providers for care of that

17 population. And in this case, we -- we certainly recognize the

18 providers that are typically included in projects, and patients

19 in medical home, which will be other consultant physicians that

20 are very important for the particular diagnosis. Other types of

21 services, like physical therapy, nutrition services. Also

22 pharmacies, for connectivity for, certainly, ordering

23 medications. Hospitals and other types of organizations is the

24 part that are providing intermittent care for the patient

25 population, and public health and other agencies. But in

2 addition we -- and labs and X-rays.

3 In addition, particularly in --in HEAL-17, we want to

4 be sure that mental health services and home care and long-term

5 care are included. So, projects must identify these -- these

6 particular providers, and how they're going to be linked into

7 their projects.

8 That makes up the -- the care-coordination zone, the

9 combination of patient population and the caregivers who are

10 coordinating the care of that patient population, makes up the

11 care-coordination zone.

12 Then at the bottom of the slide, this was to represent

13 the technical and then also the governance structure that

14 organizes this relationship across projects in New York State.

15 So from the technical side, we look for the electronic health

16 records to be connecting and communicating through standardized

17 mechanisms that are built -- built around the policy guidance

18 that's been developed in New York State, and that allows the

19 electronic health records to communicate in a standardized way.

20 And that communication across the state builds up through the

21 REOs, and through services that are provided across the state,

22 to build what we're calling the SHINY, the state health

23 information network of New York.

24 On the left-hand side, we also, in order to accomplish

25 this sort of electronic connectivity, we need a supportive

2 structure to do this, in -- in terms of two parts. One part is
3 the supportive hands-on structure of an organizational structure
4 that has hands-on support to the projects for implementation of
5 electronic health record systems and also the connectivity
6 between them. And that's what we looking for the Cheetahs to be
7 doing, to be organizing and helping support that.
8 But in addition we need organization at the state
9 level, regional and state level, and we look towards the REOs as
10 an organizational structure for the regions, and then New York
11 eCollaborative is a state-level organization that would partner
12 with the Department of Health, bring together all of these
13 groups, the stakeholders, to -- to work towards consistent
14 policies, and move regulations if necessary, and also implement
15 standards that are going to support this process moving forward.
16 So, all of our projects will be required to participate in the
17 collaborative process that we've developed through the previous
18 HEAL opportunities at the state level, as we move forward,
19 that's organized through New York eCollaborative.
20 To go to slide twelve, this talks a little bit more
21 specifically about the care-coordination zone and particularly,
22 as I said before, this is going to be targeted around particular
23 patient populations. So, in this particular case, in HEAL-17,
24 we're going to be talking about two types of patient
25 populations. One: The patient population with specifically a

2 mental health disorder, and the other is a patient population
3 with chronic diseases that -- that have a high preponderance of
4 mental health issues associated with them. And in that C.C.Z.,
5 a key component is the primary care physician, to the center of
6 the patient-centered medical home, to coordinate and refer and
7 work with all of the other stakeholders, in order to provide
8 care to this population.
9 It's very important that the applicants agree to comply
10 with the patient-centered medical home requirements as they're
11 promulgated. The N.C.Q.A. model is the model that we're
12 currently using for certification in New York State. And
13 there's an opportunity, through the collaborative process, to
14 work together with not only other HEAL-17 projects, but also our
15 Heal-10 projects, to talk about implementation methodologies for
16 medical home. And that's one of the key areas that we think is
17 going to be very important in the -- in the coming year, having
18 the projects talk together about the real practical aspects of
19 applying the requirements for the medical home into the work
20 flow.
21 And as I said earlier, the Cheetahs are a key component
22 of making sure that there's a supportive structure, and so we
23 look for, specifically, adoption of support services that are
24 coordinated through the medical home, including things listed
25 here such as sharing of best practices, support of the clinical

2 practice transformation, training providers, and ensuring that
3 there's a proper configuration of technical infrastructure to
4 allow that sharing of data. And this is going to be supported
5 at the Cheetah level, but also the collaborative process at the
6 state level, with NYeC, is intended to help support this so that
7 projects can share best practices, and try to develop consistent
8 practices across the state that will make it easier for
9 everybody.
10 If you go to slide thirteen, another requirement list
11 for the applicant, they're obligated to demonstrate improved
12 coordination and management of patient care for the target --
13 target patient population, based on clearly defined measures
14 determined to be important through the collaborative process.
15 So, one of the things we're looking at is to be sure that we
16 have the projects directly involved in -- in developing
17 specifically what we want to use as ways of measuring success of
18 the project.
19 Also explain how the information will be routinely
20 shared with patients so that they're the center of care. And
21 one of the important things that we hope to see moving forward
22 is more and more active role of patients in their care. It --
23 this goes beyond just the concept of having them be able to
24 access their medical records, but really involving them in the
25 coordination and decision-making process of their care.

And then we also are looking to hear projects explain the method that will be used to share information gained from the evaluation of the project with project stakeholders. And what we really are looking for here is for projects to be able to say how are we going to measure ourselves, and how are we going to tell the stakeholders that are participating with us that we're doing what we hoped to in the care of our patients. So, although we don't expect to see, at the end of the project, significant measures already coming back in about the improvement of care, what we do look forward to seeing is the mechanism set up by projects where they're looking at themselves, and they're sharing information, that they have a mechanism to share information with their stakeholders, to show that they -- they are improving care through the -- through the project.

To go to slide fourteen, another key component is the designated stakeholder participants in the medical home need to have an active role in the care of the target patient population and are an active participate in a -- in a recognized RHIO. And we talked about that earlier, about how it's a key component of our strategy to have participation in governance, and discussions at the -- at the regional level, and then also at the state level.

And again, the next point is the -- the importance of

2 the collaborative process through the Cheetah, to help promoting
3 the adoption of -- of the necessary tools in an ongoing basis.
4 Not only just getting them in and getting them started, but as
5 they move forward, developing the tools and the connectivity
6 across the projects, so that as we move forward in patient care,
7 we can continue to make -- continue to make improvements in how
8 care is coordinated and information is shared.
9 If you go to slide fifteen, required participating --
10 all appropriate types of providers and caregivers within the
11 medical home are expected to be included in the project for the
12 target patient population. In particular we're looking for a
13 high percentage of the primary care providers to be
14 participating, and also to be implementing the patient-centered
15 medical home. For HEAL-17, we're looking for eighty percent.
16 We think it's critically important that the providers be
17 implementing the medical home, and be the -- the center of
18 electronic connectivity and the coordination of care.
19 In addition, we're looking for at least fifty percent
20 of the appropriate patient providers and caregivers -- the other
21 caregivers associated with the care of the patient. This is the
22 minimum. Certainly projects will be graded higher, the -- the
23 higher the percentages of the other -- of patients and providers
24 are included in the project.
25 If you go to slide sixteen, one of the things that

2 we're going differently here in HEAL-17, from 10, is we're
3 dividing the projects into two specific types. The first type
4 is limited projects. And limited projects are limited in two
5 ways. One is that the maximum funding for the limited projects
6 will be ten million dollars. The other key component for this
7 is that these projects are asked to specifically work on a
8 mental health -- a directly related mental health diagnosis.
9 And in the R.F.A. there is an appendix that lists the specific
10 types and areas of mental health diagnoses. They're based off
11 of the D.M.S. criteria.
12 So, in these projects, you would pick a specific mental
13 health diagnosis for the project, the maximum to be requested
14 would be ten million. And it's still based on the medical home
15 model, should still have the patient medical -- patient-centered
16 medical home with primary care, and needs to have fifty percent
17 or more of the patients; as I said earlier, the higher
18 percentage will be scored higher. Eighty percent of the medical
19 home primary care physicians need to be included, and fifty
20 percent or more of mental health providers need to be included
21 for that specific diagnosis in the C.C.Z.
22 The other types of projects that we're looking for in
23 HEAL-17 are expanded projects. And these projects can have a
24 maximum funding of twenty million dollars. And in this case
25 what we're asking for is for the project to specifically choose

2 a chronic -- chronic disease diagnosis. Again, the diseases are
3 listed in the appendices of the R.F.A. It is -- it is -- we are
4 encouraging projects to choose one of the diagnoses in that
5 appendix. If there is an interest and a specific need in the
6 region for a diagnosis that's not listed, then that can be
7 proposed. But one of the -- the things that we require, and the
8 reason that the diagnoses are listed as they are, is because
9 we're looking for diagnoses that are specifically associated
10 with mental health disorders. So, if another diagnosis is
11 chosen that's not included on that list, we would require the
12 applicant to show, through some references -- specific
13 references and documentation, why that diagnosis is chosen, and
14 why it's more appropriate for the C.C.Z. for that project, and
15 also its association with mental health disorders.
16 In this case, again we're looking for over fifty
17 percent of the patients to be included, that have this chronic
18 diagnosis. And specifically fifty percent of the patients with
19 the chronic disease are -- are to be included, and the higher
20 the -- the percent of the population, the better. We are also
21 looking for high penetration of primary care providers with
22 medical home models, so again it's eighty percent. And we're
23 looking for over half of the mental health providers to be
24 included in the care-coordination zone, centered around that
25 chronic disease diagnosis associated with mental health

2 disorders.

3 In addition, we're looking for over fifty percent of

4 specialists, and -- to be included, and one of the key criteria

5 that we want to be sure is addressed, that at least fifty

6 percent or more of long-term care and home care providers are

7 included.

8 If a diagnosis is chosen which, for some reason, is not

9 appropriate for long-term or home care, then the project may

10 specifically address this in the proposal, and why that's not

11 appropriate for the diagnosis and why they were not included.

12 But we feel that it's very important to be reaching out to these

13 providers, and including them in the medical home model.

14 We go to slide seventeen. It's time for me to hand

15 things over to Steve, who will do the next section.

16 MR. SMITH: Thanks, Pat. The next section is going to

17 discuss an area that people are always interested in. That's

18 allowable cost. Allowable cost for HEAL-17 are very similar to

19 those that were associated with HEAL-5 and Heal-10, and

20 specifically, as Pat started talking about, what we'll be paying

21 for through HEAL-17 are the costs of the technology. This is a

22 technology, a health I.T. grant program, so what we'll be paying

23 for are the costs associated with implementing electronic health

24 records and other health I.T. tools. We'll be paying for the

25 costs associated with implementing the decision support, the

2 clinical informatics, as well as the costs associated with
3 connecting to the statewide health information network for the
4 sharing of the data that will be shared throughout the
5 patient-centered medical home.
6 So, if you go back to that three-tiered diagram -- that
7 three-level diagram that Pat talked about earlier, that had the
8 SHINNY on the bottom, clinical information and informatics in
9 the center, the reporting aggregation, the analysis part, and
10 then the electronic health records at the -- at the top, when
11 you're thinking about whether or not the cost is going to be
12 allowable, if it fits into one of those buckets, then it would
13 in all likelihood be considered an allowable cost.
14 Specifically, we will be paying for the costs
15 associated with the purchase and implementation of electronic
16 health records for providers that are associated with the
17 project, as -- as part of the care-coordination zone. This
18 would include not only the primary care providers that are
19 implementing the patient-centered medical home, but also the
20 specialists that are associated with that. And we will be
21 paying for up to twenty-five percent of the cost of electronic
22 health records for long-term-care facilities.
23 We thought it necessary to put somewhat of a cap on
24 this, since it is kind of a new area that people really haven't
25 got involved in. We could envision that the -- the full grant

2 award could get dumped into this category, so we opted to put a
3 limitation on it of twenty-five percent of the cost associated
4 with those implementations.
5 Additionally allowable costs include Cheetah services.
6 It doesn't do much good to buy the technology if you're not
7 implementing it, if you're not doing the workflow redesign, if
8 you're not ensuring that there's going to be a successful
9 adoption, an effective use of the technology that's acquired.
10 So, the services associated with physician implementation,
11 training, support, decision making associated with the
12 electronic health record, will be included as allowable costs as
13 well.
14 I'm sorry. I haven't been doing my page numbers.
15 We're on page twenty-one now. Pat talked about Cheetah services
16 earlier. Again just to iterate. Cheetah services are those
17 services that address the full continuum of implementation of
18 electronic health records. So, it's the services -- if you go
19 to page twenty-two, it shows that continuum. So it's the
20 services -- everything from when a clinician decides to
21 implement electronic health record, helping them through the
22 vendor selection, working with the practices to do practice
23 transformation, workflow redesign, workflow analysis, doing the
24 system deployment, the system implementation, supporting the
25 physicians, the clinicians through reporting, decision support,

clinical decision support models, performance measures, et cetera, working with the clinicians to make sure that they're interoperable with other providers associated with the patient-centered medical home, and then continuing to provide post-implementation support.

So the Cheetah is basically what we're looking at as being responsible for that E.M.R. implementation continuum, that entire project that's associated from when the clinician decides that they're going to implement an E.H.R., right through go-live and after go-live. So, costs associated with any of those components would be considered allowable costs under the terms and conditions of HEAL-17.

Grant -- the grant dollars -- the HEAL dollars, will -- can be used for up to fifty percent of the total project cost. Therefore, if you're applying for one of what Pat referred to, and what we're referring to as a limited project, that has a maximum HEAL award of ten million dollars, we would be looking for -- we would be requiring a total project budget of twenty million dollars. The other fifty percent comes from matching funds. Those matching funds can be in two forms. They can be in in-kind, or they can be in cash. And actually for HEAL-17, of the fifty percent that is required as match, twenty percent of that must be in the form of a cash match.

So, just to reiterate, the HEAL dollars, whether it's

2 the ten million or the twenty million, would be fifty percent of
3 your total project budget. The balance would then be made up
4 through matching funds that are coming from your stakeholders.
5 Of those matching funds, they can be either cash or in-kind,
6 minimally twenty percent of the fifty percent needs to be in the
7 form of cash.
8 The other thing that you need to keep in mind, since
9 the HEAL program was conceived as a capital improvement program,
10 there's a portion of the expenditures which must be
11 capitalizeable. That has to be at least forty percent. So to
12 say a little bit differently, noncapitalizeable expenses cannot
13 exceed forty percent. And we'll talk about it a little bit
14 later, but expenses will be allocated in the form of milestones
15 and deliverables, and we'll have specific budgeting parameters
16 and criteria and formats that will be required for the HEAL-17
17 projects.
18 We'll now move to the application process. The
19 application, similarly to HEAL-5 and Heal-10, is a two-part
20 application process, part one being the programmatic
21 application, and part two being the financial application. On
22 page twenty-six the program application is described as being a
23 maximum of thirty pages. And yes, in the R.G.A. we do even
24 specify the font, because we've seen some applicants before that
25 were able to put a whole lot into thirty pages, but they only

2 used a six-point font, which made it a little difficult to
3 review. So we've put a requirement as far as font size as well.
4 If you go to section eight of the R.G.A., there are a
5 number of forms that are listed there and incorporated there.
6 Those forms do all need to be completed and included as part of
7 the application, and are included in the thirty-page maximum.
8 Section eight point one point one of the R.G.A. has an
9 application checklist that's associated with it. We would
10 strongly encourage all applicants to go through that checklist
11 to make sure that their application is complete. Applications
12 that are received that are not complete will not be reviewed and
13 will be rejected.
14 Also as part of the program application, you need to
15 ensure that there is no cost information that is included.
16 State procurement regulations require that there's a two-phase
17 review process. There's a programmatic review and there's a
18 financial review. Program reviewers do not have access to the
19 financial information. So, you can see there's a delineation
20 there and a differentiation as to the type of review that goes
21 on, so that it's not a financially driven decision.
22 On page twenty-seven it references attachment six point
23 five. Attachment six point five has pass/fail criteria. And
24 that pass fail criteria determines whether or not the
25 application gets reviewed. On page -- on attachment six point

2 five there are pass/fail requirements. Pass/fail requirements
3 are included in attachment six point five. I've been told you
4 have to say things six times in order for people to internalize
5 them, so I want to make a very strong point here that pass/fail
6 criteria are included in attachment six point five. If those
7 requirements -- if those criteria are not adhered to -- they're
8 very specific what needs to be done, what needs to be included
9 in order for the application to pass these particular screens.
10 If those requirements, if those items are not there, the
11 application will be rejected.
12 The second part of the review process is a financial
13 review or a financial application. If you go back to the D.O.H.
14 Web site, there are a series of spreadsheets, and we'll be
15 talking about them at a relatively high level in a couple
16 minutes, but all of the spreadsheets, all of the Excel files,
17 financial attachments are required as part of the financial
18 application. Additionally, projects will be reviewed for
19 cost-effectiveness. The reviewers will be looking at the
20 financial sustainability, not only of the applicant as an
21 entity, but it will also be looking at the financial
22 sustainability of the project. Obviously this is a significant
23 investment of public funds that's being made through the HEAL
24 program, and the state wants to do everything it can to ensure
25 that the entities that receive the funding, that the projects

2 that get funded, are going to be sustainable, and they're not
3 just going to fall off the face of the earth, if you will, when
4 the contract is completed and the -- the grant period has been
5 reached.
6 The -- to talk in a little bit of detail, on page
7 twenty-nine about the project budget, there is a project budget
8 worksheet that's included on the Web site. There are multiple
9 tabs on that. There's a project budget. There's project
10 funding. There's revenue, expenses, and a technical
11 architecture tab. We'll be talking about all these in a little
12 bit more detail in a minute.
13 Keep in mind that for HEAL-17, very similar to Heal-10
14 and HEAL-5, we are looking at it as a milestone-based,
15 task-oriented type of project. So, the way the budget should be
16 put together are based on milestones. We will be paying people
17 through HEAL-17 to actually do work and show us what has been
18 accomplished, as opposed to some other grant programs where, if
19 you spend the money you get reimbursed, and that's all there is
20 to it.
21 When you're looking at the milestones, and you're
22 putting dollar figures around the milestones, keep in mind that
23 the milestones equal your work -- your work plan. That's your
24 project plan, and that's the full scope of work that's included
25 as part of the R.G.A. that's included as part of your

2 application. If you specifically, looking at page thirty, go to
3 the project budget, the top is a little bit difficult to read,
4 so we've -- we've broken it out.
5 What we're looking for from your high-level project
6 budget that needs to be submitted as part of your application,
7 is to give us the milestones that you see associated with your
8 project. It is going to be an eight-quarter, a two-year program
9 time line, so we'll be asking for you to identify the milestones
10 that you see are key to the completion of your project. We'll
11 ask you to identify what quarter you see achieving those
12 milestones, and then we'll be looking specifically for HEAL
13 dollars that you see spread across those milestones using the
14 five cost categories that will ultimately comprise your budget.
15 So, for example, if one of your first milestones is
16 to -- I don't know -- make something up, implement an electronic
17 health record, for that milestone you would need to identify the
18 software component associated with that, in terms of dollars;
19 you'd need to identify hardware dollars associated with that;
20 personnel dollars associated with that; contractual services
21 that you might be using associated with that particular
22 milestone; and then other nonpersonnel services, miscellaneous
23 dollars that would be associated with it. So, as you're listing
24 out your milestones, under the milestone column, for each
25 milestone you can have dollar figures -- or you should have

2 dollar figures, in any or all of those five cost categories.
3 The sum of the dollar figures in those five cost categories,
4 across the milestones that you have described, will equal your
5 total HEAL funds. And again, for a limited project, it's a
6 maximum of ten million dollars and for an expanded project, it's
7 a maximum of twenty million dollars.
8 If you go on to page thirty-one, the dollars need to be
9 identified as to whether or not they're capitalizeable or
10 noncapitalizeable. And again, as we mentioned, since this --
11 this is officially a capital grant program, the
12 noncapitalizeable/capitalizeable ratio needs to be maintained as
13 described in the R.G.A.
14 On page thirty-two of the presentation, you'll see that
15 there is a continuation of the milestone lines that we talked
16 about a couple minutes ago. And this is where you're going to
17 identify, for each of those milestones, what the cash
18 contribution is going to be from the applicant and the
19 stakeholders, and what the in-kind contribution is going to be
20 from the applicants and stakeholders. So, for each of the
21 milestones that you've identified, you'll have HEAL dollars
22 associated with those milestones, in the form of hardware,
23 software, contractual services, personnel, et cetera, and then
24 you'll also have cash dollars associated with achieving those
25 milestones, and in-kind dollars associated with achieving those

2 milestones. The sum across all of the milestones of your cash
3 contribution and your in-kind contribution is the other fifty
4 percent of the budget that we talked about.
5 So, in the case of a limited project, the cash and
6 in-kind would need to equal ten million dollars minimally, just
7 as the HEAL dollars that we talked about could be a maximum of
8 ten million dollars. So to kind of fine tune that, fifty
9 percent of your budget is in the HEAL dollars, the other fifty
10 percent is in the applicant match, in the form of cash and
11 in-kind contribution. And obviously, the sum of those equals
12 the total project budget.
13 When you're putting your milestones together, we
14 encourage you to have it at a level that we would be able to
15 understand that you've got a good knowledge of what it takes to
16 implement one of these types of projects. Obviously sitting
17 here today it's difficult to totally spec out every milestone,
18 every deliverable that would be associated with your project on
19 a go-forward basis, so we're looking for those key milestones,
20 those critical milestones, that are essential to making your
21 project work, to move it forward, to give us the comfort level
22 that you understand how to get a project of this magnitude done,
23 and move it forward successfully over the two-year time frame
24 that's associated with HEAL-17.
25 On page thirty-three, we're asking for project fund

2 sources. This specifically relates to the in-kind contributions
3 that you identified on the previous spreadsheet that we talked
4 about. So, what we'd like you to do here is to link the letters
5 of support that you're receiving from your stakeholders, that
6 are described in section six point three of the R.G.A., linked
7 to those letters of support by listing them. The stakeholder
8 specifically, the amount that stakeholder is going to be
9 provided in the form of cash, and the amount that that
10 stakeholder is going to be providing in the form of an in-kind
11 contribution.
12 People always ask the difference between a cash
13 contribution and an in-kind contribution. I think the simplest
14 way to think about it is a cash contribution is for something
15 that, if not for this particular project, it would not exist.
16 So, if you have to hire people that are dedicated to this
17 project solely and exclusively, that would be considered a cash
18 contribution. If you have to buy equipment that you're not
19 going to use HEAL funds for, but equipment that is dedicated to
20 this project specifically, that's a cash contribution. If
21 you're using some of your stakeholders' time to attend meetings,
22 if you've got people that are employed by your stakeholders,
23 that are going to be contributing a nominal amount of time or
24 even a fairly significant amount of time to the project, those
25 resources already exist, so those would be considered in-kind

2 contributions for purposes of your project budget.

3 On page thirty-four, we've added something new and

4 different to HEAL-17. Since this is a technology project, since

5 it focuses on technology, we need to see specifically how you're

6 going to be budgeting your technology. So this is going to be a

7 little bit different spin from your full project budget. But

8 what we're looking for here are the technical types of services

9 that you're going to be providing. So it might be any

10 electronic health record for primary care, it might be an

11 electronic health record for a specialist, for a long-term-care

12 provider, for a home healthcare provider. Tell us who the

13 vendor is going to be for that. You won't be held to using this

14 particular vendor, but if you've got vendors that you've been

15 talking to, if you're beginning to identify those vendors,

16 please list those vendors.

17 What doesn't show on this particular slide are the

18 other columns that have the headers of hardware, software,

19 personnel, contractual services, other N.P.S., and match

20 dollars. So, what we want to see for that E.H.R., for your

21 long-term-care provider, that's being provided by vendor X, how

22 many dollars are you going to be spending on hardware, how many

23 dollars are you going to be spending on software, personnel,

24 contractual services, et cetera.

25 So, we'd ask you to use this spreadsheet to basically

2 map out your technology budget, your technology plan, who your
3 vendors are going to be, and how those dollars are going to be
4 allocated across the various cost categories, as well as your
5 match dollars. And we'd ask you to do that for E.H.R.s. If
6 there are other technology components such as portals, or if
7 you're going to be doing E-prescribing separately, or medication
8 reconciliation is going to be a separate program for example,
9 list those out. If there's other components that we've missed,
10 please include those as well.
11 We also want to make sure that you're budgeting dollars
12 that are going to be reasonable to do the connection to the
13 statewide health information network. So, we're asking
14 specifically for you to identify the dollars for the connection
15 of the E.H.R.s to the SHINNY. And if there are other data
16 sources, laboratory systems, et cetera, that are going to be
17 connected to the SHINNY, we ask you to identify those as well.
18 And please add additional lines here as necessary to identify
19 other connections that you're going to be making, and then
20 include the dollars and the vendors that will be associated with
21 those as well.
22 If we go on to slide thirty-five, these are some check
23 tables that we've put in place. And I've identified one type on
24 the presentation. You can tell that some of this may have been
25 recycled from Heal-10, so when on that first line you see total

2 Heal-10 funds, please read that as total HEAL-17 funds, that are
3 requested. And it identifies where you get that dollar figure
4 from. The proposed match comes from your budget sheet as well,
5 so this will give us, at a snapshot, what your total project
6 budget is that you're -- that you're proposing. The matching
7 identification will automatically calculate, to make sure that
8 you're greater than or equal to the fifty percent level. And
9 then the sheet will also provide you the ability to enter your
10 capitalizeable and your noncapitalizeable dollars, to make sure
11 that the ratio is correct for purposes of the project.
12 So these are critical components. These are pass/fail
13 criteria, so we're trying to provide a quick snapshot for you to
14 do a double check to make sure that your project doesn't get
15 rejected because your match dollars weren't of the right ratio,
16 or your capitalizeable to noncapitalizeable was incorrect.
17 On page thirty-six, we're asking for a very high-level
18 revenue and expense budget. The revenue should be in the form
19 of both HEAL-17 and match dollars across the eight quarters
20 associated with the project. And then a high-level anticipated
21 expense number for each of those different quarters, so that we
22 have an idea of what the cash flow's going to look like, what
23 your projected revenue stream is, how you anticipate the dollars
24 coming out, so that it all net -- nets out at the end of the
25 day.

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2 On page thirty-seven, we've provided, and this is an
3 attachment in section six point two, and I believe it's a
4 separate spreadsheet that's posted as part of the R.G.A. as
5 well, a Cheetah services template. Again because acquiring the
6 technology is only part of the battle, the successful
7 implementation is a critical component, and it is obviously, for
8 anybody that's worked on this before, the more difficult piece.
9 We want to know, we want to be assured, that our dollars are
10 being appropriately allocated to each of the different
11 components of that E.H.R. selection, implementation, acceptance
12 continuum. So you'll see, on slide thirty-seven, and in the
13 R.G.A., the various services, ranging from readiness assessment
14 through workflow redesign, product selection, interfaces,
15 dictionary mapping, et cetera, all of the different components
16 associated with implementing an electronic health record, all
17 the types of services that a Cheetah would be providing. We
18 want to see for those what the dollar figures are that are going
19 to be allocated to those. We want you to give it to us on a per
20 F.T.E. basis, so you'll see on the bottom there's a place to
21 plug in the total F.T.E. physicians, and the total F.T.E. other
22 clinicians that will be incorporated as part of the project, so
23 we can look at the number provided that you're going to be
24 implementing, and the dollar figures that you're going to be
25 using, across the continuum of implementation services that will

be provided by the Cheetah.

On page thirty-eight, the application submission process is fully described in section five point four, but very quickly, at a high level, again the program application, which cannot include any cost information, and the financial application, are considered two separate and distinct parts of the application. We ask that you provide one hard copy that needs to be a signed original, and two electronic copies of the -- of both of the applications -- both the program and the financial. We ask that -- actually we require that you submit them both in the native format, Microsoft Word, Microsoft Excel, as well as including a searchable .pdf. It makes it much easier, much more expeditious for us to find things in your application if you include the searchable .pdf, and actually a searchable .pdf is a pass/fail criteria. So if you're submitting a nonsearchable .pdf, your application will be dismissed and will not be reviewed.

Again section eight includes an application forms checklist section. Encourage you to go to section eight and make sure that you've included everything, and again, although it's not on this slide, I'd refer you to section six point one five which are the pass/fail criteria. And again, not adhering to these requirements will result in a disqualification and a nonreview, nonfunding of the application.

Application submission, on page thirty-nine, we must receive applications by three p.m. on August 29th. The address is here. It's included in the R.G.A. as well. Please note --.

DR. HALE: Steve, I'm seeing August 9th? You said 29th.

MR. SMITH: Oh, I'm sorry. August 9th.

DR. HALE: Yeah.

MR. SMITH: Thank you. August 29th (sic). Please note that there has been a correction to the ZIP Code in a couple places in the R.G.A. There was a typo. I think it was listed as 12234. The ZIP Code for us is actually 12237, so please note that and we've also posted that in a -- in a red box on the D.O.H. Web site as well.

Again, those applications must be received by three p.m. on August 9th.

The awards process. Going to slide forty-one. There's a multiple-part review process. The first phase is described in section four point one of the R.G.A. It's basically looking at a very high level at the completeness of the R.G.A., determining whether or not the applicant is really an --an eligible applicant, making sure that the budget at a very high level has got the fifty percent match, and that twenty percent of that fifty percent match is in the form of cash. It's also using the criteria in section six point one five, which again I will

2 repeat six times, so that people make sure they review that, to
3 ensure that all applications pass those criteria as well.
4 The second phase of the review process is more of an
5 analytical phase. It looks at the organizational plan, the
6 technical plan, the clinical plan, the personnel qualifications
7 in the project management proposal, and does an evaluation of
8 those components.
9 As I mentioned, the financial plan -- or excuse me, the
10 financial evaluation is a separate review. That looks at the
11 project budget information, the funding revenue projections. It
12 looks at cost effectiveness, it reviews the sustainability of
13 both the project and the applicant, to make sure that it's going
14 to be a sustainable project on a go-forward basis. Excuse me.
15 Awards will be made based on six regions across the
16 state. As Pat had mentioned, there's a total of a hundred and
17 twenty million dollars that will be disbursed as this component
18 of HEAL-17. What we'll do is after we've scored and
19 consolidated all the scoring that takes place, we'll array the
20 applications from high to low, and then we'll simply be making
21 awards based on high scores. So, we'll start at the highest
22 score and make awards.
23 On slide forty-five you'll see that there will be a
24 minimum of one award per region. Awards, as Pat mentioned, will
25 be made for a maximum of ten million dollars for the limited

2 projects, and a maximum of twenty million dollars for the
3 expanded projects. After each region has received one award, if
4 there are dollars remaining, we will then take the remaining
5 applications, again arrayed from high to low, and we'll award
6 projects based on the fundability of those projects, starting
7 with the high score and going down from there. This second part
8 of the awards process will be irrespective of region. So we'll
9 assure - assuming we get applications from all six regions -
10 that each region across the state has one award. And then after
11 each region has one award, we'll go back to the high scoring
12 projects and then just sequentially award them based on high
13 score, assuming that it's a fully fundable project.
14 So, for example, if we get all done with awarding one
15 project per award -- per region, and we have ten million dollars
16 left, and the next high scoring project is twenty million
17 dollars, we'll skip over that project and go down to the next
18 ten-million-dollar projects, because we don't want to partially
19 fund projects. If we're going to make awards, we want to have
20 those awards fully fund the projects.
21 As Rachel mentioned, we're on a tight time frame. We
22 have to get the award letters out by the end of the state fiscal
23 year, so those letters will be coming out late in the third
24 quarter of 2010.
25 On slide forty-six are the required New York State

2 rights. The right to reject any or all applications, the right
3 to adjust and correct cost figures in consultation with the
4 applicant, the right to waive minor irregularities that have
5 been submitted, the right to reject any application submitted by
6 an applicant who is felt to not be in compliance with state and
7 federal requirements. There are additional state rights listed
8 in section five point six that I would encourage you to review.
9 From a contracting perspective, we're looking at a
10 contract start date to be January 1st of 2011, and the term of
11 the contract will be a two-year contract.
12 On page forty-eight, payment and reporting. Payment,
13 as I mentioned, will be made on a milestone-deliverables basis.
14 There will be quarterly deliverables. Payments will be made on
15 a quarterly basis. One of the first-quarter deliverables will
16 be taking the high-level budget that you submitted as part of
17 your application, and doing a full detailed project budget, and
18 a full detailed implementation plan associated with that.
19 Grantees, awardees, will be submitting vouchers
20 quarterly to the Department. And during the grant period,
21 grantees will be required to submit quarterly reports, along
22 with the vouchers to the Department of Health.
23 And that brings us to the end of our presentation.
24 We've got about forty-five minutes left for questions and
25 answers. But before I get into taking questions over the phone,

2 I would like to remind people once again that any responses that
3 are provided as part of this Web-Ex are considered unofficial.
4 We ask that all questions, whether you get to ask them today and
5 we respond to them, or they're questions that you come up with
6 or don't get a chance to ask today, be submitted to us in
7 writing. The e-mail address is listed there. We would ask, to
8 facilitate our response to your question, to have you please
9 site the R.G.A. section and paragraph, to the extent possible,
10 so that we can hone in on specifically what you're asking,
11 and -- and appropriately respond to your question. We'll be
12 accepting questions through five p.m. on July 16th, and we will
13 be posting a written response to those questions on or about
14 July 23rd.
15 Before I start doing questions, and hopefully
16 responding -- hopefully providing some responses, we do need to
17 come up with a list of participants from today's call, so I
18 would ask that you please e-mail your attendance to the e-mail
19 address that's on page fifty-one. Please include your name,
20 title, organization, and telephone number, in case we need to
21 get back to participants. This will greatly facilitate that
22 process. If you are going to be responding in one mail from
23 multiple individuals, please include each of the individuals'
24 e-mail address as well. If you're doing a one-on-one response,
25 obviously we can get your e-mail address from the e-mail that

2 you send, but if you're responding for other people, I would ask
3 that you please include everyone's e-mail address.
4 And with that, we'll start questions and answers. The
5 way we're going to approach this is again asking everyone to
6 submit their questions to the address provided, so that we can
7 provide a formal response. The responses that we give today
8 will be considered unofficial, and I notice that some of the
9 Web-Ex participants have started posting questions. I thought
10 what we would do is go through those questions first, and if we
11 totally exhaust those questions, then we'll do an unmute and
12 attempt to take questions from the masses in an orderly fashion.
13 So, I'm just looking down through the questions that have been
14 submitted.
15 The first question is: Does the applicant have to be
16 an N.C.Q.A. certified P.C.M.H. or can it be a Cheetah? Pat, do
17 you want to address that?
18 (No audible response)
19 MR. SMITH: Okay. I'll take --
20 DR. HALE: Sorry. I had to turn the mute off.
21 MR. SMITH: -- that as -- okay.
22 DR. HALE: So, I'm sorry. I had to get -- get back off
23 of mute again.
24 The -- the applicant does not have to be a
25 patient-centered medical home. And in fact, what we're looking

2 for is supportive organizations to be doing -- to be the
3 applicant. However, the -- the stakeholders in the application,
4 who are the primary care physicians, need to have, at a minimum,
5 gone through the application process for N.C.Q.A., to start the
6 process to become a patient-centered medical home.
7 MR. SMITH: Thank you. The next question is does the
8 partnership with a RHIO require joining the RHIO or only a
9 requirement -- or only -- my screen just flashed here. I
10 apologize. Does the partnership with the RHIO require joining
11 the RHIO, or only a requirement that the project is compatible
12 with the RHIO's goals and objectives? If it requires joining
13 the RHIO, can part of the grant be used to fund the fees
14 required to do so, even if all, or the majority, of the
15 providers defined in the C.C.Z. are local?
16 DR. HALE: In terms of the RHIOs, it is not necessarily
17 to use -- to join the RHIO for using their technical structure
18 or data exchange. However, we do require that the participant
19 be participating in the RHIO for other purposes in terms of
20 governance, and you know, other work that the RHIO is doing.
21 So, the one exception for the level of participation in the RHIO
22 is that it is not necessary to use the RHIO technology for
23 connectivity for data sharing.
24 MR. SMITH: And the second part of that question is
25 about funding -- funding from the project can be used for the

2 technology connection to the SHINNY, so if that's done through
3 the RHIO, obviously funds would flow.
4 The next question. Would like clarification on the
5 requirement for eighty percent of providers being certified
6 P.C.M.H. level two by the beginning of the project, 1/1/11.
7 This does not align with the current Heal-10 vision for P.C.M.H.
8 by 12/31/11.
9 I'll let Pat response, but I would -- respond, but I
10 would just say that we're not one to one linking Heal-10 and
11 HEAL-17. There's a number of similarities. You'll see a lot of
12 the concepts are the same between the two, but it's not
13 considered a direct sequential process.
14 Pat, anything you want to add?
15 DR. HALE: Yeah.
16 MR. SMITH: Or Rachel?
17 DR. HALE: I would -- I would agree with that.
18 MR. SMITH: Okay. Where can we find the measures that
19 we are required to use in order to demonstrate improved
20 coordination and management of patient care?
21 You'll like this one. Go ahead, Pat.
22 DR. HALE: That's -- yeah, that's where we're -- we're
23 looking for projects to develop their own measures. We are
24 looking towards projects working together through the
25 collaborative process. I think -- and we've heard already from,

2 you know, 10 projects, that there is a lot of benefit that can
3 be accrued by projects working together across the state, and
4 looking at similar measures so they can compare across each
5 other.
6 There are some measures that have gotten, you know,
7 support in the past, published -- you know, published measures
8 that have been used for coordination of care, such as looking at
9 the timeliness for receipt of data electronically, from -- from
10 providers across the full processes or discharge processes. So
11 there are, in the literature, several types of measures that can
12 be considered. So, we're looking for projects to -- to, you
13 know, make suggestions on what measures that they would propose
14 to be looking at, and also we would look for projects working
15 together in a collaborative process, to hopefully come up with
16 things that would be useful across -- across projects. But
17 there's not a specific list.
18 MR. SMITH: Under allowable project costs, attachment
19 six dot ten bullet three A, it states quote, "maximum of fifty
20 percent of the costs of long-term-care E.H.R.s is permitted."
21 Slide nineteen states twenty-five percent; which is correct?
22 I would say that the R.G.A. would be the correct
23 figure, but please submit that, and we'll get a definitive
24 clarification on that and get that back out to you.
25 Next question: Can a new stakeholder join in an

2 application, or are all stakeholders required to meet a minimum
3 threshold?
4 I'm not sure what that question is asking, so we'll
5 skip that and hopefully get clarification when we open up the
6 line.
7 Next question: On a ten-million-dollar grant, total
8 expenditures equal twenty million, is the cash match two million
9 or four million? Need an explanation of twenty percent of fifty
10 percent.
11 Well, in this case if it's a twenty-million-dollar
12 grant, ten percent is the match, so that's ten million dollars.
13 Twenty percent of ten million dollars -- I don't have my
14 calculator, but I believe that would be the two million dollars,
15 so I would say it is the two million dollars.
16 Next question, can you please walk us through an
17 example of a C.C.Z.?
18 DR. HALE: Sure. So, for example, let's chose an
19 example of a project that is choosing -- we'll -- we'll use the
20 limited projects for psychiatric diagnosis. And we'll say that
21 a project is choosing to cover a psychiatric process such as
22 schizophrenia. In that -- in that project, rather than looking
23 at a specific geography of patient with schizophrenia, that may
24 be appropriate. It may be that the referral pattern in the
25 community is such that it matches up with a specific geography

2 of two or three communities or towns, two or three hospitals.
3 However -- but alternatively, it could be really just the
4 referral pattern where, for schizophrenia in a particular
5 region, there'd be a primary care physician to be involved in
6 the care of a specific population of -- of patients with
7 schizophrenia. There would be perhaps a mental health
8 institution that -- that would be involved, an acute care center
9 that may be seeing those patients, emergency room and others.
10 There may be specialists who actually are involved in the care
11 of those patients that, may not actually be in that particular
12 geography, but very important in the care of that patient
13 population. There could be supportive structures like care
14 within supportive environments -- home environments and others,
15 where there might be some home healthcare and other that's -- or
16 that -- that's caring for that care population.
17 So, those -- all of those, that patient population of
18 the schizophrenic patients, and the caregivers who all would be
19 sharing that patient population, including the primary care
20 physician and the referral physicians who are caring for their
21 patients, they in -- would be making the clinical part of the
22 care-coordination zone. Layered upon that would be the
23 supportive structure of the Cheetah, and the Cheetah supportive
24 structure would be either institutions that are already in that
25 community, it could be a supportive structure for -- there's a

2 hospital other than that community has, or implementing
3 electronic health records and health records systems.
4 It could be a RHIO - excuse me - a RHIO in that
5 community that's supporting implementation, or it could be that
6 the providers in that community are going to be hiring out
7 another third party that's -- that's good in -- in helping and
8 supporting implementation of health records. But that community
9 would be pulled together for the implementation aspect of the
10 project, and that would be the Cheetah component of -- of the --
11 the C.C.Z.
12 MR. SMITH: Okay. Thanks.
13 What preaward costs can be applied to matching funds?
14 Additionally what is the period prior to submission or award to
15 identify and track preaward costs?
16 As people may be aware, on the HEAL programs
17 historically, we've been able to allow projects to accumulate
18 matching -- to accumulate their required match as part of the
19 application process. This has typically been able to be counted
20 back to the release of the R.G.A. My assumption is it would be
21 the same for HEAL-17, but we will get official clarification on
22 that. So, please make sure that gets submitted as part of your
23 application. But I would anticipate that you could start
24 tracking matching funds back to -- all the way back to July
25 12th, which is when the R.G.A. was released.

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2 The next question is: If we choose to address a

3 chronic illness, do we need to identify the mental health

4 diagnosis associated with the chronic illness?

5 Pat?

6 DR. HALE: Yes, that would be definitely advantageous

7 to discuss what the mental health illness is. There's not

8 specific requirement on what specific mental illnesses would be

9 approved or disapproved, however the -- the association of a

10 mental illness with a chronic illness, and it is important in

11 order for you to describe the psychiatric component in terms of

12 who, from the mental health profession network, is going be

13 included in your C.C.Z.

14 MR. SMITH: What denominator do you use to calculate

15 the eighty percent and fifty percent P.C.P./specialist and

16 patient population in a C.C.Z.?

17 DR. HALE: The patient population will be determined by

18 the choice of the diagnosis, and the -- well, the -- both

19 really, the referral network required. So, it's a combination

20 of the patient population with the referral network of the

21 providers caring for that patient population. So, if you have a

22 community with, you know, three hundred thousand patients with

23 diabetes, and you're -- you're including in your

24 care-coordination zone the primary care physicians who are

25 taking care of that population of three hundred thousand, then

2 eighty percent of those primary care physicians for that three
3 hundred thousand patients with diabetes would need to be in the
4 patient-centered medical home.
5 In terms of the -- the physicians associated with that,
6 in the case of mental health, then you would need fifty percent
7 of the mental health providers that would be involved in the
8 care of patients with the physicians in that primary care
9 medical home. In the case of diabetes, you know, depression and
10 other psychiatric syndromes are -- are the ones that you'd most
11 likely be targeting with.
12 MR. SMITH: Does the thirty-page limit include the
13 program and financial applications, or just the program
14 applications?
15 Just to clarify that, it's a thirty-page limit for the
16 program application, and it is a thirty-page limit for the
17 financial application.
18 Can a RHIO be listed in more than one application in a
19 region?
20 The answer to that is yes.
21 Kindly clarify the minimum of twenty percent that must
22 be in the form of stakeholder cash.
23 I believe we've already addressed that, so we should be
24 set there.
25 If a medical center is connecting independent practices

2 via a local interoperability hub, and then connecting to the
3 SHINNY via a RHIO, are HEAL-17 funds allowed to be used to
4 connect the independent practices to the medical center's
5 interoperability hub?
6 DR. HALE: The R.F.A. does specifically address the
7 discussion of -- of the local hub technology. So, as long as
8 the requirements that are listed in the R.F.A. are met, then --
9 then that could potentially be allowed.
10 MR. SMITH: And the final question that I have from the
11 Web-Ex participants is -- well, somebody just added another one,
12 but anyway: Are entities other than those who received HEAL-5
13 and HEAL-10 awards eligible for and be awarded a HEAL-17 grant?
14 The answer to that is absolutely. In the R.G.A. there
15 are a list of eligible applicants, and we encourage any and all
16 people who feel that they can comply with the requirements of
17 the R.G.A. to please do so.
18 Final question that's posted is how will you fund
19 projects that cross regions?
20 What we're asking projects to do, similar to in
21 previous versions of HEAL, is, as part of the application, you
22 need to identify a region. If your project traverses regions,
23 you need to select the region where the majority of the
24 population resides. And that would determine what region you
25 would be -- would be utilized for purposes of funding. So, an

2 absolute, a six-point-one-five-attachment requirement, is that
3 as part of the program application, there's a check box where
4 you need to identify in what region you are applying.
5 And that brings us to the end of the questions that
6 were submitted by the Web-Ex participants. If I can figure out
7 how to do it here, I will unmute all lines and we'll try to take
8 additional questions.
9 FROM THE FLOOR: Steve?
10 RECORDED VOICE: The leader has unmuted your line.
11 MR. SMITH: Okay. Are there additional questions from
12 people who were not able to connect to the Web-Ex?
13 And I would ask --
14 FROM THE FLOOR: Yes.
15 MR. SMITH: -- if you're not asking a question, please
16 put yourself on mute to cut down on the background noise. Put
17 yourself on mute. It's a pound five. Excuse me. To put
18 yourself on mute, it's a star five. To take yourself off mute,
19 it's a pound five.
20 Any questions from people on the phone?
21 MS. GLANIS: Steve, it's Christina Glanis (phonetic
22 spelling) from Southern Tier Health Link.
23 MR. SMITH: Go ahead, Christina.
24 If everyone else would put themselves on mute, star
25 five, please.

Go ahead, Christina.

MS. GLANIS: I have -- hi. I have two questions. One, are you or -- or anyone at the D.O.H. aware of where we might access a list of pending or registered N.Q.C.A. (sic) organizations in the state?

MR. SMITH: You're breaking up, Christina, the list of what?

MS. GLANIS: Pending or registered N.Q.C.A. (sic) organizations.

MR. SMITH: N.C.Q.A. organizations?

MS. GLANIS: On medical homes.

MR. SMITH: I'm not aware of anything.

Pat, are you?

Or Rachel?

Or anyone else on the line?

FROM THE FLOOR: Yeah. You can -- there are requests --.

DR. HALE: Well, the -- you could -- you could request it from N.C.Q.A. You could contact them and -- and request it.

MS. GLANIS: And if there's an applicant in our region who wishes to connect to the SHINNY directly, what document would we refer them to for the technical requirement?

FROM THE FLOOR: Just commit the organization to --

FROM THE FLOOR: Yeah. And that's part of -- this part

2 is not --.

3 DR. HALE: If you're not asking a question, please go

4 on mute. We're hearing a lot of --

5 MR. SMITH: Star five to put yourself --

6 DR. HALE: -- background discussion.

7 MR. SMITH: -- on mute.

8 FROM THE FLOOR: Sure.

9 MS. BLOCK: Are you sure it's five, or six, Steve?

10 MR. SMITH: Oh, I'm sorry. It is six.

11 MS. BLOCK: Yeah, star six to mute, pound six to

12 unmute. Star six to mute.

13 DR. HALE: So, the question was what are the technical

14 requirements for connectivity outside of the RHIO --

15 MS. GLANIS: To the SHINNY.

16 DR. HALE: -- and the technical requirements currently

17 are represented in the policy guidance. However, all projects

18 will be required to participate in the collaborative process

19 that will advance further development of the policy guidance,

20 and all projects would be required to abide by those changes.

21 So, policy guidance is an evolving document. It can be viewed

22 now to look at the current existing policy guidance. However,

23 projects, as I said, would be required to move forward with any

24 additions that are added to that policy guidance through the

25 collaborative process. And those would be the requirements for

2 connectivity.

3 MS. GLANIS: All right. Thank you.

4 FROM THE FLOOR: I have a question about the definition

5 of mental health provider. Is this OASAS-licensed providers, or

6 people with psychiatric or other relevant S.E.D., or could OASAS

7 providers be included in that?

8 DR. HALE: We specifically listed in the -- in the

9 R.G.A., there -- how to, you know, determine a licensed

10 provider, and we're going through the O.M.H. licensing, as the

11 mechanism to determine if they're a qualified mental health

12 provider.

13 MS. ROMANOWSKI: I have a question regarding the

14 twenty --.

15 MR. SMITH: I would ask that anyone asking a question,

16 before doing so, please identify themselves for the transcript,

17 as well as their affiliation.

18 MS. ROMANOWSKI: Absolutely.

19 MR. SMITH: Go ahead.

20 MS. ROMANOWSKI: This is -- this is Jennifer Romanowski

21 at A.D.L. Data Systems. I'm looking on page twenty-three under

22 the section under E.H.R.s. If we were to basically use a

23 specific E.H.R. as part of this grant, does that E.H.R. need to

24 be certified as C.C.H.I.T. currently, or is that a requirement

25 for moving forward, as being part of this grant?

2 DR. HALE: In order for the -- the cost to be approved
3 for reimbursement for any E.H.R., they must be certified. So at
4 the time of application it's not required that they -- that you
5 show certification, however there would be the necessity to show
6 either CCHIT certification, or the new federal certification, as
7 it -- as it comes in place, prior to the ability for the state
8 to reimburse -- to approve funds to be used for that E.H.R. And
9 we will require you to submit, you know, the proposed E.M.R.
10 that would be -- that -- that -- that you were proposing to have
11 paid for.
12 In addition, not only is the certification required,
13 there are also the contract with that E.H.R. vendor must include
14 the -- the language that says that they will abide by the policy
15 guidance in New York State.
16 MS. ROMANOWSKI: Okay. Thank you.
17 MS. SMITH: This is Nancy Smith with Hackney (phonetic
18 spelling). I have two questions regarding definition of
19 eligible applicant, other than a Cheetah. On page ten it states
20 that applicants must provide, at a minimum, evidence of
21 completed or -- or and been accepted for N.C.Q.A. That suggests
22 that the applicant must be a primary care provider. That's one
23 question.
24 The second question is it requires that they be active
25 in the RHIO. Does that mean currently today, or in the -- in

the two-year project?

DR. HALE: To -- to reiterate, as we said earlier, in terms of the applicant, the applicant need not be the patients' in the medical home provider. How -- however, the providers in the Cheetah that are -- are primary care physicians must be -- have met the requirements in terms of this is a patient-centered medical home.

So, the Cheetah is a collective of organizations. It is not the primary care physician's practice that is the Cheetah. It is the organization and the organization can chose who would be the lead for that application.

FROM THE FLOOR: Okay. So, we won't do it.

FROM THE FLOOR: I like Ken.

FROM THE FLOOR: I like him too.

MR. SMITH: Again I'd ask people --

DR. HALE: I'd just ask you to mute. We cannot --

MR. SMITH: -- if they're --

DR. HALE: -- hear --.

MR. SMITH: -- not asking a question to please star six to mute.

We have to bring it up to --

DR. HALE: What was the other part of the question?

MR. SMITH: -- section --

MS. SMITH: The other question is --

2 MR. SMITH: -- three point two point one.

3 MS. SMITH: -- is it requires that -- it requires that

4 the applicant be an active participant in a RHIO. Does that

5 mean that they must be active at the time -- at the of

6 application, or during the project?

7 DR. HALE: Well, yeah, there is a requirement with the

8 application to have a letter from the RHIO, describing what the

9 relationship is. And as has been said earlier, it's a

10 relationship -- a governance relationship of participation

11 that's required.

12 MS. FRYDEN-WARSH: I have a question. This is

13 Cynthia --

14 MR. SMITH: Please identify yourself.

15 MS. FRYDEN-WARSH: -- yes. Cynthia Fryden-Warsh

16 (phonetic spelling), at APS Health Care.

17 I just need some clarification in terms of the eighty

18 percent for primary care providers. This means that eighty

19 percent or more of the primary care -- and I'm asking the

20 question. Eighty percent or more of the primary care providers

21 in the -- in the primary care health E.C.H. -- E.C.M.H. must

22 agree to, or must be providing services, to the population?

23 DR. HALE: What we're talking about is that once you've

24 determine your patient population for your C.C.Z., eighty

25 percent of the primary care providers must participate in the --

2 in the project.

3 MS. FRYDEN-WARSH: Okay. So, they don't have to --.

4 DR. HALE: And those providers need to be participating

5 in the medical home model.

6 MS. FRYDEN-WARSH: Okay. Thank you.

7 MS. SMITH: This is Nancy --

8 MR. SMITH: Another question, or --?

9 MS. SMITH: -- at Hackney again. Yeah, I have another

10 question. If fifty percent of the grant will cover the E.H.R.s

11 I -- I believe, for both the primary care providers and the

12 long-term care, could the other fifty percent be counted as cash

13 match?

14 MR. SMITH: Say that again, Nancy? I'm not following.

15 MS. SMITH: Sorry. If -- if -- if the allowable

16 expenses include up to fifty percent of the cost of an E.H.R. --

17 for -- for example, for long-term care, or for a provider in

18 the -- in the medical home, would the other fifty percent of the

19 cost of that E.H.R. be considered cash match?

20 MR. SMITH: What we're saying is that using HEAL funds,

21 you can pay for up to fifty percent of the cost of the E.H.R.

22 for the long-term-care facility.

23 MS. SMITH: Correct. And therefore --.

24 MR. SMITH: So, if you want to use matching funds for

25 the balance, that's acceptable.

2 MS. SMITH: Thank you.

3 MS. GLANIS: Steve, it's Christina. I just got

4 confused. I thought it was twenty-five percent, and then

5 reviewing whether it was or not, for long-term home care.

6 MR. SMITH: Yeah, what we had done is there was a typo

7 in the PowerPoint presentation. The PowerPoint presentation

8 said twenty-five percent.

9 MS. GLANIS: Right.

10 MR. SMITH: If you go to page thirty-five of the

11 attachments, section six point one, which is allowable project

12 costs, number three is E.H.R.s for other health providers. And

13 it says, I quote, "A maximum of fifty percent of the cost of

14 long-term care or home healthcare providers' E.H.R.s is also

15 permitted."

16 MS. GLANIS: Okay. Thank you. I wasn't sure which

17 version had won.

18 MR. SMITH: The R.G.A. will prevail. Sorry for the

19 confusion.

20 MS. GLANIS: Okay. Thank you.

21 VALLA: Hi, this is Valla (phonetic spelling). I have

22 a few questions.

23 MR. SMITH: And I'm sorry. Where are you from?

24 VALLA: I'm from Lincoln. Lincoln Hospital --

25 MR. SMITH: Thank you.

2 VALLA: -- in New York.

3 MR. SMITH: Go ahead.

4 VALLA: My question is regarding the lead applicant

5 P.C.M.H. status. If the lead applicant is not a P.C.M.H. and is

6 going for a P.C.M.H. status, but then eventually becomes

7 P.C.M.H. -- P.C.M.H., would the -- would that count into the

8 final eighty percent?

9 MR. SMITH: Any participant in the project who is a

10 primary care provider, their status in relationship to P.C.M.H.

11 would be included in the calculation.

12 VALLA: Even if they're a part of the lead applicant

13 organization?

14 MR. SMITH: Well, I'm assuming, and it's more than an

15 assumption, it's a requirement, the lead applicant needs to be

16 part of the project.

17 VALLA: Okay.

18 MR. SMITH: So, since they're a part of the project,

19 their clinicians' P.C.M.H. status would be included.

20 VALLA: Right. And we also noted that the --.

21 MR. SMITH: And again, I would point people to -- let

22 me interrupt you for just a section -- a second.

23 I would refer you to section three point two point one

24 that talks about lead applicants. And it says the lead

25 applicant must be either a designated stakeholder participant in

2 the P.C.M.H., or a Cheetah. So, the P.C.M.H. has multiple
3 different types of stakeholders, one of which is a primary care
4 provider.
5 And you had another question?
6 VALLA: Yes, on the same --
7 FROM THE FLOOR: This is --.
8 VALLA: -- section -- I'm sorry. The same section it
9 is stated that entities contracting with D.O.H. are not
10 eligible. That -- is that including the city D.O.H., N.Y.C.
11 D.O.H.?
12 MR. SMITH: No, if you're looking at the note on page
13 thirteen, it -- that D.O.H. refers -- well, the only D.O.H. that
14 can contract for HEAL-17 is New York State D.O.H., so that would
15 not include New York City D.O.H., no.
16 VALLA: And my last question is related to the care
17 coordination. If -- if a diagnosis does not include all the
18 elements of care coordination, including referral to
19 long-term-care facilities for example, will that be considered
20 as a negative for the application?
21 DR. HALE: The -- if --.
22 VALLA: Some of the diagnoses may not include all the
23 care coordination items.
24 DR. HALE: If the -- if there is a good reason
25 presented in the application for why a specific type of provider

2 is not included, and why it is not appropriate for the diagnosis
3 that was chosen, then it wouldn't necessarily result in a
4 decreased score. However, if that provider type is appropriate
5 for the diagnosis and it is not included, then that would result
6 in a decrease in score.
7 MR. SMITH: However I would like --
8 DR. HALE: It would have to be a very good explanation
9 of why any given provider is not appropriate.
10 MR. SMITH: -- however, I would like to iterate that
11 the -- the focus -- the strategic focus of HEAL-17, yes, it
12 relates to the patient-centered medical home, but it has a focus
13 on mental health, long-term care, and home care, so I would
14 encourage projects to incorporate those components, to maximize
15 their -- their scoring, and to comply with the requirements of
16 HEAL-17's strategic plan.
17 DR. HALE: Yeah. And to also add to that, mental
18 health must always be included. The only ones that there might
19 be an explanation for not including would possibly be long-term
20 care. Even less likely, but possible, home care. However,
21 mental healthcare must be included in all applications.
22 VALLA: Thank you.
23 PAULA: I -- this is Paula from New York Presbyterian
24 Hospital. The question I still have is if an institution has
25 begun an application for N.C.Q.A. patient-centered medical home

2 certification, are we still eligible to apply, or does that
3 application have to be completed?
4 DR. HALE: If -- if the application has been submitted,
5 that is -- and you can document the submission of the
6 application to N.C.Q.A., that is appropriate; right, Steve?
7 MR. SMITH: Yeah. That's correct.
8 PAULA: Well, the R.G.A. says applied and accepted.
9 MR. SMITH: The acceptance that we're referring to
10 there is the fact that N.C.Q.A. has taken your application. And
11 my understanding, through my conversations with N.C.Q.A., is
12 that when you submit an application, they give you a letter or
13 some documentation of receipt slash acceptance. So, that's what
14 we're looking for.
15 PAULA: So, if you have not submitted, then you're --
16 you're -- you're excluded from applying; is that correct?
17 DR. HALE: Right. And the reason behind that is we're
18 looking for -- for projects that have, you know, begun the
19 organization towards the medical home, because of the -- the,
20 you know, really aggressive time line that these kinds of
21 projects are going to require. So, if someone hasn't even --
22 hasn't done anything towards that process at the time of
23 application, then, you know, the chances of being able to
24 complete the entire project in the time -- the -- you know, the
25 aggressive time line is -- is -- would be extraordinarily

2 challenging.

3 PAULA: Thank you.

4 MS. KING: This is Cheryl King from D.O.H. M.H. I

5 asked a question about the care-coordination zone denominator.

6 And my question is if you have a diagnosis, like schizophrenia,

7 and you're in a crowded place like Manhattan, other than

8 geographically, how do you define your patient population?

9 DR. HALE: You define it by care-coordination referral

10 patterns. So, you may have a specific group -- patient

11 population that's cared for in a specific population of primary

12 care physicians, and others, who would -- who have a referral

13 pattern. And we've seen projects that have been able to very,

14 very carefully and --and very nicely describe referral zones as

15 coordination-of-care zones that don't necessarily match a

16 specific geography.

17 MS. KING: Okay. Like, maybe centered around a

18 hospital or a catchment area, rather than geography.

19 DR. HALE: Correct. Geography is fine to use. This --

20 this doesn't mean -- this doesn't mean you can't use it.

21 However we didn't want to limit projects to geography, because

22 care isn't always given on a geographic basis. And we wanted

23 to --

24 MS. KING: Right.

25 DR. HALE: -- allow for the best coordination of care.

2 And referral patterns -- the best referral patterns are not
3 always tied to geography.
4 MS. KING: Thank you.
5 MS. GLANIS: Pat, it's Christina Glanis --
6 DR. HALE: Uh-huh.
7 MS. GLANIS: -- again from Southern Tier. A follow-up
8 question to the last one. Would we assume that any kind of
9 funding is limited to New York State entities, for those of us
10 that do have care-coordination zones across state borders?
11 MR. SMITH: I would ask you to submit -- make sure you
12 submit that question in writing, Christina, and we'll get
13 clarification.
14 DR. HALE: Right. Because we'll have to find out if --
15 if any money can flow outside of the state. Probably not, but
16 we will definitely check.
17 MS. GLANIS: Well, to -- to granulize it, perhaps
18 funding could be for connectivity, for interoperability, but
19 perhaps not for purchase of the --.
20 FROM THE FLOOR: Well, we're already online, so --.
21 MR. SMITH: Well, we might also have to --
22 DR. HALE: We'll have to -- to --
23 MR. SMITH: -- we may also have to do a differentiation
24 between state funds and matching funds, but please submit the
25 question and we'll get clarification.

MS. GLANIS: Okay. Thank you.

MS. SMITH: This is Nancy Smith again in -- at Hackney. Two -- two expense questions.

One: Is an eligible expense participation -- the -- the time for participation in the statewide collaborative process and high tech?

And secondly, for state-owned facilities, which I presume includes the SUNY system, can they still participate and does their time in the -- in the project count towards in-kind?

MR. SMITH: The first question was participation in the statewide collaboration process. Projects can use in-kind --

MS. SMITH: And High Tech.

MR. SMITH: -- and High Tech, projects can use in-kind funds for that, but HEAL funds do not get used for that.

And the second one was around state-owned facilities -- give me that one again.

MS. SMITH: Yeah, state -- state-owned facilities, which I'm presuming includes the SUNY medical systems, they are not eligible to receive any of the award money, but could their time on the project be counted towards in-kind, if they're a participant?

MR. SMITH: Yes.

We've got a few minutes left. Are there other questions?

(No audible response)

MR. SMITH: Hearing none, I will thank people for their participation.

Again, I would repeat that the responses that were provided today should be considered unofficial. We ask that people please submit all questions to the address that was provided, and I also remind people to please submit their attendance and demographic contact information as well, so that we can have a record of participation.

And with that I'll thank everyone, and look forward to receiving your applications.

(The presentation concluded at 1:48 p.m.)

I, Amy L. Pike, do hereby certify that the foregoing was taken by me, in the cause, at the time and place, and in the presence of council, as stated in the caption hereto, at Page 1 hereof; that the foregoing typewritten transcription, consisting of pages number 1 to 76, inclusive, is a true record prepared by me and completed by Associated Reporters Int'l., Inc. from materials provided by me.

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