HEAL NY -- Phase 5
HEALTH INFORMATION TECHNOLOGY GRANTS

ADVANCING INTEROPERABILITY AND COMMUNITY-WIDE EHR ADOPTION

RGA No. 0708160258

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MS. EVANS: How is everyone doing? Good. Well, welcome. It's a little bit after 1, so I thought we would let the games begin. And before we start, I wanted to thank this amazing group of people to my left that have supported this process. And I think we're all still amazed that we got everything out last Friday. And it was the last day of summer, and we said we would get it out by the summer so we used every last possible minute we could, but thank you all so much for all of your help. And maybe we'll just go down and do introductions real quick. Marybeth.

MS. HEFNER: My name is Marybeth Hefner, and I'm the Director of the Bureau of Accounts Management in the Health Department which is responsible for the contracting process in the Department.

MR. VEINO: I'm Bob Veino, DOH counsel's office.

MS. FAZIOLI: I'm Laurie Fazioli with HEAL New York.

MR. LEDUC: Joe LeDuc, HEAL New York.

MR. BAILEY: Keegan Bailey, Office of Health Information Technology Transformation.

MR. VOLK: Larry Volk from the Dormitory Authority.

MS. RALEIGH: Tracy Raleigh with the Dormitory Authority.

MR. FIGGE: Jim Figge with the Office of Health Insurance Programs.

MR. GOTHAM: Ivan Gotham, Information Systems and Health Statistics Group.

MS. FLYNN: Michael Flynn, the Immunization Program.

MS. EVANS: All right, thank you all, and again thank you so much for your help. It has been a real team effort to get us to where we are today, and we've been looking forward to this day especially. And our agenda is as follows. I'm going to go over some quick ground rules, and that because Marybeth told me that I had to. And that I'm going to do a quick overview of the RGA and then hand it over to Laurie and Joe, and they're going to talk about the

application process and the award process. And then they are going to hand it over to Keegan, and he's going to talk about the allowable costs, and then we'll get into questions and answers. And, hopefully, we'll just be about an hour between all of us, maybe a little bit longer, but we wanted to leave as much time as we could to address your questions.

So before we really start, here are the ground rules, and the first one essentially says that anything we say today here really doesn't matter. No, not really, but that the -- it's sort of an unofficial proceeding, and the official responses appear in writing on the website, and we will be prepared to publish that full document by October 26.

Private questions cannot be answered, so make sure you ask yours in a group setting here today, and then you'll also be able to submit e-mail questions up until October 12. So if you don't ask a question here, you'll still have another couple of weeks to submit it. And we'll try to answer the questions as

they come in and post them, but at the latest we will have them all up by October 26.

And a transcript of this conference will be published, and an attendee list will also be published. Did I cover everything? Yeah, okay, great.

All right, so turning to -- turning to the overview, I know there were a lot of acronyms and analogies in the set of documents, and I promise not to introduce any more at least for a few more weeks. And I also told the team up here that I wouldn't say that shine -- you shine your CHITA during the day or say that CHITAs aren't eligible to apply for SHIN-NYs. We've had quite a fun time about teasing ourselves about the acronyms.

But we are here today to really help lay this out at a high level and again answer your questions. And I think, you know, the overarching goal of HEAL New York Phase 5, and this Health Information Technology Grant Application, is to really start to lay a foundation. We want Health IT to support improvements in health care quality and

affordability and outcomes for New Yorkers through vastly improved availability and uses of health information. And in order to do this we need to evolve and develop an organizational and a clinical and a technical infrastructure, and a lot of the concepts in the grant are about those set of activities and how we're trying to combine them to develop New York's health information infrastructure.

And so I'll say a little more about the goals in a minute and go over the investment framework -- that's section 2 of the document -- say a little bit about the collaboration process and then a little bit about evaluation.

So the next slide, as I was saying, is really about again supporting improvements in health care quality, affordability and outcomes for New Yorkers, really starting to build the infrastructure and capacity we need and really setting three foundations related to organizational infrastructure, clinical adoption and technology infrastructure, and really combining those and addressing them

together so that we can realize value along the way. We can realize the benefit of vastly improving the availability and the uses of health information, so it's a key concept in terms of those three foundations, and a lot of the discussion around RHIOs and then introducing the Community Health Information Technology Adoption collaborations really emphasize the importance of each of those activities, and again how we combine them and evolve them together through these grant projects.

And the other concept that was introduced -- if you go back up -- is this notion of cross-sectional interoperability. And when I get to the technical framework, and as you saw in the RGA it was figure 1, being able to take a cross-section of the Statewide Health Information Network for New York that's focused on health information exchange capabilities, a clinical informatic service component that's focused on aggregating and analyzing data for quality purposes and for population health purposes, and then the actual information tool or the

electronic health record for the clinician are personal health tools for consumers and how we really take a cross-section of those and advance them in a coordinated fashion. And taking that cross-sectional approach is important because it helps us start to get benefit right from the start for clinicians. It helps us focus on community-based adoption, which is what we need to do, to have benefits internal to a group of doctors, especially when they implement electronic health records, due to some of the network externalities or some of the market imperfections that exist when it comes to Health IT. And then also being able to integrate, I think, the demand side coming from the clinicians and the supply side which gets to the evolving health information exchange capacity through the infrastructure we're developing, again so we can start to realize value right from the start.

So those are some of the -- a little bit of the thinking into these concepts that I think are really, really, important, again combining organizational, clinical and

technical and then driving cross-sectional interoperability.

So moving to the next slide, the next one, this figure is in the document. It really just illustrates what I just described in terms of the Statewide Health Information Network for New York. And again this is where we are driving the health information exchange or the interoperable health information exchange capacity, that next layer of clinical informatic services and then above that where we have electronic health records for clinicians, personal health tools for consumers and other community portals for public health purposes. And, again, emphasizing here the organizational piece of interoperability and the people component, again getting back to that organizational foundation that's so critical.

The next slide. All right, so getting to sort of the overall framework. And, you know, initially sort of the first dimension was that technical framework, those three high level building blocks on the slide

that we just showed you before. And the second part was being able to take -- to focus on clinical investment priorities, and each of these clinical investment priorities has a corresponding use case, and in essence we want these to be goal. We want you to demonstrate these as the goals of your project. And they're listed here, and each of the gray categories has an assigned set of use cases, and we'll go through that in a little while, but some of the key points here, as they're very high level clinical and business requirements in the use cases, they're meant to serve as a guide for you to respond to how you will demonstrate them based on the project that you will be choosing. And as part of the project award you'll really have a chance, as a grantee, to hone these use cases, to iterate them, to work on them and really refine them quite a bit. So again they're meant to be as a guide here. They're meant to serve as a real clinical foundation and a clinical goal for your projects, but again there will be plenty of time as an awardee to really hone them and

get them to a state where they can turn into technical requirements and then feed into an architectural design. But we had a great time thinking about these. We had teams of people working on each of them. And again when we get to the grant categories, which is the next slide -- I'll say a little bit more about them.

So we have this technical framework. We have the clinical investment priorities in the corresponding use cases. And given that, we have three categories of grant applications. And category 1 is the Statewide Health Information Network for New York, which we have been affectionately referring to as SHIN-NY. And this is where we want to develop the organizational and technical capacity to achieve interoperability, to achieve health information exchange. And the RHIO applicants -- and I'll talk about -- I'll go through the eligible applicants in a few minutes, but RHIOs are the only applicants that are eligible to apply for the Statewide Health Information Network for New York. You

have to demonstrate two out of the following four use cases, so either connecting New Yorkers and clinicians, health information exchange for public health, interoperable electronic records for Medicaid, or quality reporting for outcomes. So again demonstrating two out of the four as part of your application. And we really want -- you know, we introduced this term, and it is a new term, the Statewide Health Information Network for New York, but I want to emphasize that there are -- its regional implementations, its regional health information exchange projects, and trying to drive common health information exchange capabilities in this same way across the regions. So we're not all of a sudden jumping to say this is about inter RHIO interoperability. It's not about that. It's about technical capacity in your region but coming together and, through the statewide collaboration process, trying to drive common health information exchange approaches together. Because at the end of the day we want to avoid having an extra layer of

technology to have to connect all of the regions. We want to try and avoid that as much as possible. So the focus really is on what you need to do in your region -- the technical capacity for health information exchange, the organizational capacity, but trying to infuse, through the collaboration process, some common approaches related to the concepts introduced in Section 7.2, which is the technical discussion document where we have this common health information exchange protocol, and each of the four health exchange services can communicate with other services that they need to fulfill this function through this protocol. And again that's going to help us drive a common nervous system across the State at a regional level. So I really wanted to emphasize that point in terms of focusing on the regional capacity and what you need to do in your region to make health information exchange a reality, but again layering on this statewide collaboration process to help drive common approaches. Hopefully that's clear.

We'll have up to eight awards, and

"up to" is an important emphasis. And 55 percent of the available funds, or 58.16 million, are available in this category, are expected to be awarded in this category. And Laurie and Joe and Keegan will say a little bit more about that during their presentation. So that's category 1.

Category 2 is Pilot Implementations of Clinical Informatic Services. And as we stated in the RGA, these are community-based quality and population health tools which aggregate, analyze measure and report data to support quality reporting, to support population health reporting, to support new options of payment and to facilitate quality interventions. So the RHIOs and the CHITAs can apply for grants in this category.

In the grant application, you have to discuss how you will demonstrate one out of the following two use cases -- the quality reporting for outcomes use case, and also the clinical decision support and the health information exchange environment use case. We have attached a few documents related to the quality reporting use case. It's really

based on the Office of the National Coordinator's quality use case that they've published, in addition to New York State's priorities with respect to quality measures. And then we've asked that applicants that are interested in demonstrating the clinical decision support use case, submit that as part of their application, and that will be considered in the evaluation process.

There will be a minimum of two awards in this category and a maximum of four. And 45 percent of the total funds available, or 47.58 million, is expected to be available for not only this category but the electronic health record category as well. So we're really going to combine category 2 and 3, follow our award process that Laurie will explain, and really use the scores to award these categories together. And, again, Laurie will go through that a little bit more during her presentation.

And then category 3 is community-wide interoperable electronic health record adoption. And this is about ambulatory care, clinician office-based electronic health

record adoption in a defined care coordination zone, which you define as the applicant that includes clinically affiliated providers to drive results delivery into the electronic health record and to help advance effective use in adoption. So again ambulatory care clinicians with clinically affiliated providers, again to support results delivery into the electronic health record to advance adoption.

The RHIOs and the CHITAs can both apply for this category, and through your grant application you are required to demonstrate one out of the following three use cases -- immunization reporting with electronic health records, quality reporting for prevention and interoperable health records for Medicaid. I think some of the key concepts in this category are really important in that the care coordination zone needs to have sufficient scale so that the group of doctors or the community of clinicians that are adopting electronic health records will be big enough to realize the benefit internal to that group. We're

trying to help compensate for some of the market imperfections when it comes to Health IT from an economic perspective. Think of the fax machine problem, right? To have real value using a fax machine, you need lots of people using it. So the scale of a care coordination zone is important to help drive benefits internal to that group of clinicians in the care coordination zone, and interoperability and the requirements around working on the results delivery, again so results from the providers get interfaced into the electronic health record, that's -- you know, emphasizing the importance of those clinically affiliated providers is really important and then for that results capability to be able to interface to the Statewide Health Information Network for New York. So we're really setting a foundation to drive interoperable electronic health records. So those are really important concepts, purposeful concepts in those categories. And again the emphasis on the small -- the solo and small practices is critical, and those small and solo practices

that have contracts with and serve Medicaid beneficiaries and also serve long-term care providers are also an important emphasis that's in the grant application.

So in this category we have up to eight awards, emphasizing the "up to." And again 45 percent of the total available funds, or 47.58 million, is expected to be available for this category and the clinical informatic services, so again we'll be awarding them based on score.

Okay, the next slide is the state collaboration process. It's in Section 4. It describes the statewide collaboration process that the New York e-Health Collaborative will be facilitating. This is a really important role to bring together all project awardees, to collaborate with each other and with us to drive and advance the implementation of the grant awards. And I mentioned the importance of the collaboration process when I talked about the Statewide Health Information Network for New York category, in being able to convene projects and again help drive common technical

approaches and standards in a coordinated fashion, getting back to the point where we want to try and avoid that extra layer of interoperability that we would need to connect the regions across the State. We don't want siloed regions, so it's going to be a balance of, again, focusing on the regional needs and the success that we want in the regions, but collaborating with partners across the State to drive technical approaches. And the statewide collaboration process will also be an important vehicle for the other projects as well, because if you get -- if you think back to figure 1 and that image and how the layers build on each other, at the end of the day they're all interconnected, so we want to have the convening process support the connection points between the projects. And obviously, depending upon the use cases you pick, that will really inform with whom you need to collaborate to, again, advance interoperability. And once projects are awarded then there will be some early deliverables around thinking about that

collaboration process. So if you're a CHITA and you're doing an electronic record project, when we kick off the collaboration process when the grants are awarded, there will be early deliverables about discussing, well, with which RHIO would you like to work, to talk about things that you'll need to talk about during your project. So again that will be an early deliverable and a part of the collaboration process that we facilitate through the New York e-Health Collaborative.

And then just two more points where applicants are required to allocate five percent of their project funds to support the collaboration process, and the source of funds can either be reimbursable funds from the grant or matching funds. And you certainly are welcome to ask questions about that when we're at the question and answer period.

And then also when you read Section 4 and you're really thinking about the approach to your project, plan and think about how the collaboration process will impact your work, and it will be important to think about that

as you put together your project application and your project plans.

Oh, right, eligible applicants. We have two. The first is the RHIO, the Regional Health Information Organization, and it's outlined in Section 3.1. And then we have the CHITAs, or the Community Health Information Technology Adoption collaboration, and they are described in Section 3.2.

The RHIOs have discussion around the definition of a RHIO which gets to the lead applicant and the not-for-profit status, multi-state or participation. Mission to improve health care quality efficiency, etcetera, through advancement of Interoperable Health Information Technology.

The stakeholder section, there was a list of, I think, 12 stakeholder types. We're requiring you to have at least six of them included as part of your RHIO. We want to see a matrix or a table that lists your stakeholders today, and it includes specifics about their name and other items that we included in the application, but also your

future plans and the new stakeholders that you'll be bringing in as part of this matrix to make it very clear who is participating now, who the new stakeholders are, so it's very easy for us to see how you are thinking about growing the RHIO and covering the stakeholders that are listed in the RGA.

We also included a section on service area, to do a summary -- to really just try to describe the service area, and hopefully that's really straight forward. The scope of services for the RHIO are important and will be evaluated as to how you first describe what types of services you provide today and then again your plans to enhance those services as part of your grant application. And these services are, in essence, what a RHIO is and why RHIOs need to exist. They're of and for the providers and the doctors, right? And that's -- you know that's really their purpose in life, to enable the kinds of collaboration and other activities we need to advance interoperable health information technology to improve quality and reduce health care costs. So those services are

related to all of the things that I think a lot of you are doing related to privacy and security and governance, and having good governance processes, having a lot of clinical discussions, keeping clinical priorities at the forefront, addressing the business model complexity of all this. So those services are really important. Again, I think we ask for a matrix, talking about which services you provide today and then what services you will be providing as part of your two-year grant project. And then I think there are a few other criteria listed there. One is that if you're A RHIO applying for an electronic health record project in category 3, you also have to satisfy the Health IT adoption and support services that are specified in Section 3.2 under the CHITA section.

So moving to the CHITAs quickly. In contrast, CHITAs are community collaborations. They don't have to be a separate not-for-profit organization. They are meant to comprise clinicians and clinically affiliated providers, again in the

spirit of care coordination and emphasizing care coordination and the scale that we need to have in place to adopt electronic health records in the best way that we can, again to realize value, and to have that value result in patient care improvements.

So the participants are listed in Section 3.2. One of those participants -- there is a list of participants, and then there is, I think, a subset that lists those that can be the lead applicant. And the lead applicant has to enter into the contract with New York, and those can be physician groups, and community health center consortiums, and hospitals, and long-term care providers, rural health networks. I think I covered them all, but if you have questions about who can lead just ask during the Q and A.

And then I think I talked about the care coordination zones -- try to say that fast three times -- and how important that is again to emphasize the value that we want to result from electronic health record adoption, getting to the information and how that benefits patient care, and really

needing the right providers and the scale of those providers to realize the benefit. And that, in essence, is why we define that care coordination zone. And again you have to define that as part of your grant application. And we really didn't put any requirements on the size or the type other than saying you have to follow the requirements about who can participate in one; that's defined in Section 3.2.

And then the Health IT adoption and support services are very important also as a key component of advancing electronic health record adoption related to the "soup to nuts services," as we say, that clinicians need in their quest to implement electronic health records and again realize patient care improvement. It's everything from readiness assessments to work flow, to project management, to supporting product selection, all the way to ongoing process and quality improvement services, again a really important part of the electronic health record adoption equation and why the CHITAs are so important.

Okay, so evaluation quickly. There is a project evaluation, and that is in Section 5.1.4. And then there is how we will review and score and evaluate the grants to make awards, and that is in Section 5.2. So I'll go to the project evaluation first. And essentially this is saying that a project evaluation, the HEAL New York Phase 5 Program will be evaluated, all of the projects, by a third-party evaluation team; that's to be determined. And applications must be allocate five percent of their project funds to support the project evaluation. The source of funds can either be reimbursable grant funds or matching funds, and that anticipate planning for participation in the evaluation as part of your application. So again to be determined, but a very, very important part of this, and we will want you to be prepared to participate in that as we kick it off as part of the start of the grant projects.

So the grant -- turning to how we will review and score the grants and make the awards, and I'm just going to say a little

bit about this. There are two parts. There is a technical application, and there is a financial application, and Laurie will talk about the critical parts of that. I just wanted to emphasize that as part of the technical application there are the following parts. The organizational plan, the technical plan, the clinical plan, leadership and personnel qualifications and project management. I think the financial plan actually doesn't go there. There's a business model discussion that should be included in the organizational plan, and that is indicated in Section 5.2 where it talks about the organizational plan. So that's an extra bullet there. So not only is this the format with which your application should be in -- and Laurie will talk about this -- but these are the sections, these are the parts that you will be evaluated on as we score and then award your grant projects, very important. And again we listed the criteria in Section 5.2.

And then with the financial application there is the project budget, a

discussion of cost effectiveness, sustainability, project sustainability, and applicant sustainability, and Laurie will go through and mention the format and some of the components to that. But again the technical and the components of the technical application and the financial application, two pieces. I think you guys really know that from the rounds that we've been through.

So I'm going to stop there and hand it over to Laurie to go through the application process.

MS. FAZIOLI: Okay, I'm going to go through the application process. I work in the HEAL office and wanted to bring to your attention some basic points to have you avoid -- sorry, I'm short -- having your application eliminated from further review. We find with every RGA deadline we're going through and doing the initial screening process and some basic information will be missing, and after all the work you've put into these applications, you can have your application disqualified. I'll also be referencing some sections of the RGA that I

think are helpful in making sure you have completed and packaged your applications properly.

I'd like to begin with one of the most important points that the deadline is November 19 by 3 p.m. at the Hedley Building in Troy. Please do not send your applications to the Albany office. And if you're going to hand deliver your applications, make sure you have enough travel time to reach the Troy office because no applications will be accepted after 3 p.m.

Section 6.5, "How to File an Application," this guides you through the appropriate number of copies, signatures. A common mistake is there are two original applications required, both need to be signed. Many times we'll see the first original application signed and the second original application is not signed, and these are really simple things that can lead to your application being disqualified. Please include two copies, either two CDs or two USB drives, and please quality assure those copies. Many times we'll get CDs and they're

blank. So these are real basic things, but if you just take these steps -- you put so much work into these. If you take these steps before the final submission, it will save your application from being disqualified.

One last point, no cost figures in your technical application.

Section 9 includes all of the forms and checklists. This is a very important section, again, in packaging your applications to us. Please use the checklist provided. This will ensure complete submissions. If you go through every point there, you will have everything you need in your package to make sure there is no disqualification. Make sure you identify your lead applicant, identify the category you're applying for, the region. Please note that the RHIOs and the CHITAs have separate sections for forms, and also in the financial section there is a different cover page for a RHIO or a CHITA, so just make sure as you're going through your packages you are using the correct forms.

Again, I want to stress, incomplete submissions may be eliminated from further review.

Another important section is your minimum requirements, which is Section 7.4. This describes the initial screening process for completeness. Again, your sections, forms, format, copies, this is where we'll also do an initial review for eligible applicant, that your stakeholder requirements have been met. We'll review for match requirements being met, and also that your project is not in conflict with Commission mandates. Again, this document, 7.4, is very important, because again any missing critical elements may result in the elimination of applications. I hate to see all the work go into these and have them eliminated for a basic reason.

Just to touch on a few points for the award process. Section 5.3 describes the award process. Separate applications must be submitted for each grant category. You cannot apply more than once per category. If you apply for multiple categories, the

applicant needs to describe the interrelationship between the projects. If an applicant is applying for multiple categories, the total requested funding cannot exceed 15 million. I know I'm going fast, so questions and answers, feel free.

And again this was stated previously, but we expect to make awards in three grant categories; our Statewide Health Information Network for New York, or our SHIN-NYs; Clinical Informatic Services, our CIS; and Electronic Health Records, EHRs.

Section 5.3.6 is a very important section. It details 55 percent of the total available funds, or 58 million, is expected to be available for the SHIN-NY category in step one of the award process. The remaining 45 percent of the total available funds, or 47 million, is expected to be available for the CIS and EHR categories in step 2 of the award process. Applications meeting a minimum score will be -- and awards made using the 4-step award process which is detailed in Section 5.3.6. It goes into every step of the award process in that

section; 5.3.6 is very important to review. It lists your regional allocations and how we will proceed through the four steps of the award process.

Joe LeDuc of our HEAL staff is going to take you through the rest of the awards and reporting and contract processing. And thank you, and feel free to ask questions at the end.

MR. LEDUC: The first category of awards is going to be in the SHIN-NY category. We're expecting an award up to eight awards. It's going to use the Commission mandates, the Commission on Health Care Facility in the 21 century regions, and so awards based on a single-commission region is expected to be the lesser of the regional allocation, or up to 10 million, and this is again in Section 5.3 in further detail.

For co-applying RHIOs, serving more than one commissioned region, the maximum award amount is expected to be the sum of the regional allocations but not to exceed 15 million.

The second category is the CIS, and

we're expecting a minimum of two awards and up to a maximum of four. The maximum award amount is expected to be 5 million or the lesser of the regional allocation.

And the third category is the Electronic Health Records, the EHRs, and we're expecting to make up to eight awards in this category. The maximum award is expected to be 8 million dollars, or the lesser of the regional allocation, and again this is in Section 5.3.6.

Section 6.6 describes the New York State Reserve Rights, and too I wanted to point out related to the award process. We reserve the right to reject any or all applications, and to adjust or correct costs for errors of concurrence of the applicant if errors exists. And there are more rights reserved in Section 6.6, so you should review those, that section further.

Contracts are expected to start in the first quarter of 2008, and they're going to be for an initial term of two years. We're going to have the option to renew the contracts for up to two one-year periods to

ensure completion of the projects with no additional funding, so you'll have extra time to finish. Any renewal must be approved by the State Attorney General and the Office of the State Comptroller.

During the two-year period, you're going to be required to submit quarterly vouchers to the Department of Health based upon eligible expenses actually incurred by the grantee, and you're also going to be required to submit quarterly reports on the project itself. And written questions based on anything in the RGA will be accepted through October 12 at the e-mail address here and in the RGA.

And now Keegan is going to talk about allowable costs.

MR. BAILEY: I just have a few slides on allowable costs. And so primarily to start off, up to 75 percent of the application -- the application's total project costs will be covered by HEAL NY Phase 5 or, in other words, reimbursable. In addition, it is required that at least 25 percent of the application's total project

costs be matching funds, and also all applications that include the 10 percent cash as part of, or in addition to, the 25 percent match will be evaluated more favorably than applications that do not include the 10 percent match.

It's important to refer to sections 934 through 936 for information in how the applicant should allocate funds in the budget. These documents can be found in Section 93, Financial Form for RHIOs and CHITAs. 934, HEAL New York, Phase 5, Health IT Allowable Costs provides a definition of capital, explaining the difference between non-capitalizable expense capitalizable expense and provides guidance in how the applicant should allocate the expenses. And so total capitalizable expenses must not exceed 40 percent of total reimbursable expenses. And also there is the responsibility of applicant to allocate at least 60 percent of all reimbursable expenses as capitalizable.

In addition, applicant project expenses have been broken down into four

phases that are listed here on the slide. Just for the purposes of qualifying what is matching and what is reimbursable, and those phases are planning, implementation, post-implementation and evaluation collaboration. And I'll go through really quickly what those are. Again, this is in Section 934. So under "planning" we have expenses related to developing organizational strategy, developing technical strategy which includes your five-minute use cases, technical requirements, and architectural requirements, and developing clinical strategy. Under "implementation", expenses related to personal services, executive director, project director, other staff, software licenses, hardware and installation, implementation integration services, testing, quality assurance training, Health IT and adoption support services, administration pools and real-estate services. And for post-implementation it's basically the same list with hardware and software maintenance included. And then for evaluation and collaboration we have evaluation and then

participation in the statewide collaboration process. And there is a grade in this attachment that kind of explains this, just to kind of lay this out for you a little more clearly.

And then finally for the purposes of the RGA, matching funds can be used for planning implementation or post-implementation phases and reimbursable funds for all expenses listed under implementation, post-implementation and evaluation collaboration phases, and that's subject to limits in 935.

I'm going to turn it back over to Lori to lead into the Q and A section.

MS. EVANS: All right, well, thank you, Laurie, and Joe and Keegan. When we started I failed to introduce Steve Smith over here. He's the director of operations in my office, which is the Office of Health Information Technology Transformation. So sorry, Steve, we forgot to introduce you.

All right, so who wants to go first?

MR. HATCH: I'm representing a group of 12 community-based chemical

dependency providers in Rochester, and one of the standards -- we'll be looking at the EHR section. One of the standards says that the software that's being used has to be CCHIT certified. Now, my understanding is that right now CCHIT certification is only available for ambulatory physical health care, and that the CCHIT standards for behavioral health are nearing completion and may be adopted as early as late October or November. And clearly nothing is going to be certified until some period of time after that. Can you help sort out what we can do?

MS. EVANS: Yes. Good question. I think what makes the most sense is to do what we did I think in the -- or what the Department did in the first round of HEAL, which is say that when certification is available then the applicant has six months after that time to submit it for certification to become certified. So that would depend on -- once it becomes available, you have six months to apply, and there will be some dependencies with when they facilitate that time, but that's what we can

do for that.

Can you repeat your name please for our transcriptionist?

MR. HATCH: Sure. Carl Hatch, H-A-T-C-H.

MS. EVANS: Okay. How does that sound?

MR. HATCH: That's terrific.

MS. EVANS: Great. And, sorry, please say your name and where you're from before your question and also wait for a microphone.

MR. CAPPONI: Hi, I'm Lou Capponi, New York City Health and Hospice Corporation. I have several questions. The first one is regarding Section 3.2, the lead applicant, you point out hospitals. What about public benefit corporations that are overseeing hospitals, would those be included under that umbrella, or could a public benefit corporation apply on behalf of hospitals?

MS. EVANS: One sec. Okay, we will talk about that after the meeting and get back to you with the answer via the

website.

MR. CAPPONI: My second question is regarding the participants, Section 3.2, talked about small practices, and in parenthesis there is 1 to 5. Is that meant to define small practices 1 to 5 providers?

MS. EVANS: It is.

MR. CAPPONI: Okay, and in that same section regarding the small practices you say hospital-based practice ambulatory care is not included. What about practices that are in the community but under a hospital's license?

MS. EVANS: Wouldn't that be the same?

MR. CAPPONI: Not physically in the hospital.

MS. EVANS: If they're still under the hospital's corporate umbrella, then you can't use grant funds for those.

MR. CAPPONI: Okay, those are considered hospital?

And then the third question is on page 9 and slide 5 of this presentation, the diagram has some lines going through it. I'm

just wondering if it was deliberate to have the lines go through the left part of the diagram for any particular emphasis or --

MS. EVANS: No.

MR. CAPPONI: Just Power Point?

MS. EVANS: Yeah, just trying to emphasize the cross-section and the importance of advancing each in the building blocks together.

MR. CAPPONI: Thank you very much.

MS. EVANS: You're welcome.

MR. HEIMAN: Jim Heiman from LIPIX RHIO. I have a couple questions about the stakeholder requirements, Section 3.1.2.1. In a couple of instances for stakeholders the word "end" is used. So, for example, in Part H it says data suppliers including pharmacies and webs and music centers. Are you implying that all three must be included as a stakeholder?

MS. EVANS: No. It could be four. It depends on your needs, the scope of your project, what's happening in your community, but it could be more.

MS. HIGGINS: Kelly Higgins from the Center of Excellence in Buffalo. Can a state university medical school be considered the lead applicant for a CHITA since it's a legally constituted network function with other community providers advancing Health IT?

MS. EVANS: One sec. Can you repeat the question?

MS. HIGGINS: Can a state university medical school be considered the lead applicant for a CHITA, since it's a legally constituted network functioning with other community providers advancing Health IT?

MS. EVANS: Are you delivering the health care services? Are you delivering care? No?

MR. VEINO: It doesn't appear to be in one of the categories. It's a legal entity. You can have a contract, but it doesn't appear to be among the legal categories.

MS. EVANS: Okay. I think the answer is no. Marybeth? A tentative no.

We'll look into it, but probably not.

MS. SWAIN: Hi. Elizabeth Swain from the Community Health Center Association. I have a couple of questions. I'd just read them. In the category of community-wide HR limitation, Section 2.3.3, the RGA says that the majority of grant funds are required to be spent on, quote, ambulatory physician office space, EHR implementation and solo small physician practices, including those that serve Medicaid beneficiaries. Is this definition inclusive of the community health centers?

MS. EVANS: Yes.

MS. SWAIN: The second question, referring to the lead applicant list for CHITAs, quote, legally constituted network or consortium of community health centers, end quote, and diagnostic and treatment centers, does this mean that a D and TC that is also an FQAC must be part of a network in order to serve as a lead applicant but a regular D and TC can serve as a lead applicant on its own?

MS. EVANS: Both can serve as lead applicants on their own.

MS. SWAIN: Okay, thanks.

MS. EVANS: Yup.

MR. McHUGH: Patrick McHugh representing Columbia University, health sciences. This might be a redundant question but perhaps I could get a little more guidance on it, so specifically a faculty practice organization at a medical school cannot serve as the lead agency? Is that what I'm hearing, or shall I wait for consideration?

MS. EVANS: We'll post a response.

MR. McHUGH: Thank you.

MR. TURNER: Benny Turner with Bronx RHIO, four quick questions. Just for clarification on the grant funding and the matching funds, if an applicant is in category 1 and has a strong application that takes it to the maximum limit on the grant funding, does that mean it would be a 10.33 million dollar total project cost with 10 million dollars in grant funding coming from the State and 333,000 in matching funds? Is that the maximum award? In other words, the

total project costs, to realize a 10 million dollar grant from the State, the total project costs would be 10.33 million?

MS. EVANS: That's my understanding.

MS. HEFNER: Yes, the 10 million is the amount that would be reimbursed under --

MR. TURNER: For a total project cost, 10.33.

The financial plan, there was some question about where the financial plan fits into the application. Is that in the technical application or in the financial?

MS. EVANS: As part of the organizational plan in the technical application there are a few bullets about business, a business model, so you should address those bullets as part of the organizational plan in the technical application, but the financial application includes the budget and the other elements that are required as part of the financial application.

MR. TURNER: But on page 26 in

the RGA, Section 5.2.6, there is a whole section on the financial plan.

MS. EVANS: Right.

MR. TURNER: And so numerous points that have to be addressed in the financial plan.

MS. EVANS: Yes.

MS. RALEIGH: That is the financial application.

MR. TURNER: That goes into the financial application.

MS. EVANS: Yeah, right. There is no financial plan. There is just the financial application, and then it includes, you know, those five areas as part of the financial application.

MR. TURNER: Respond to all of those points in the financial plan.

MS. EVANS: Yes.

MR. TURNER: Letters of commitment, there is one called for in the financial plan and one called for in the technical plan. And the technical plan is focused on governance, and of course in the financial plan it's about financial

commitment from the stakeholders. Can those be combined into one letter and then put the same letter in both parts?

MS. EVANS: Yes.

MS. HEFNER: No.

MS. EVANS: No?

MS. HEFNER: I'm sorry. You could, but you would have to redact the component of that that discussed the dollars that would be part of that relationship.

MR. TURNER: So really it should be two letters.

MS. HEFNER: It should be two letters, yes, but it could be one letter as long as the dollars don't appear in the technical side. So if you redacted that so it was clear to the technical reviewers what those costs were, then that would be fine.

MR. TURNER: In terms of getting signatures on letters, I really have to have two letters.

MS. HEFNER: Yes.

MS. EVANS: If you don't include specific dollars amounts, then you can have one letter. If you want to include specific

dollar amounts, then you have to have two letters, because you can't have dollar amounts in your technical applications.

MR. TURNER: But you do require dollar amounts.

MS. HEFNER: Correct.

MR. TURNER: So that's two letters signed separately.

MS. HEFNER: That's fine.

MR. TURNER: Regarding the required service area analysis, will the State be able to provide any data sources to do that analysis? A lot of different things in that analysis.

MS. EVANS: No.

MR. TURNER: Okay, thank you.

MS. KING: Barbara King, Continuum Partners. I was wondering if a project or applicant did not receive funding in HEAL 1, does that impact at all whether or not you could receive funding in HEAL 5?

MS. EVANS: No.

MS. KING: No, okay.

MS. FYFE: Dorothy Fyfe from SUNY Downstate, Brooklyn. I have a quick

question. Matching funds, can TELP (phonetic) outpatients be included as a matching fund?

MS. HEFNER: Can what?

MS. RALEIGH: That's the Dormitory Authority tax exempt leasing program?

MS. FYFE: Yes.

MS. RALEIGH: If I understand, that's a source of borrowing.

MS. FYFE: Right.

MS. RALEIGH: I would say yes.

MS. EVANS: Can you repeat the question please?

MS. FYFE: Yes. In terms of matching funds for the stakeholders, I was inquiring whether TELP (phonetic) funded equipment, capital equipment could be included as a matching fund.

MS. RALEIGH: And that's borrowing, so I would say yes.

MR. HEIMAN: Jim Heiman from LAPIX RHIO. I have a question. As we are -- we're kind of leading the way in most of the software development from our software

vendor side, and as our software vendors actually develop the technology that fits one of these use cases and we're actually paying for it, we actually own that software as the RHIO, and you're saying that we can't turn around and sell that build that we didn't buy -- we didn't -- we actually gave it to -- the software is developing that software for us, so we technically own that particular part of the software. Can we then in turn sell that build to other people?

MS. EVANS: So you're asking if LIPIX can sell software?

MR. HEIMAN: Specific aspects of the software, not selling the whole software.

MS. EVANS: Well, you know, I think that raises a lot of different questions. One of the things that I talked about in the RGA related to RHIOs is how important they are as an organization that's building trust and collaboration and dealing with privacy issues and engaging New Yorkers as consumers, dealing with some of the business issues, and that in fact in our view RHIOs enable the development and

implementation of Health IT because those services are so important to realizing those goals, but in fact RHIOs are not technology organizations. They're not developing software. They're not turning into sort of physical proprietary health information exchange networks because again we want to drive -- try and drive common approaches across the State in a nervous system type of fashion. So based on what we've included as this point, I would say no, you know, based on that definition that's included in Section 3.1. I don't know if you're getting into sort of intellectual property issues that are very different --

MR. HEIMAN: Yes.

MS. EVANS: -- than what I'm saying. And I don't know if there's a section in here related to intellectual property.

MR. HEIMAN: Intellectual property is pretty much what we're referring to.

MS. EVANS: Okay, we'll talk about it and provide a written response back,

and if you can sort of tease out, perhaps, the question a little bit more, that would be -- in an e-mail.

MR. VEINO: Yes, that would be helpful.

MS. EVANS: That would be helpful also.

MR. HEIMAN: But just one question. You say 5 percent goes to NYeC and you say matching funds or reimbursable funds. Is that supposed to be end?

MS. EVANS: It's 5 percent of the total, but you can reimbursable funds or you can use grant funds to satisfy that 5 percent.

MR. HEIMAN: So it's 5 percent of the total project costs.

MS. EVANS: Yup.

MR. HEIMAN: I just have one last question. You say that after a CHITA gets granted an award they're going to actually come and pick the RHIO that you're going to be working with. Is that for integration into the RHIO? And if so who is going to be paying for that after the fact if

it's not included in anybody's application?

MS. EVANS: Well, I think if you should -- if you're a CHITA you should include the scope of work in your application, at least in terms of what it's going to look like from a development point of view. There will be instructions -- there will be specifications between the Electronic Health Record and the health information exchange capability of their Statewide Health Information Network for New York, so we want you guys to be able to collaborate on those components and to be able to sort of talk about what makes the most sense after the grants are awarded. So if you're applying as a CHITA in that application, you should contemplate that and consider that in your proposal. And whether you want to end up paying for it but actually ask the RHIO to do it, or whether you want to do it in partnership with the RHIO because you need the specifications, it's up to you. You should put what you want to do in the application.

MR. AMRHEIN: I'm Scott Amrhein,

and I'm with the Continuing Care Leadership Coalition, and this is also a question about CHITA lead applicants. I see in the list of long-term care organizations are listed as potential lead applicants. Can consortia of long term care organizations be lead applicants, multiple organizations coming together?

MS. EVANS: Yes.

MR. AMRHEIN: And could such a consortia be organized, for example, as a preexisting trade organization that represents --

MS. EVANS: No.

MR. AMRHEIN: Okay, so it would have to be a newly formulated consortium of long-term care organizations.

MS. EVANS: Well, you could have one entity be the -- you know, one of the consortium take the lead if you're not a formal consortium, but it's sort of up to you. I mean you'll still satisfy it if there was one entering into the contract with New York State on behalf of the group.

MR. AMRHEIN: Thank you.

MR. VEINO: Emphasize, it has to be -- the key issue there, it has to be a legally -- entity capable of entering into a formal contract.

MS. DePERRIOR: Dawn DePerrior from the Rochester RHIO today. A couple questions. The first one is really easy, and that is on page 24 of the RGA, 5.11. It says that costs incurred after October can be used for matching funds. Does that mean after October 1 or after -- starting November 1?

MS. EVANS: October 1.

MS. DePERRIOR: October 1, okay, thank you.

The second question is really related to the slide that we're looking at now, and the slide on page 23. And the question is for --

MS. EVANS: Sorry, what's on page 23?

MS. DePERRIOR: Page 23 refers to -- if an applicant applies for multiple categories, the applicant should describe the interrelationship between each category. So if the Rochester RHIO is looking at use cases

that really cross-section each of these different categories, and it's a project that has a budget, and so we're thinking through how we present that budget across three separate category applications.

MS. EVANS: Well, I would focus on the use case. If a use case is on one category, you can address it in one category. You don't have to address it across other categories.

MS. DePERRIOR: Okay, so that would be the preferred.

MS. EVANS: Right, that would be the preferred.

MS. DePERRIOR: And this description of the interrelationship between the three applications should be probably an executive summary of all three, I would imagine.

MS. EVANS: Yes.

MS. DePERRIOR: Okay, thank you. And then the next question is can a RHIO supply corps services to another community's CHITA as a service provider? So the Rochester RHIO has a vendor which we are

using as an application service provider. We do not own software or hardware. And if a CHITA was interested in using the Rochester RHIO services but not intellectual property would that be allowable?

MS. EVANS: Yes.

MS. DePERRIOR: Okay, thank you. That's all for now. Thank you.

MR. GILBERT: Hi, I'm Jeff Gilbert from New York State Affiliates of Planned Parenthood. I have two questions. One relates to the regional structure of the program. Does that preclude an application from a statewide network of providers?

MS. EVANS: No, it doesn't. We would just have to figure out -- you would have to -- you would have to suggest how the allocation would work across the regions based on which clinics are where and tell us as part of your application.

MR. GILBERT: Okay, and then the second question is regarding the provider makeup of the CHITA. Do you require some sort of a provider mix? To be specific to Planned Parenthood, what I'm thinking about,

does a network of diagnostic and treatment centers operate on Planned Parenthood Affiliates, can they in and of themselves form a CHITA, or would we have to -- other types of providers?

MS. EVANS: One second. Well, I think for the -- depending upon your grant category, what you're proposing, the clinical affiliation of other providers that are listed is important because you'll want to drive the results into the record. So for the purposes of successful EHR adoption and those interfaces from the clinical affiliate providers, that's really important to have as part of it.

MR. VEINO: Also, there's also a reference here. On page 21, CHITAs are required to include ambulatory care clinicians and solo and small physician offices, including those that have contracts with and serve Medicaid beneficiaries and provide care in long-term care facilities.

MS. EVANS: So you would need to include --

MR. GILBERT: If a CHITA is an

applicant, then that mix has to be included as the applicant as opposed to an applicant that has associations with other types of providers.

MS. EVANS: No. I mean your applicant is going to be one entity, and you need to include the others as part of the project as part of the -- I mean one organization enters into the contract with New York as part of the CHITA. The others are participants. So there is a difference between -- I mean you can select from that list which participants you want to be included.

MR. VEINO: We assume that CHITAS will not themselves be legally constituted organizations that enter into a contract themselves. They're made up more loosely organized, so somebody has got to be the lead contractor.

MS. SCAMURRA: Hi, I'm Sue Scamurra, and I'm from Western New York RHIO, and I've got some questions from a large group of physicians that have been working concurrently with the RHIO over, probably,

two years, so it's a lot of cross-over, and they're written by e-mails, so I can't explain them any further. But the questions were, first, is there a preferred organizational structure for a private-practice-physician-driven CHITA?

MS. EVANS: No.

MS. SCAMURRA: Okay. Related to that, would a CHITA -- could it be a 501C3 if they were to formally organize a much larger group of independents as a consortium similar to the way we formulated a RHIO in Western New York?

MS. HEFNER: I think that's okay.

MS. EVANS: Yeah, it's fine. We would have to make an adjustment to who can be a lead applicant.

MS. SCAMURRA: Okay.

MS. EVANS: Are they already a 501 -- is it DASNY?

MS. SCAMURRA: Yeah.

MS. EVANS: Are they already a 501C3?

MS. SCAMURRA: No. We are

probably at an organizational stage now to decide, in terms of business' state ability, you know, there are a lot of options open to us in Western New York, because we've had physicians involved so long. So then the third question would be, could the lead applicant for a CHITA be the RHIO?

MS. EVANS: It depends on the -- I mean RHIOs can be the lead applicants for each of the categories. It depends on what they're doing.

MS. SCAMURRA: So that would be pretty much explained out and, say, that the business model or the relationship --

MS. EVANS: Well, if they're applying for the Electronic Health Record category, RHIOs are allowed to lead that in addition to CHITAs. I'm not sure what you're getting at, but --

MS. SCAMURRA: Well, it's just, you know, understanding, you know, the lead concept in being able to explain that back to them.

The last part is the idea of direct accountability for groups of physicians that

come together as a CHITA. So the accountability would then fall financially and project wise on the lead applicant, so the governance structure would have to be built around that to ensure the accountability across all the members.

MS. EVANS: Yeah, I think the governance structure of a CHITA includes all of the participants as a steering committee. It has one RHIO leader, but it should include the participants, but the lead -- you know, the leader is entering into the contract but I think the broad participation, through a steering committee or any similar body, is important. It's noted in the application.

MS. HEFNER: I think the RGA, it lists entities that can be the lead on a RHIO -- or on a CHITA, and a RHIO is not listed.

MR. VEINO: Right. This is on page 203.2.1.1.

MS. HEFNER: I mean we can certainly look into it, but as it stands right now it's not allowed.

MS. EVANS: Yeah, I think it's

sort of -- I would say it really gets back to what the project is, because I think if you go back and look at what project they want to do, then it can be the RHIO or the CHITA doing that, so I guess I would go back and ask that question to the group.

MS. SCAMURRA: Like I said, I just have an e-mail back and forth at this point, but it's good to ask while I have the audience. So what you're saying basically is the accountability is developed within your local governments or on the regional level. There's no -- other than the State accountability of a signed contract by a lead organization, that subdivision of accountability then falls within the governance of that local organization, whatever it is.

MS. HEFNER: Yeah. From our perspective, the accountability is going to be with the lead applicant because that's who we have a contract with.

MS. SCAMURRA: Okay, that's it. Thank you.

MS. SMITH: I have three

questions. One, could answers to questions that are critical in making decisions who's lead applicant and who can and cannot partner, can those be answered sooner than October 26?

MS. EVANS: Yes.

MS. SMITH: That would be, I think, helpful for those of us who are trying --

MS. EVANS: Yes, we'll answer them as quickly as we can, as they come in. Nancy Smith.

MS. SMITH: The second question --

MS. EVANS: So, Nancy, which are you coming in on --

MS. SMITH: With Health -- of New York.

MS. EVANS: No, I'm sorry, just with your first question are you -- what exactly -- are you referring just to the questions that have been asked to date or do you have --

MS. SMITH: No. My point is that in making -- in building the plans among

different organizations you need to know early on some core questions about eligibility, who can be a lead applicant; otherwise, we're going to be really late in just getting to the writing of the grant.

MS. EVANS: Do you have a question about that right now or do you --

MS. SMITH: No. It's a question whether or not you can post the answers to those questions as soon as possible versus October 26.

MS. EVANS: Right, we can. I was just going to see if I could answer it now versus --

MS. SMITH: I do have two questions. Thank you, Laurie. Under Category 3 is an eligible applicant a medical society?

MS. EVANS: No.

MS. SMITH: Under category 1, 2 and 3, could an eligible applicant be an organization that has a mission for controlling costs, quality and safety, and is doing like planning around RHIO activities --

MS. EVANS: Yes.

MS. SMITH: -- but is in itself not a RHIO? It has a broader mission. In its mission is not the word "RHIO."

MS. EVANS: Well, the mission -- if your mission statement is to advance interoperable health information technology to approve quality, if that's part of your mission, you can apply.

MS. SMITH: But if -- it's not in the mission statement. The mission statement is to improve quality, control costs and improve safety, but activities include, but are not limited to, interoperability.

MS. EVANS: Well, if you include that, then it's part of your mission, so I would say yes.

MS. SMITH: No, I'm saying it's not in the mission. It becomes an activity not in the mission statement -- the by-laws of the organization.

MR. VEINO: It's something your organization is doing legally? It's not precluded from doing it? It's committed to making that part of its operation?

MS. SMITH: Correct, but if the IRS asked if we were a RHIO, we would say no.

MS. EVANS: I think if your mission -- if it's part of -- if your answer to Bob's question was yes, then I would say that you should apply.

MS. SMITH: So we're not precluded from doing activity.

MS. EVANS: Right.

MS. SWAIN: I'm Elizabeth Swain again from CHCANYS. Based on the way a couple of other questions were answered, I wanted to ask that if the Community Health Care Association of New York State, which is a primary care association, is a legally instituted network or a consortium of community health centers, are we legally -- are we legal lead applicant, the Primary Care Association of Community Health Centers?

MR. VEINO: It's like a preexisting organization or association made up of these entities.

MS. SWAIN: Yeah. Our members are community health centers, so we would not be eligible to be an applicant.

MS. EVANS: You would not.

MS. SWAIN: But legally constituted networks of community health centers or legally constituted consortium. By legally constituted you mean already existing incorporated bodies --

MR. VEINO: Capable of entering into a contract.

MS. SWAIN: Right.

MR. VEINO: Legal entities.

MS. SWAIN: Right.

MR. VEINO: Established for the purpose --

MS. EVANS: It could be a community health center.

MS. SWAIN: Right.

MS. EVANS: One community health center could support a broader network if the network isn't yet its own entity.

MS. SWAIN: Right.

MS. EVANS: I might want to go back to Nancy's question. One second. Can you wait one second?

So, Nancy, we just want you to -- can you put that question in writing and have us

respond in a written format so everyone can benefit? And we'll do that quickly. Okay, thanks, that will be great.

MS. GALANIS: Christina Galanis, Southern Tier Health. We've received a lot of inquiries since it was released pretty much around the same question I think I heard other people ask. There's a possible impression that anyone who is awarded a HEAL 1 contract is a RHIO, and we know that -- so we looked at the definition of a RHIO and tried to pick through that and figure it out. It doesn't actually say that a RHIO is currently engaged or will at some point in some timeframe engage in actually creating a data exchange. Was that your intent?

MS. EVANS: I'm not -- I'm not understanding what you mean. Sorry.

MS. GALANIS: You can be formed as a RHIO and not actually be down the path of creating a data exchange, apparently.

MS. EVANS: So like a new -- so you're saying that someone who's younger that's -- that that's perfectly fine. If those are your goals -- if your goals are to

advance, you know, interoperable health information technology health information exchange, that's great. If you're just starting out, that's fine, if that's what you're getting at.

MS. GALANIS: Right. In this grant process you can form yourself legally as a RHIO and then apply for grant funding to actually do the technology.

MS. EVANS: Sure.

MS. GALANIS: That's helpful, because we had that question asked a few more times. Okay, thank you.

MS. EVANS: Yup.

MS. JOHNSON: Hi, I'm Natasha Johnson from NYCLIX, and I have a question about the use cases. For the quality use case, if an organization wants to create a quality report of clinical and other data, does that report actually have to be implemented, or can it just create a report that can be used?

MS. EVANS: I'm not sure I understand the difference.

MS. JOHNSON: With quality use

cases, what I'm trying to find out is if the quality report has to be implemented within that period.

MS. EVANS: We would like to have demonstration of -- yes, yes.

MS. JOHNSON: Okay.

MS. O'CONNOR: Hi, I'm Heather O'Connor. I'm with ARCHIE. Many of the practices in our organization applied for the MSSNY grant, and they're still waiting to hear about that award. Does that preclude them? Okay, and then what are the implications if, by chance, they do get an award?

MS. EVANS: No implications.

MS. O'CONNOR: So they can withdraw from --

MS. EVANS: Pardon?

MS. O'CONNOR: They can withdraw their application from the HEAL 5?

MS. EVANS: Sorry, can you start over?

MS. O'CONNOR: I'm just wondering if, by chance, they received a MSSNY award after submitting for a HEAL 5,

what would be the implications to the HEAL 5 application?

MS. EVANS: They're totally separate.

MS. HEFNER: It wouldn't be the same project under the 2, right?

MS. EVANS: Are you saying --

MS. HEFNER: If it's the same project we're not going to fund the same thing twice.

MS. O'CONNOR: But the other practices who might not have applied for MSSNY who applied for HEAL 5, would that jeopardize their chances with HEAL 5?

MS. EVANS: No.

MS. HEFNER: The evaluations are separate from each other, but, you know, if one occurs first in time, we won't duplicate that same project and award it in the other. We would not do that.

MS. O'CONNOR: Thank you.

MS. HAWKS: Hi, Christina Hawks, Continuing Care Health Information Exchange. Can a non-profit organization, which consist of entities that could be considered a CHITA

also be considered a CHITA, the non-profit?

MS. EVANS: It gets back to whether CHITAs can be not-for-profits. Is that --

MS. HAWKS: Yes.

MS. EVANS: If they satisfy the requirements in the lead applicant and participant section, then they could -- I mean if they happen to be a not-for-profit also.

MS. HAWKS: But if that organization is not the type of entity that participants in the CHITA are, it's not a health care.

MS. EVANS: Can you give an example?

MS. HAWKS: Just a non-for-profit that supports collaboration and exchange of information from organizations.

MR. VEINO: But it's not among the organizations listed there as a potential lead applicant for CHITA; is that what you're saying?

MS. HAWKS: Right.

MR. VEINO: Well, they have to be one of those categories in order to be a lead applicant for a CHITA.

MS. HAWKS: Okay, thank you.

MR. BROGAN: My name is Barry Brogan. I'm with the North Care Behavioral Healthcare Network, and I'm thrilled to see that some other behavioral health care providers are interested in linking up with primary care amongst themselves. My question is from page 24, Section 5141 -- I'm sorry, 5142, where it talks about the matching funds, and specifically we, as a rural health network, receive funds from New York State, and we have for the last four years had budget items to support the development of IT. We would like to use that budget line to support the matching funds part. Is there any restriction based on this section that would preclude us from using DOH funds as part of our match?

MR. VEINO: Only the non-state share of matching funds or services may be counted towards the match requirement.

MS. HEFNER: We sort of consider

that to be also our share, so we would expect that your share would come from other than state grant sources.

MR. BROGAN: Okay. That's disappointing for rural health networks.

MS. HEFNER: Sorry.

MR. BROGAN: It's primarily running on a single grant that comes from the New York State Department of Health --

MS. HEFNER: You're talking about the funds from the State that are grant funds, not Medicaid reimbursement type funds or anything like that?

MR. BROGAN: Correct. These are contract -- these rural health networks -- there are 35 of them across the State -- are under contract with the State to provide various coordination and program development services.

MS. HEFNER: Right. We wouldn't expect that those funds would count as a match for the HEAL 5 program.

MR. BROGAN: Okay, leave it at that. And then the other area I was wondering with regards to the regions that

have been designated by the Berger Commission report -- although, they see the North Country as two regions, we don't. And I was wondering if you could highlight any specific issues that we're going to need to address when we put forth a proposal that includes three counties -- six counties, three from two different territories. Are there any specific issues that we need to address?

MS. EVANS: I think there is just one which is the -- just make sure you explain how you're allocating -- you know, based on the regional allocations, how you're summing those and what your rationale is, because if you're covering more than one region you'll pull funds from each region. You'll just tell us how you've done that.

MS. HEFNER: There is a section in the financial forms that asks you to do just that, to take your costs and divide them among the regions based on where the cost will actually go.

MR. BROGAN: Thank you.

MS. STUARD: Susan Stuard, New York Presbyterian. With regard to an

application in category 3, when the CHITA is contemplating its sort of later integration with a RHIO, just to sort of scope that out, certainly some of that integration is corps services, but you wouldn't necessarily have to do all of the corps services to achieve that level of integration. Is that sort of --

MS. EVANS: Yeah.

MS. STUARD: Great. So in terms of scoping that out, just the ones necessary to achieve the integration.

MS. EVANS: Right.

MS. UPADAHAY: Hi. I'm Asha from the THINC RHIO. I just have a couple of questions here. How many applications can a RHIO apply as a partner?

MS. EVANS: As a partner.

MS. UPADAHAY: In any form, which no limit?

MS. EVANS: No limit.

MS. UPADAHAY: Okay. And would the State please clarify your expectations of CHITA applicants in the region already served by RHIOs, existing RHIOs.

MS. EVANS: Depending on the goal the RHIO or the CHITA can apply.

MS. UPADAHAY: Any specific expectations they have on CHITAs or --

MS. EVANS: Well, I think that, you know, CHITAs are about -- you know, they're really the adoption champions. They're about the clinician at the point of care and really supporting that need. There is a need to collaborate closely with the RHIO when you get to the interoperability components that are so important. Can they exist in the same area? Of course. Do they need to work harmoniously? Yes. Hopefully, that helps a little bit?

MS. UPADAHAY: Yeah, it does. And then just one more question. Would a CHITA have to get documented letters of support from a RHIO, or would a CHITA have to define a plan of how to work with a RHIO?

MS. EVANS: We talked about -- in certain parts of the application, we talked about sort of describing the working relationship, but we stopped short of requiring letters of support between RHIOs

and CHITAs because we wanted that to be addressed as part of the kick-off of the projects, and then people would be convened, and we would talk about what would make the most sense based on what awards were made. So there may be -- let me point to -- let me just find the one section. So I think the discussion about the collaboration is important, and we sort of drew the line with respect to letters of support because we wanted that to be an already deliverable of the grant award. Does that make sense?

MS. UPADAHAY: Thank you.

MS. DePERRIOR: Dawn DePerrior again from the Rochester RHIO. Three additional questions. The first for the Rochester RHIO. How does the co-applicant process work with two RHIOs? Can you confirm one application or two?

MS. EVANS: One application, one application and one of the RHIOs has to step up and enter into the contract. Both RHIOs can't enter into the contract if there are two. One can, but we really feel like it's a partnership, and it's really a co-activity,

but again somebody has to step up to enter into the contract with the State.

MS. DePERRIOR: So then if two RHIOs are working on similar projects it's beneficial to apply as co-applicants with the one grant application.

MS. EVANS: Yes. Sorry.

MS. DePERRIOR: The second question is from page 27 of the RGA, Section 5.2.1.13D, and it states, "What is envisioned -- oh, the question is, "What is envisioned in a plan" -- and I quote -- "a plan for providing incentives for participation by New Yorkers and supporting electronic communication with clinicians?"

MS. EVANS: I think we wanted to start to get your ideas around how to engage patients.

MS. DePERRIOR: We weren't sure. You were looking for incentives for patients and clinicians or just --

MS. EVANS: This is under the patient engagement section?

MS. DePERRIOR: Right. That's what I thought, okay.

MS. EVANS: And I think financial incentives for clinicians can be discussed under the business model component if you so choose.

MS. DePERRIOR: Okay, and then the last question is would it be possible to have additional sessions of the RGA provided in Word format? Because a lot of the checklists, we could save ourselves some time if they were in Word format rather than the PDAs. It just would be administratively a little helpful to us.

MS. EVANS: PDF, you mean?

MS. DePERRIOR: Yeah.

MS. EVANS: Sure.

MS. DePERRIOR: PDF, yup.

MR. MURPHY: Ray Murphy, HIXNY. With regard to the satisfaction of qualifications for RHIO, the six categories, do they need to be six separate members, or can a single member qualify in multiple categories if in fact they fit?

MS. EVANS: I don't know how that would work. It has to be six different types.

MR. MURPHY: Six.

MS. EVANS: Types.

MR. MURPHY: But does that mean six different members?

MS. EVANS: Can you give me an example?

MR. MURPHY: You have large organizations that provide --

MS. EVANS: Let's say hospitals. If you have eight hospitals that's the hospital type.

MR. MURPHY: Okay.

MS. EVANS: You need to go -- you need to satisfy another type.

MR. MURPHY: Okay, a hospital that has a lab in it doesn't satisfy the lab documents essentially.

MS. EVANS: If that's the only lab, I mean I would sort of go to -- that's why we listed, I think, 12 or 13, and you have six, because there's going to be some differences. And if that's the only lab around, you know, I would then go look to -- you know, for the purposes of evaluation, you know, going through that process, I would try

and cover the six types without having to do the lab inside the hospital. Of course, it depends on the region. If it's the only lab and it's a more rural place, that's fine, but you know, try and make sure you check off the six.

MR. HATCH: Carl Hatch again from Recovery Net. Excuse me. For a CHITA could the lead agency be an Article 31 or 32?

MR. VEINO: No. Well, not unless it also has an Article 28 license. Some of them do, but, you know, diagnostic and treatment center we define as being an Article 28 licensed entity.

SPEAKER: Would you repeat the last part? We didn't hear that.

MR. VEINO: The term in the definition of lead applicants for CHITAs in reference to a diagnostic and treatment center, for us that is a term of art within the Public Health Law, meaning an entity licensed under Article 28 of the Public Health Law. It can't be just licensed under Article 31; though some entities are dual licensed.

MS. GARCIA: Hi. My name is Arlene Lozano Garcia from the Primary Care Development Corporation. I had a question about the contracting and DOH's option to renew the contract without additional funding, if necessary. Something like a category 3 application from a CHITA where part of the members don't have the EHR yet and part of the project is to implement that and that could cause delays, are you going to look at, at the end of the two-year project, if there were a particular circumstance that would cause the project to last longer than two years, or is it simply okay to put in a really ambitious project in two years and know that it's okay if it goes beyond that time?

MS. HEFNER: I would certainly not rely on getting any extensions to the contract. We're putting it in there pretty much as a fail-safe in case we need it, but at this point we're hoping not to use it at all.

MS. GARCIA: Okay, so at what point, though, within the project if that

consideration needs to be taken?

MS. HEFNER: Do you mean at what point would you begin to seek an extension?

MS. GARCIA: Yes.

MS. HEFNER: Well, as soon as you know you'll need it, I suppose.

MR. HALL: John Hall from the INSNC RHIO and Southern New York Association. Expanding upon the stakeholders of a RHIO, whatever function and stakeholders you have as members of your RHIO apply towards the two, or does it have to be additional six stakeholders --

MS. EVANS: No, no, it's six, but what we did ask is for a real -- we emphasized growth and inclusion and giving us a table that says here are current members, here's our plan to embrace new members and to really spell that out and talk about how you're going to get there.

MR. HALL: Thank you.

MS. FLOCK: My name is Deborah Flock. I'm with CVPH Medical Center. For an application for where the hospital is the lead applicant, are we able to include

emergency room physicians as part of the application in working with community physicians to advance the health --

MS. EVANS: Yeah, as long as you include those other physicians.

MS. TYLER: Virginia Tyler with Tyler Consulting. I have three questions. They're all fairly technical. The first one is there is a 30 page maximum. I'm wondering does that apply to the financial and the technical application, or is it 30 pages for each?

MS. EVANS: No, we decided 30 pages for the technical.

MS. TYLER: Okay.

MS. EVANS: And -- one sec.

SPEAKER: The checklist says 30 pages. The checklist for each section says 30 pages.

MS. HEFNER: It says it twice? I think it's intended to be 30 each.

MS. EVANS: Thirty each.

MS. TYLER: Thank you. The second question pertains to the match. If applicants are able to get a match greater

than 25 percent, will you view that more favorably than if they only get the 25?

MS. EVANS: Yes, of course.

MS. TYLER: The third one has to do with care coordination zones. In very rural areas with low population density, would you be willing to look at the total geographic region or the percent of population covered?

MS. EVANS: Of course.

MS. TYLER: Thank you.

MS. EVANS: Going once -- darn.

MS. FOULGER: Judy Foulger from CDPHP. Is a health plan eligible to serve as a lead applicant for a CHITA?

MS. EVANS: No, but we strongly encourage participation and equal partnerships.

MR. AMRHEIN: Scott Amrhein again. Three quick questions. Could you clarify what a standardized electronic approach to aggregating and presenting clinical information to improve coordination of care, or care outcomes, qualify as a clinical decision support in an

HIV environment -- or HIE environment under category 2?

MS. EVANS: Sorry. Would that -- yeah, yes.

MR. AMRHEIN: Okay. It doesn't have to be analytic software, per say. It could be a different approach.

MS. EVANS: Just explain it, and you'll be evaluated accordingly.

MR. AMRHEIN: Very good. Secondly, also category 2, does the clinical decision support in an HIE environment use case approach need to include measurement and reporting on physician quality, or is that more related to the quality reporting for outcomes use case?

MS. EVANS: The latter.

MR. AMRHEIN: The latter. And then this is a category 3 question. Would a CHITA, working to implement community-wide Electronic Health Records under category 3, qualify if it offered support across several care coordination zones if it were more than just one zone?

MS. EVANS: Yeah. Just define

the big zone or the zones in the big zone.

MR. AMRHEIN: Great, thanks.

MS. GALANIS: Christina Galanis again from Southern Tier Health Link. To follow up on the rural health question, can they receive grant funding, and can county health departments receive grant funding as part of a project; for example, a county health department that wants to put in a CCHIT certified EMR in their free clinic?

MS. EVANS: Yes.

MS. GALANIS: And the same for rural health, if they wanted to assist either a CHITA or a RHIO in supporting rural health doctors for some of the EHR support functions?

MS. EVANS: Yes.

MS. GALANIS: Thank you. One more question. Has any thought been given to extending the duty? I'm only asking because we have a lot of collaboration to do.

MS. HEFNER: We did give it some thought.

MS. GALANIS: Okay, and you're still thinking?

MS. HEFNER: No, we're done thinking. I don't think we can extend the due date at this point.

SPEAKER: You can or you can't?

MS. HEFNER: No, we can't.

MR. MARINO: Al Marino, Queens Network. On page 20 on the participants in a CHITA it says the participants have to be from a separate corporate structure. Does that imply that all the participants have to be from separate corporate structures, or can you have a hospital and a nursing home from the same structure?

MS. EVANS: You need to make sure you satisfy all of the other requirements for the physician outside of the structure.

MS. SMITH: Nancy Smith again with Health Advancement Project. Under category 1 you state that look more favorably if RHIOs collaborate, which I understand in terms of the ultimate goal. In the case where you have a significant region that at this point is absent in a RHIO HIT ground work, does that still apply?

MS. EVANS: I think it's up to you and what you think is best for the region. I'm not sure I -- sorry, Nancy.

MS. SMITH: I like that answer, but in the RG it's really clear that there will be -- that there is a preference for collaboration. So I'm asking is that also the case in an area where there is really an absence of beginning work.

MS. EVANS: I think -- I think it's up to you and what you think is going to be best for the project and the region and what you're trying to accomplish.

MS. ESPOSITO: Marybeth Esposito, Mather Hospital, and my question is how would an EHR for a hospital as a project expense be viewed?

MS. EVANS: We -- not favorably. We want the electronic health record adoption to be focused in the ambulatory environment. The hospital participation is important because you want to get results from the hospital integrated into the electronic health record. And to the extent that the hospital needs funds to do that in

participation of the project, then funds can be used for that integration but not for the electronic health record for the hospital itself.

SPEAKER: Could you repeat that, please?

MS. EVANS: She asked if funds could be used to implement an electronic health record in a hospital. The answer is no. If a hospital is participating -- leading or participating in an electronic health record adoption, the electronic health record adoption should be focused on the ambulatory care environment, but to drive adoption and interface results from a hospital, for example, into the office-based electronic health record, that's a really important component, because that's going to drive successful adoption and effective use of the electronic health record. So the funds that would be required to build that interface for the hospital are allowable. Does that make sense?

MR. GOIOIA: Phillip Goioia from the Cayuga Community Health Network, Rural

Health Network. You're thinking about -- community CHITA with integrating electronic records with third-party administration is a community health plan, would the administrative cost for the payment be part of the grant or it would just be the payment for performance or payment for outcomes part be part of the --

MS. EVANS: I'm sorry.

MR. GOIOIA: The system of the integrated financial --

MS. EVANS: This is --

MR. GOIOIA: -- health records so.

MS. EVANS: So you want to integrate the practice management health system with the Electronic Health Record?

MR. GOIOIA: With the community basis.

MS. EVANS: Yeah. I think that's an important part of the Electronic Health Record adoption, so to interface the two could be included, yes.

MR. GOIOIA: Would the third-party payment administration be part of

the grant, or would that be separate, just the evaluation for the payment for performance or payment for outcomes would just be more --

MS. EVANS: I'm sorry, I'm not --

MR. GOIOIA: So there's like a financial administration system which you would be using for getting payments from local chamber of commerce and small businesses to the health care providers, and part of it would be a quality part, part of it would be administrative costs for developing --

MS. EVANS: Paying for the quality part would be preferable.

MR. GOIOIA: Okay. The administrative costs for financials --

MS. EVANS: What exactly would the administrative costs be?

MR. GOIOIA: Well, it's a question of developing software and hardware to create a system where people could -- community people could pay to the community pool --

MS. EVANS: Yeah, I would leave that out, that part out of the budget.

MR. GOIOIA: But the integration part and the quality part --

MS. EVANS: Yeah.

MR. GOIOIA: -- would be important?

MS. EVANS: Yeah.

MR. TURNER: Benny Turner, Bronx RHIO. It's a question about getting cost information or helping us develop cost information on two use cases -- immunization in accord with the EHRs and the interoperable EHRs for Medicaid. Is there anyone we can contact at the State so we can talk with to get a more intelligible cost estimate?

MS. EVANS: Correct me if I'm wrong, Marybeth. I think the process would be e-mail, and we'll use the team to respond through e-mail. Does that work, or is that right?

MR. VEINO: No private questions.

MS. EVANS: No private

questions.

MR. TURNER: Thank you.

MR. HEIMAN: Jim Heiman from LIPIX RHIO. Two questions. One, the CHITA certification, 2006 versus 2007, is that an issue?

MS. EVANS: Oh, good point.

MR. HEIMAN: There are only nine -- that are 2007.

MS. EVANS: Only nine so far?

MR. HEIMAN: Yes.

MS. EVANS: You know, we'll provide a written response. I think it's more the expectation that that will happen within X number of months in terms of having a feasible approach to submitting -- I mean it's important if you're certified to stay certified, so we'll just allow time to allow that to happen in a reasonable way. But if your vendors aren't getting recertified, you should ask them to get recertified. And I think, while we're on the vendor topic, I would just encourage everyone to really talk to your vendors and have conversations about what they want to be when they grow up and

how they view -- and I mean that in a way that the environment is changing rapidly. Health IT is still a new area. We're all learning. We have a lot to learn. We're going to have course corrections along the way, and being able to really talk to your vendors about how they view themselves in this field over time is really, really important. I mean there is a big difference between facilitating results delivery into an Electronic Health Record and clinical messaging. That's very different from health information exchange and being able to think about health information exchange in a way that not just, I think, allows information to be shared in your community but that can really support clinical informatic capabilities for quality reporting and public health surveillance reporting and for supporting interoperable EHR adoption. Those are critical components of health information exchange, and those capabilities are critical to driving the corps services and this common health information exchange protocol that we've addressed as part of what it means to

do health information exchange. So just, you know, ask the hard questions, and it's -- you know, you may need a few vendors, and one of reasons why we included a health information service provider committee as part of the statewide collaboration process is because we want the projects and your vendor. We want you to bring your vendors along, and we want to really start to talk about some of the things that we should be talking about to drive these corps services. And I'll stop there. I just wanted to emphasize and encourage you to have those conversations. And, you know, we're going to take, which has always been the case -- the vendor responsibility questionnaires from the vendors are a really important part of the process, as it always has been.

MR. HEIMAN: My other question was, quickly, can you just give us a little more understanding of what NYeC is going to be doing with the money, the 10 million dollars?

MS. EVANS: They are going to be -- they are going to be -- hang on. It's

actually -- it's 5 percent of the 105, so it's 5 million, and --

MS. HEFNER: Up to.

MS. EVANS: Pardon?

MS. HEFNER: Up to.

MS. EVANS: So I think the key role for NYeC is to be able to convene, and basically it's a home for collaboration and convening all of the projects in each of the gray categories and to drive -- especially with the Statewide Health Information Network for New York projects, there's a lot of discussing and thinking we want to do around health information exchange, getting back to the point that we don't want to do this in a way where in two years or three years or four years we have to do inter RHIO interoperability. We want to try and have successes in the region and drive health information exchange but do it in a way where we are doing some things exactly the same. So NYeC's role is to convene the projects and the vendors, especially in that category, to drive corps services and to drive this common health information exchange protocol. So as

I was saying in the beginning, that process will be determined and worked out. Once the awards are made, the group will come together; we'll have a kick-off meeting; we'll talk about what makes sense in terms of the working sessions and the series of meetings and so forth. But, you know, you need to think about that and anticipate it in your applications. And then the other key pieces will be based on which project -- which use cases are selected and then the key intersection points between some of the grant categories. You know, if a CHITA is doing an electronic health record project, we really want to have that collaboration happen with the RHIO and be able to facilitate those discussions. So we're really trying to use the convening and the collaboration process so all of you can benefit and all of your projects can benefit, but also for us to be part. We want to be a part of helping and supporting and providing technical assistance and using our knowledge to support the projects as well, so it's a real home to be able to have that be a part of the process.

MR. HEIMAN: So it's going to be 5 percent of the total dollars of the reimbursable --

MS. EVANS: Yes.

MR. HEIMAN: -- dollars then, correct?

MS. EVANS: Yes. Well, you can use matching dollars but it's the 75 percent.

MR. HEIMAN: Yes.

MS. EVANS: Yeah, sorry, clarification.

MS. SMITH: Just to clarify, because you said before that it would be of the total project. You're saying it's just the --

MS. EVANS: Well, it's the total, the reimbursable. The total --

MS. SMITH: And that's the same for the evaluation? Five percent?

MS. EVANS: Yes.

MS. SMITH: My question was if an applicant is not currently working a vendor or wants to consider working with a different vendor for a project, does that vendor have to be identified in the grant, or

can that vendor selection process be part of the two-year request?

MS. EVANS: Nancy, if you don't think you have time to interview or decide on a vendor now, I would just tell us how you're going to do that, but be very clear about what your goals are and what you need and how you're going to do it, because I think it's something that has to happen really fast once the awards are made. You know, you can even bring it down to some choice and options and put that in the application and say how you're going to select the final choice upon grant award.

MS. KOCH: Irene Koch from Brooklyn Health Information Exchange. We talked about it a couple of times today, but I think it might be worth while to just have clarified on the website the interpretation of the last sentence in the first paragraph of Section 4.2 about 5 percent of the funds going for the collaboration process and, additionally, 5 percent of the funds going for evaluation and 5.1.4.1 because there seems to be some ongoing confusion about the

total project cost.

MS. EVANS: Right. So just to be clear, it's 5 percent of -- it's 5 percent of the hundred and 5.75, so it's the 75 percent side -- is that clear? -- for both the statewide collaboration and the evaluation.

MR. HALL: Right, and the text of the RGA says allocate 5 percent of reimbursable funds or matching funds, so I think that's leading to some confusion.

MS. EVANS: Yes, and I think the point there, for the 75, the source of funds could be reimbursable or in kind or matching, but it's still coming from the 75 percent denominator. Does that make sense? We'll make sure it's clear in the writing, but it is based on the 75 percent denominator.

MS. GARCIA: Arlene Garcia again from Primary Care Development Corporation. Two quick questions. One, can a 501C3 that provides EHR adoption services to community health centers be part of the CHITA as long as they're not the lead applicant?

MS. EVANS: If the participants

of a CHITA want to work with you to satisfy the goals of their project, that's up to them.

MS. GARCIA: Okay, so that leads up to my second question. In 3.223, the HIT Adoption and Support Services, is it expected that the CHITA members provide those services, or are those to be contracted out?

MS. EVANS: They can decide how they're going to provide those services.

MS. GARCIA: Thank you.

MS. SCAMURRA: Susan Scamurra from Western New York again. One more clarification on the evaluation process. If a third-party is hired by the State to go out and do an independent evaluation and they come back to each of the projects and want information or work done by the projects to gather the information or whatever, do we have to worry about additional costs on our part, or would that be considered all inclusive in what they receive money on? For instance, if they wanted us to conduct surveys --

MS. EVANS: Who is the they, and

who is the us?

MS. SCAMURRA: Well, you're talking about an independent third-party evaluator.

MS. EVANS: We'll put it in writing.

MS. SCAMURRA: Okay. That's one of the issues that's going on with the HEAL 1 now is just, you know, information or pieces of information that are needed, we have to now find people to gather that information, so we need to know whether we need to include those costs as well.

MS. EVANS: Going once, going twice --

MR. VEINO: Lora, I would like to make one thing. Earlier on, a question was raised as to whether or not, as I understood the question at that time, a faculty practice could be a lead applicant for a CHITA. I would ask the person who has that question to follow that up with an e-mail, and when you do, focus please on the issue of how or if that faculty practice is separately organized as an entity separate

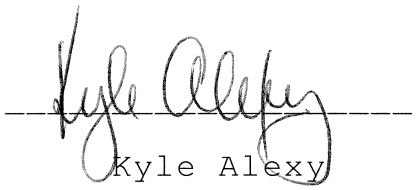
from its sponsoring medical school or hospital.

MS. HEFNER: Now you can clap.

MS. EVANS: Thank you so much.

C E R T I F I C A T E

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



Kyle Alexy

DATE: October 1, 2007