

NEW YORK STATE OFFICE OF MENTAL HEALTH
OMH Version

BIDDER'S CONFERENCE

Day 1

Electronic Medical Record

Monday, February 6, 2012
9:00 a.m. - 12:10 p.m.
NYS Office of Mental Health
44 Holland Avenue
8th Floor Conference Room
Albany, New York 12229

PRESENTERS:

Joel Rubin
Susan Froatz
Hao Wang
Gerald Engel
Dr. Greg Miller
Scott Derby
Dave Milstein
Sheila Long

MR. RUBIN: All right, good morning everyone. Welcome to the New York State OMH Central Office in Albany, New York. My name is Joel Rubin. I'm a business analyst with the OMH Project Management Office. I'm one of the contributors, editors, aggregators of all the information that went into the Electronic Medical Record system Request for Proposals that we released back on December 16th. It bears repeating that we posted a few updates on the RFP website, and so make sure that you're checking that often so that you're apprised of the latest developments.

During the day today -- this is day one of the pre-bidder's conference. During both today and tomorrow, you're going to meet a lot of the contributors and authors, subject-matter experts for the bids once they arrive. During day one, we'll hear about our vision for the OMH clinical over -- for the EMR clinical overview. You'll learn about our technology environments. We'll walk through the sections of the RFP. You'll learn about how to submit the bid correctly, and then we'll wrap up about halfway through the day, a little bit after lunchtime.

I'd like to bring up now the acting

director of the project management office, Sue Froatz.

MS. FROATZ: Good morning, everybody. Welcome. We just want to provide a few ground rules and general information real briefly before we get started today. First of all, in your packet you're going to see that there is a copy of the agenda. You will note that there are two forms on the top. Sheila Long will be describing them later on during this morning's presentation, but within your packet there should be an agenda. We've also given you some pens and the Power Point presentation so that you can document your notes, should you need to.

One important point is today's session is going to be not only audio recorded, but it's also going to be transcribed, so we're asking for some cooperation in that fact. If there is some confusion, the transcriber will raise her hand, and we're just going to have to wait and possibly repeat a couple of items.

One important note is if you haven't already registered, please register at the front door. It is mandatory, and we do have a list out there. We also have timekeepers so we can stay on

track today.

We just want to note some important information. The restrooms and water fountains are to the right, out of this door and towards the front of the building. We also have emergency evacuation procedures; hopefully, we won't need them, but they're posted on the stairway, and we do take the stairs during emergencies.

We're asking that there be no questions during the presentations. We are unable to answer questions related to the RFP during this conference. We're asking that these questions be submitted in writing, and we will post the answers on our RFP website on Monday, March 5.

We're also asking if folks could please silence their cell phones. And if you do have to make a phone call, if you could kind of go out the door and over towards the elevators where it's a little quieter; there are no offices. And we're also asking if you could keep the side conversations to a minimum, mostly because it's difficult to hear for the transcriber.

We would like to just quickly go over the presenters today. The first presenter is going to be Dr. Wang. He's our Deputy Commissioner and CIO;

again, myself, just giving you these ground rules. We also have Gerald Engel, who is our Director of Health Services; and Greg Miller, Dr. Greg Miller, who is our Medical Director of Adult Services. Following that will be Scott Derby, who is our Director of Application Services. Joel Rubin will be providing a brief presentation from the PMO. David Milstein from the Consolidated Business Office will be giving us an overview of the RFP, and Sheila Long will be giving some additional information. And these folks are people who you're probably going to meet in your day-to-day work within OMH. These are people who have subject matter expertise and do play a role in our facilities and in the RFP.

And, finally, we have a few folks who are not going to be presenting today; Michele Chenette, who is a Project Manager from our PMO. We have some clinical teams who are attending in person: Dr. Marc Mentis from Pilgrim Psych Center, Catherine Benham, who is our Director of Pharmacy Services from central office. We also have Kristine Weber, Director of Nursing, Saint Lawrence; Dr. Andy Coates, Medical Director, Capital District Psych Center; Jayne Van Bramer,

who is our Director of Adult Operations here at Central Office; and, finally, Mari Pirie-St. Pierre, who is our Health Information Management Director at St. Lawrence.

We do have some people attending via teleconference today: Darrilyn Scheich, who is the Director of Nursing at Manhattan. We also have Tom Uttaro, South Beach Psych Center, Executive Director; Dr. Mary Barber, Clinical Director of Rockland; and, finally, Dr. Mark Cattalani, Clinical Director of Hutchins.

Again, here's your pre-bid conference, day one agenda. Joel has kind of gone over this information, so you can just refer to that in your packet. We also have day two's agenda included in the packet, as well. All right? Thank you very much.

And now I'd like to introduce Dr. Wang, Deputy Commissioner, Chief Information Officer.

DR. WANG: Good morning, everyone. We are , thanks to Sue, we are way ahead of schedule, so we hope to keep it that way today. Right? So, you know, for those of you who are having Superbowl hangovers, we have coffee out there. And I know that whenever our transcriber needs to stop me, you

know, when I talk too fast, feel free to ask me.

So I would like to introduce the broader mission of OMH Electronic Medical Records. It's been in the making in the past many years. For those of you who know -- I think most of you know about OMH, right? So I was pretty encouraged that when I saw the list of the vendors. We have about 28 vendors, probably more than that those officially responded that they wanted to be here today or received information about this pre-bidder's conference. So one of the things that we know we needed, we need to help you today and tomorrow to prepare a better RFP response. So that's why Sue and the team, they put together a good agenda. You know, my role is to introduce to you what OMH does, why we need EMR and how we expect EMR to roll out and implement in the next few years.

For those of you who know about OMH, OMH is actually not only a regulatory governmental agency, but also it is a provider itself. As a matter of fact, it's the third largest provider system in New York State. It is the largest mental health provider system in the country. You know, we believe, all health care providers included, OMH is behind only the Columbian Presbyterian Hospital

system and Long Island Jewish Hospital system. We are the third largest, and we are subject to CMS and the Joint Commission of Regulatory Compliance, just like any other health care provider. So that's also for the EMR, so our EMR has to be compliant with CMS requirement and the Joint Commission requirements.

We treat -- you know, together with the community-based program, we serve about 695,000 people in New York and we employ about 16,000 people. Out of 16,000 people, 9,000 plus are those clinicians, nurses, social workers who take care of patients throughout the state, and this EMR application system is for those 9,000 workers in the state agency.

Our hospitals are the ultimate safety net, and it is the ultimate safety net tertiary providers for people with behavioral health issues in New York State.

This is a map that shows us the distribution across the State, all of our psychiatric hospitals. The total number of hospitals may change over time, but right now there are 25 hospitals, and we also have, approximately, 310 outpatient facilities. And during our adult

medical director's, Dr. Greg Miller, presentation you'll learn what kind of facilities of outpatient settings we have.

And what we wanted to, especially, emphasize is that we are transforming our agency and our whole mental health system for New York State, as we speak. We are moving from what we call casualty model of mental health care to more of an early prevention model of mental health care. In the casualty model, as you can imagine, we treat patients only after they already have severe mental illness, and our services are delivered through an episodic volume-based system that, you know, was not well coordinated. The system has been fragmented for years. you know, throughout the year, we learned that the mental health patients -- they actually receive very good health care from us, but after discharge the care is not that coordinated. And because of the fragmentation of the system, our patients may fall through the cracks after discharge and the chance for them to be readmitted to our facility or other facilities is much bigger than what we wanted.

So those, among other key reasons, our transformation is determined that we are going to

get to more of a supportive, continuous, accountable and early intervention model. And we also emphasize our collaboration with the community providers because mental illness needs to be dealt with at the onset, or at the beginning, and no matter if the patient is at their primary physician's office or at school or at their employment place. Right? So whenever the early indication, the risk factor is high, we hope the patients are being supported -- I'm sorry, before they become patients, we hope New Yorker's are being supported and so that they can have resilience in their life.

Like I mentioned earlier, we will restructure our care from an episodic, volume-driven model towards this effective support model, which is highly dependent on a successful electronic medical records system to better interact with the community, to better conduct care for the patient. Our early intervention model for people and their families is closely aligned with the primary care setting, with our and the community's quality management systems, and we need to align them with a service utilization management system, align them to the school system, education

system and the employment support system. And EMR, again, is one of the key links in that entire chain of services.

We also focus heavily on the health care quality. You know, we believe that what New York needs is an integrated health care system, and the health care system needs to be based on evidence, and both of that will benefit greatly from Electronic Medical Records. Only that system can help the individuals to maximize their resilience and help them to achieve what they need in life and reduce the cost and impact of the severe mental disease.

We have been promoting quality of care, and, hopefully, we want to make sure that the care is sufficient and appropriate. Electronic Medical Records plays a big role in that.

As some of you know, OMH, for many years, has been working with the community providers, developing very good quality metrics and delivers those quality metrics and associated data to the community providers who help provide and better manage their care delivery and help the performance of the whole system. I'll just give you one example. Our PSYCKES, you know, is one of the

decision support tools that's based on quality metrics. The two first indicators for PSYCKES, one was the polypharmacy, the quality indicator for medication management for our patients, we developed in-house for our inpatients, then we applied that to the Medicaid population and applied to the outpatient community and hand that tool to a lot of the outside providers, the community providers, help them to identify the risk of polypharmacy and help them procure -- not procure, help them deliver better care. And we are going to strive to do so continuously, all right? So we want to deliver the data to clinicians, to the providers, to the policy-makers and to health care policy administrators, as well, for them to better manage the entire care ecosystem.

EMR, needless to say for all of us here who are familiar with Electronic Medical Records, we know is the key ingredient to the solution for all of those above requirements. At the core and foundation of our EMR, first and most, is digitizing and electronically capturing data about our health care delivery and about our patients and our services. And those data are being used, subsequently, to direct the care

coordination to better make an evidence-based health care decision, as well as a health care policy decisions. And throughout the study of the VA VistA system, over the years we know that the VistA system has EMR for all VA hospitals developed more than ten years ago. After it was installed in the VA system, the operating efficiency for running that health care system was remarkable. The study showed that yearly efficiency gain, because of EMR, was about six percent per year for veteran affairs and for their hospital systems. You know, what that means is throughout about a six- or seven-year period, the VA's clinicians, the head counts, stayed flat, about 200,000 people delivering direct care; however, the ability for VA to take care of the population that's 67 percent larger six years later is remarkable without increasing the head count of the health care professionals, and equivalent efficiency gain is about six percent. We want to duplicate that in OMH, as well. Eventually, it will reduce the burden on taxpayers and, hopefully, improve the care and quality of care, as well. Because when you have the EMR, we're not treating patients blindly because we will have more

information, hopefully all of the information necessary, and all of the information available, and the care delivered to the patient will be more appropriate than otherwise. And the EMR will modernize our system, and we hope it will modernize our community provider system. Many of our larger providers have already installed their EMR. And for a smaller sized provider, they do not have the financial ability or sophistication for technology to install and develop their own EMR system. And the choice of an open source, public domain based EMR, like the VistA, is a smart choice in my view. It's because the open source portion of VistA plus the work-to-hire portion of this EMR implementation that, with your help, we will wire the Medicaid rules and wire those evidence-based, division support rules into the EMR for behavioral health. That work-to-hire portion, in conjunction with the VistA based system, will be made available to community providers if they need it to practice behavioral health care in New York State. Now they have a functional EMR that can -- not only can it be used in the hospital system, but also it can be used in the outpatient clinic system, and it will have a lot of the customization needed to function

in New York State automatically available for our community providers. And I think if we realize that, this project will not only transform our own state-run operation to a modern care system, but also transforming general health care, transforming our community providers' practice and their systems. Like we mentioned earlier, OMH will strictly adhere to the regulatory compliance with CMS and the Joint Commission. And it is my wish that the vendors, when you do EMR implementation elsewhere, you will have your best practice to help the providers adhere to that regulatory compliance, and we want to do the same. Right? So this chart actually shows where we are today.

OMH, actually, is at stage one of the three stage CMS meaningful use of EMR model. OMH is capturing health information in a coded format already. We have our in-house built MHARS; that's in-house EMR equivalent. You know, somebody will give you a demonstration on day two, right? You will see that we are capturing a lot of the data in a coded format, and we are using those coded data to make decisions for care coordination purposes, even though we believe we are not doing it in the full

extent, but we have the foundation, and we hope that foundation can be expanded through the EMR implementation project.

The decision support tools, such as our PSYCKES tool and our, I believe, SHAPEMEDS in our facility, those tools are developing in the last few years and are being used today, and we are continuing to, you know, make it a more perfect tool for our operation. And we are reporting quality measures. You know, in CMS Meaningful Use area, there are at least six behavioral health quality measures that I know of that are built into our requirements, and I believe there will be -- more quality measurement needs to be built into our EMR system; you know, that's our goal.

Then stage two, we wanted to go to stage two fairly quickly in 2013. One of the reasons that in the EMR RFP, you'll see that we had a two-track strategy. The first track is to develop, actually deploy, largely out-of-box CPOE functionality and bar-code medication administration functionality, that's because we wanted to achieve that stage two in 2013. And we believe that out-of-box functionality of VistA can largely meet our needs, and we can transform our

internal operation to adapt to that. And with minimal configuration and customization, we wanted to deliver that functionality fairly quickly. Then broader user interface for clinicians and the work flows will be done in the subsequent years in parallel. Hopefully by 2014, we will achieve stage three goal by CMS.

And this is a broader OMH health care IT roadmap we develop two or three years ago. It's gone a long way, but it's still valid. We keep refining it. As you can see, EMR is a core part of that health IT road map. On the top portion is our platform selection. We already concluded, we selected Vista. And we planned our work, the result of this RFP -- as a result of the work is this RFP. And we did have our EMR strategic roadmap, we also have our health information exchange roadmap, to communicate and interoperate with community providers. And outside EMR, we wanted to build a solid foundation for the EMR system and for our whole health care delivery. You know, the foundation includes things as master patient index, using industry leading master data management solutions, and we wanted to make that MPI ready before vendors started working on

EMR implementation, and we are well ahead of the schedule to deliver that piece.

In conjunction to the master patient index, we are developing our controlled vocabulary for clinical practice which, essentially, standardizes the terminology solution. We had Apelon solution procured. We're in the process of implementing that to standardize the clinical terminology to anticipate EMR implementation. That will be made available to the vendor, as well.

During that four- or five-year period of the EMR implementation, as you can see in the blue box, many of the EMR components are existing, many of those items are in progress, but particularly with track one work in the EMR RFP correspond to those CPOE and electronic medication administration and closed-loop medication administration environment. You know, detail can be adapted to the RFP, but that's really the portion that we want to leverage Vista out of the box and, hopefully, leverage your prior work to accelerate our pace in that regards.

The bottom half of that blue box, largely, are existing today. Like I mentioned earlier, we are at stage one. We are doing clinical documentation. We are doing decision support, but

we need to do it better, right? So that's the track two work, is that, in parallel with track one, we wanted to work with all of these functionalities and make them adapt to the New York State Health Care Policies and reimbursement rules and make it available very quickly for our facilities, eventually to the communities.

On the bottom outside of EMR, we are having multiple projects for health information exchange for mental health care. That will be carried out in parallel to EMR, as well. And that ensures, once our EMR is ready, it's not a solo system, it's not a system that cannot talk to the providers in the community, right? So that's our IT for health care roadmap.

I believe our director of health services, Jerry Engel, will give you more of a broader view of our clinical environment later, but, really, this chart shows our major existing clinical systems in our facilities today. And you can see that green boxes are those systems function that -- functionally will be replaced by VistA. And those white boxes will coexist with VistA going forward, and they have to be integrated with the VistA solution that, hopefully, some of you will help us

integrate.

And to integrate our health care system with broader communities in New York State, I just want to give you a context where the EMR fits in. The EMR is not only a software system, it's one of the components of the broader strategy for us to better service New Yorkers through closer interaction and integration with community providers. As you can see on this chart, we are, in parallel to EMR, doing a number of things, you know, information exchange with state agencies, information exchange change with the local agencies, the counties and information exchange with the local RHIOs are all happening at the same time. And they are done by a standard-based, interoperable approach, and we heavily emphasize data and records initiative. In addition to health information exchange, we work with long Island community providers in the past three or four years to standardize what we call the clinical records for New York State. Essentially, I believe, approximately, 12 programs, more than two or three dozen forms are standardized across the entire community in Long Island. And about a year ago, we rolled that out to statewide. Hopefully,

eventually, we standardize the clinical records for the entire state for behavioral health. This is a project we are doing in conjunction with OASAS for the substance-abuse population, as well. Like what I mentioned earlier, we are doing master data management, not only creating the master patient index, we are creating a master provider index and a master employee index. You eventually will have a master services index. And we are doing -- vocabularies. DSM, ICD, CPT, all of those clinical terminology relevant to mental health care will be standardized across our facility, eventually. So all of those will be working in conjunction with EMR. So for your RFP responses, I know that not everything will be rated or scored. We're going to strictly adhere to the state procurement practice, but keep in mind the EMR is not an isolated system. The ability to integrate with our existing system, our existing initiatives and the ability to integrate and inter-operate with the community providers' EMRs, it is critical for our broader success, and that the more you can help us, the better value our system will be. And the Electronic Medical Records that you help us implement will help transform our business

entirely, that entire OMH, as an agency, as a hospital provider system, will be engaged and will be mobilized to participate in this particular project. As you can see, essentially, all stakeholders of OMH will be part of our team. We not only have a steering committee that's chaired by our CMO, the medical director and me, but also we will have an operating committee that will be, you know, formed by the hospital CEOs, hospital COOs, nursing directors because EMR, quote, unquote, -- the implementation of EMR, quote, unquote, can be very intrusive to their day-to-day operation. We have to have a well organized and well coordinated project team working with the people running the hospitals and the clinics on a daily basis to get this done in the next few years, and the operation committee is very essential to the success of this project, and we realize that. And most importantly, we will have a clinical transformation team that will be headed by Dr. Greg Miller and Dr. Stewart Gabel, Dr. Grace Lee and Gerry Engel, and many others that will help us redesign our clinical work flow which is largely based on paper today. So with a new EMR system developed and implemented a lot of this clinical work flow has to change, and we

have to move away from paper centric of clinical care delivery, and we have to move to a more electronic and automated fashion, and we have to standardize that automated electronic-based clinical delivery across the entire spectrum of our facilities; the 25 or 26 hospitals, the 300 plus outpatient facilities have to adopt the standard treatment plan and the standard work flow. So the close interaction with our clinical leadership is a must for this project to succeed. And we expect -- I think it's evident in that RFP, we expect the firm or the vendor bring to the table the clinical champions who've had a similar experience in transforming the clinical work flow in other provider systems in the past, and only that will, you know, help us better interact with our clinical leadership and better persuade our users, the 9,000 plus caregivers, to adopt to the new model.

In addition to that, we will have a clinical advisory committee that will have leaders not only in the statewide system, but also from the academia environment who know what research tells us about evidence-based medicine, who can tell us what's the best practice today and how do we closely integrate our system to the research community to help the translational research. And

we need to have participation from the local and community providers who are working, you know, with us for our patients together, so our system, even though it's for statewide hospitals, and they should be acceptable and should be friendly with our community providers. So we'll have additional clinical expertise and leadership in our advisory capacity to help guide this initiative. You know, further down the chart, you will see that our billing operation, our facility operation, our quality management will all be involved, and we have to deliver a far-reaching system than just installing software, per say, right?

So the last slide, really, is my expectations. Our system has to be developed openly, not only that open source-based and, ideally, being able to be released to the community for the community providers to take advantage of, but also the system has to have the inherent ability to talk to other EMR systems, such as those in other agencies in the State, state and local, and also talking to the primary care physicians, talking to the physical health care community and

talking to the community providers for mental health and behavioral health care. And we have to focus on not only the inpatients but also the outpatients. I believe the VistA is proven, it's well known, it works for the inpatient environment. It will be able to support our inpatient operation in New York State, but what most importantly is, it has a significant gap to support outpatient facilities, and that needs to be one of the focuses in this project. So the more best practice and clinical leadership and transformational leadership you could bring to the table, the better off we are. And it has to be conducive and enabling to our business and clinical transformation. Like I said, it is not a simple system installation. It has to fundamentally transform how we deliver and manage our care, and clinical work flow transformation is important and other business work flow is equally important. And one of the VistA shortcomings is, because it was developed for VA it did not have a in situ billing component that's, you know, closer to our reimbursement and Medicaid environment in New York State, we have to have that, because not only the state needs the reimbursement capabilities to bring the revenue to

the state health care system, but also when we release some of our components in this system to the community providers, and they -- you know, I think the most value to them is that reimbursement rules, a service capturing, coding and all of those things need to be automated. It will make their life much easier, so we have focus on -- one of the focuses is really the physician functionality. We have to supplement the VistA out of the box.

The implementation, both the plan, the approach and the software system and architecture needs to be scalable because, as you can see, it's a long term implementation. It takes four years. During that four years, the environment may change one way or another. We have to stay flexible and scalable, right? You know, this system can work for 26 hospitals, and it can work for 20 and work for 30, right? And we can deliver in a four-year span to 26 hospitals, or we can deliver to 20 hospitals, or 30. So up and down, we need to have the ability to adjust our, you know, capability in the system, so that adapt to the -- you know, we -- adapt to the change one way or another. So, you know, it takes a lot of leadership in project management, a lot of leadership in solution

architecture, and a lot of leadership in clinical transformation change management to ensure that to happen.

Then, lastly, we want to be agile, right? So what we don't want to see is we hire talented vendors to, you know, work on the system for three years, without contact with us, and come back three years later and deliver a system that may not fit our needs then, right? So the more frequent and the earlier we can deliver the use of the components to our user community, the better off we are. That's why we always hope that you bring to us your expertise in an agile approach in system development and implementation. If not, you know, we have one -- OMH has identified this as an initiative about half a year ago. We've already developed our methodology, we'll share with you if you don't have one, but the key is we need to stay agile and deliver on a periodic basis rather than, you know, wait for six or nine months before the clinician can see it -- and we hope that, you know, if they request something, they need to see it in a matter of a few weeks. I wouldn't dictate the frequency, but we have to be much more agile than conventional methodology. The two-track model in

our track one and track two, was developed with Agile emphasis as well, because, you know, well, on one hand, we know that the CPOE medication and administrative module are largely available on day one, then we can deliver that functionality to our users on day one, right? While we are working on our, you know, treatment planning and user interface, that probably will take a few months to come. So we have to be agile to ensure the success.

So, lastly, you know, I just want to thank you again for coming here and express your interest to support us. So this system and this project will be one of the largest and one of the most significant, strategically significant IT investment--the state will make in the next few years. And OMH is one of the largest agencies, as you know, and it is a very large provider system. And if you could help us to succeed, not only the 9,500 clinical users in our agency will benefit from this, but also 695,000 people every year and countless other community providers will benefit from your work. So, you know, God Bless and hope you guys can help us make this happen. Thank you very much.

DR. MILLER: Good morning. Hi, my name is Greg Miller, and I am a psychiatrist. I am

the medical director of adult services here at OMH, and I am involved both working with the state operated services, as well as the community services, so I sort of have a view across the domain that Hao was talking about as we talked about how we would like this project to really move into what we see happening across the state of New York in terms of how this project will be part of the transformation of clinical care and the development of evidence-based services across the state.

I actually am sort of involved in a little bit of everything and over nothing, which is a perfect job. And I have two colleagues over each of the corresponding division, Dr. Grace Lee in forensics, who is a medical director for forensics, and Dr. Stewart Gabel, who is the medical director for child and adolescents. And we have a chief medical officer, Dr. Lloyd Sederer who cannot be here today, unfortunately, but all of us are deeply committed to this project and see the value from a clinical perspective. And I think that beyond that, you will find a very wide array of interdisciplinary clinicians and specialists, some of them who are pretty expert with informatics and who have created some very advanced approaches at

their individual facilities, and some of them who are strong clinicians and have, like me, a good working knowledge of the context of EMR, but who are not informatics specialists, ourselves. I think you'll see, over the course of the RFP review process, that group of clinicians who will move on to be very crucial people and partners for the implementation process as this goes forward. Some of them are actually here today, so I think that you will see that there is a very strong component of people who are going to be partners around the clinical process of this to make it be a successful process. Dr. Gerry Engel, who is our director of health services, is going to present on some of the functionality issues around the medical functionality, such as CPOE, lab, pharmacy components; the track one, if you will. I'm going to talk a little bit around some of the ideas that will impact the functionality of the core behavioral health product. And I will tell you that I've been involved in an implementation in an EMR at an institutional level twice in my career, and I know it to be a fact that whatever product you end up going with that, perhaps, the core behavioral health component is always the component that

requires shaping out of the box, harder than it is with some of the other specialty components of an EMR. We have a wide variety of clinical arenas, and we have a wide variety of both community services and inpatient services. We have done a tremendous amount of work to try to pull that clinical flow together. It will be reflected in the RFP. We also know that the work is a work in process and that some of the functionality issues will emerge on the ground as we go. So it's been a process for us to try to create an RFP that covers all of the requirements but also recognizes that we want to have this process be a transformative process. We want to ride the bicycle while we build a brand new one, if you will.

I'm going to talk about domains of clinical functionality across some several axes, and I'm going to talk a little bit at a higher altitude because the detail is in the RFP around the clinical requirements when we get to this part.

Just a little tiny bit of history. We are a strong, central, state-operated, mental health system compared to most of the other large states where you will see that there's more local control, county control. New York State became a centralized

mental health system in the 1900's.

Yet the state hospitals came together as very different organizations and spread across wide geography. Many of them were private hospitals before they became public hospitals. Many of them were public county hospitals before they became state hospitals. So while we have a very large, state operated system with a very strong central core of governance, these hospitals are also local hospitals. They're part of their communities. They have strong leadership at each one of the 25 sites across the state, and they have developed solutions to their clinical process that reflect the environment in which they live in and the history that has gone into their own particular facility and their partners around clinical care and the particular leadership. So you will see those nuances across our state. And part of the process of our clinical implementation is going to be integrating the strengths that we have across the State with our goal of consistency across the State in this process.

So the first axis I'm going to talk about with functionality will be our divisions, our clinical divisions. We have three: Adult services, child and adolescent services and

forensic services. All of these services, to some degree, interdigitate but have strong core services separately. Across the State, we have -- I'm sorry, it's not 25 psychiatric centers in the adult service. We have a total of 25 psychiatric centers across New York State, each one a hospital with inpatient and outpatient care. That number may change because we are finding that, as clinical services transform across the state, capacity is changing. One of our hospitals just closed this year and the services merged into another one. That may happen with other hospitals over the course of this long implementation. I would venture to say that it will. Our psychiatric centers in the adult services vary from greater than 500 beds to less than 100 beds. On the inpatient side, there is about 3,000 to 3,500 bed capacity of patients, and the majority of those patients within the state adult division are transferred to our state hospitals for inpatient care after having had rather lengthy attempts to stabilize their issues in acute care settings. By and large, there are exceptions to every rule, but in the adult system, by and large, we don't admit directly. That's different from some state systems. We see our purview for the adult system

to be to manage people who are not able to be stabilized and released into the community, but who do have community integration potential and remain seriously ill at a hospital level of care despite a lengthy acute stay. Those patients we see as needing a higher specialized level of care in a longer stay hospital. It's not the idea anymore of the old state hospital where you send patients to stay for the rest of their lives. It's an idea that we have a longer length of stay focused on aggressive more specialized attempts to help people who have not gotten better in acute care to be mobilized into the community. A few PCs have accommodated to community needs, and they do acute care inpatient psychiatry. I think these are two completely different clinical missions and often require different clinical components that will impact on our core behavioral health EMR when we have it.

We have two research institutes within the system where clinical research is done, both inpatient and outpatient clinical research. The Nathan Klein Institute down near Rockland Psychiatric Center, as well as the New York State Psychiatric Institute, which is near Columbia Research, obviously, has impacts around

functionality that will have to be incorporated within the system.

As Dr. Wang had stressed, outpatient is really becoming more and more a strong focus of treatment as the system is transformed. We have a very large adult outpatient service, over 20,000 patients. We have clinic, we have specialized outpatient services like ACT, Aggressive Community Treatment, family care where patients are taken care of within families. We have case management. We have peer supported services at some of our facilities. Not all of these will be in the first round of EMR. The core component for EMR is going to be our clinics, obviously, and that will stretch across all three divisions. The clinic, by the way, NYSCRI that Dr. Wang referred to, that has standardized clinical documentation across the State that is being implemented in Long Island and being integrated into some outpatient EMR products at this point in time, is a set of records that came from compiling all of the requirements for outpatient care and developing the minimum standard templates and documents that were required for clinic level of care. So we do have a standard that we have supported as the outpatient standard in New York State, and that is the NYSCRI.

The NYSCRI project did not involve inpatient care, so that's an important fact.

Division of Child and Adolescent Services, they have a larger acute care mission. So we have six or seven child psychiatric centers, I believe, across the State, and those are specifically committed to the clinical domain of child and adolescent care. We also have adolescent units and child outpatient services that are located integrated into some of our adult services where there isn't easy access to child PCs, or psychiatric centers so you'll see that some of the child clinical mission does float over into the adult psychiatric centers.

The child and Adolescent is a little bit different from adult in that they do have a greater mission towards acute care, so about a third of our clinical inpatients and child psychiatric centers are admitted directly. They are not transfers for longer term treatment. Two thirds are referrals. The child PCs work together with the adult PCs around the mission of Child and Adolescent Services, and there are some documentation differences. So for those facilities that have child and adolescent outpatient services, there are

sort of clinical requirements for documentation that differs somewhat from the adult requirements. Obviously, the Child and Adolescent Services, we all think of ourselves as looking at age appropriate in developmentally focused clinical assessment and interventions. In the child and adolescent, this is, of course, a very top priority. Developmental assessment is a crucial component to all of the child and adolescent services. And their array of community services include day hospital, children's day hospitals clinic, residential treatment facilities across the state which are different from congregant care residential services for adult in that they really many of the child and adolescent residential facilities rise to nearly the level of a hospital. They have nurses, they have medication administration, they have a higher involvement of doctors. We don't run any of those, so the EMR won't directly involve those services, but the interaction with those services is crucial to our child and adolescent hospitals.

And one of the more complicated services in terms of how care gets given is our forensic services. So, obviously, in our forensic hospitals, people come to those hospitals by virtue

of some legal problem. They are not admitted because they meet criteria for a clinical hospitalization. They are sent there because they come through the law, through the legal system in some way, and are, by virtue of the legal process, determined to need some sort of service out of our mental health services. Again, like with child, even though we have some three separate forensic psychiatric centers in New York State and one very large and vast outpatient service that operates within the Department of Corrections in prisons, much of the forensic domain of care occurs within adult settings and child settings. So this is one of the more complicated ways in which patients come to us in terms of how they are legally admitted to the hospitals. There are multiple -- you know, in the child and adult, you're either sort of voluntary or one of two or three, but mainly two and, particularly, one form of involuntary admission, all of the details of which are easy to learn; whereas, in the forensic system there can be multiple ways in which legally patients come. So there can be an unfit to stand trial designation, which can lead to someone being admitted to one of our forensic psychiatric centers or one of our civil psychiatric centers if it's simply for

assessment and determination of whether further inpatient care is needed. We have people that are acquitted by reason of insanity and, therefore, they have to go to a psychiatric facility until the legal process determines that they are able, in a very structured and sometimes lengthy process, to move back out toward community integrated care. And those insanity acquittees, called 33020s, actually can be seen in either forensic facilities or in our state-operated facilities. And, of course, those people in our system who are there by acquittal by reason of insanity, obviously, require a tremendous amount of partnership with the legal system. Every step of the way with moving those people through to being out of the hospital and in community care, requires collateral work with the legal system in order to move them. When we have patients in the civil hospitals who are determined to require being in a forensic setting because the behavior they're exhibiting within the civil setting is dangerous, and we mean the bar is pretty high because the civil hospitals are already hospitals designed to manage high levels of potentially aggressive behavior, sometimes those patients are transferred on what is called a par 57 into a forensic facility. They remain a civil

patient. They have been designated in need of a forensic facility, so we have patients, many times, who belong to one of the civil hospitals who get transferred to a forensic hospital, the goal of which is being to get them ready to go back to that civil hospital as soon as possible. When state prisoners require inpatient care, they will be transferred to one of our state hospitals to receive that inpatient care. This is one incident in which we will be doing acute inpatient care in our state hospitals. And often, when county jail inmates are in need of inpatient psychiatric care, they would be transferred into one of our forensic hospitals to receive that.

We also run what is called -- we call it SOTP, it's S-O-T-P, Sexual Offender's Treatment Program. You may or may not know that across all the states, how to deal with sexual offenders has been a major source of controversy and a major source of public concern. The program within New -- and a large part of this concern is what happens when people are nearing the end of their sentence in jail that are deemed -- but there's a question about whether they still remain highly and potentially dangerous for further offense if they were released. And we have a very complex

mechanism for evaluating the level of risk and dangerousness in that population in deciding whether or not they are safe enough or at low enough risk to be released. And, if not, they turn into long term psychiatric patients in our civil psychiatric hospitals. There are designated hospitals that have specialized programs for sexual offenders who have been designated to be too much at risk to be released. The process for their moving into the community is, like with the insanity acquittees, often slow and arduous and in strong collaboration with the civil services. And others, we do have sexual offenders that come into our system in other directions and may move into and out of the system.

I'm going to move faster for the sake of time, but the next axis I would focus around our clinical domains is our clinical process. Now in many ways on the inpatient side, these processes are going to look similar to what they do everywhere. We bring patients in, we assess them, we do medical evaluations, we decide on a treatment plan, we create interventions that are geared towards helping them out into the community. And one of the biggest things that we need to look at in how we do that across our system that I would

say is most universal is how do we create a system within our inpatient services that really kind of organizes and integrates how we provide that care? So if you think of the treatment plan as the core functional component of what we're going to do with patients in the hospital, how does that treatment plan interdigitate with all aspects of care? How do those nursing assessments, doctor assessments, medical assessments, psychology assessments all come together in a way to create a good treatment plan? And then how do the interventions, the groups, you know, the recovery-based services, how do those all come together in a treatment plan that allows a team to see how's this patient doing, are they getting what they need, and is what they need doing what it needs to do in order for us to move forward? And we need data, so we need this system to help provide us data that will evaluate this process. So we need text, but we also need a whole lot of data that comes into our system from this.

In the community-based services, we need to focus on some of the integration across broad community spectrums of care. For the sake of time, again I'm going to move forward. Integration is a big issue. We need integrated services on both of our inpatient and outpatient. On the data side, I

can't emphasize enough how we are currently using our more rudimentary mental record service, EMR services, to begin to collect data about our population. We have a huge population of people, and we need to use the data that we can get to tell us how we're doing and to tell us about the quality. So Hao mentioned, for example, our shaped meds project. We have a project that is a clinical tool across all inpatient and outpatient services that looks at people that are antipsychotic medications and ask our providers to answer electronically a set of questions about how that choice was made, whether or not they're on more than one antipsychotic, whether they've thought of better, more healthy medical antipsychotic choices, whether they've thought about the use of Clozaril. That data, once we get it, will be able to help us understand how we're prescribing. We have a lot of handicaps. We don't have a good database in our outpatient services around who is taking what medications. In some places we have, essentially, no database, so we're kind of using this shaped meds to create a database. It's kind of the proxy for a database, so we're having to identify if patients are on antipsychotics and then do the shaped meds. If we easily add a database around

medications in our outpatient services, we would be starting at a much higher level. Inpatient, that's not a problem, obviously. We have other quality improvement projects, PSYCKES, Hao mentioned, but we are moving forward a project at a time, and we are continuing to now with clinical care, quality implementations in the electronic medical environment that we currently have, those things we need to try to incorporate into what we have as we move forward. We have a huge discrepancy across the facility regarding technical sophistication, so we have some facilities that have already created some incredibly brilliant interfaces with high utility and with a lot of user friendliness, and the users like them. We're going to need to try to see how we can take those advances into account. We have other facilities where that has not been a priority, and they're just looking for something to come in and create an environment for them. So we need to try to maintain individual facility gains as much as possible. We have got to attract our physicians and our clinical leaders, our nurses. We've got to try to find something that is going to be efficient for them over time. I know that, initially, it's not going to be efficient, no implementation is, but it should quickly be

efficient, and it should hold the promise for efficiency for our clinicians in order to be something that they see as likeable.

And, finally, I would talk about this is -- you know, it's really a co-mutual process. There is no degree to which for this particular track we would be able to tell you exactly what the end product is going to look like in every detail. We have collated a huge amount of clinical requirements across our system, it's in the RFP, but we also are going to need to have a process that, as we go on to the ground, we sort of find out, learn, modify, you know, and create and innovate at each one of the particular facility implementations. I think you'll find strong clinical leaders that will be in an active part of that process. We're looking to collaborate with clinical and informatic expertise in our vendor to make that process doable.

All right, normally, I would say do you have any questions? but I guess I'm not allowed to say that now, so thank you. Gerry Engel, our director of health services, is now going to talk to you about the other track. He is currently the leader of informatics around our health services electronic environment across the State. Thanks.

MR. ENGEL: Hi, thank you. Thanks, Greg. I'd have to say that in terms of the EMR environment and the behavioral health sides, Greg has the much more difficult side of the job, so I'm glad he was able to go first.

MR. ENGEL: What are the OMH EMR clinical goals? Some of these are obvious: Enhanced communication, monitoring of care, reduce adverse drug events, reduce medical errors, reduce or eliminate duplicate or unnecessary tests or tasks, eliminate redundancies, increase clinician efficiencies in medication administration, monitoring processes, documentation and communication, replacing legacy systems, and the bottom line sums it up, as Dr. Wang talked about, in the VistA VA environment. Basically, our goals are to increase the quality of care while, at the same time, reducing costs of providing care and leveraging technology to do so.

Current clinical systems, which you will be seeing throughout the two days, which there will be much more detail concerning those systems. This is really an overview of how they kind of fit together in our current environment. We've got the pharmacy, the lab system, the dental, infection control, our Mental Health Automated Record System,

or MHARS, and PSYCKES.

(Discussion was held off the record.)

MR. ENGEL: You saw this in the previous presentation. Really, this is a number of our different systems, some of the interfaces that have been developed and, really, how they fit together.

As you can see from the outset, we do have a number of electronic systems currently in place, and we do have some interfaces that allow us to collect a significant amount of data and also to be able to utilize it in care.

This, however, probably is a summation of some of our challenges, and I picked this as the medication administration or medication ordering system. So we have a very detailed and in-depth pharmacy system currently with Horizon's Meds Manager. But if you look at the process of ordering the medication from start to finish, basically you've got a paper order from a clinician that's, basically, writing an order on paper which is then transcribed by a pharmacist into the pharmacy system. These medications are then delivered on a medication cart without any technology, no bar code medication administration administered by the nurse, and the nurse, again, paper-based documentation. So although we have all

of these systems, we really -- what it comes down to is our entire system is really a paper-based system, for the most part. And I could repeat the same process if we're looking at labs where we have a laboratory system, but a lot of it is manual entry and redundancies.

Our laboratory system is somewhat unique. We have one statewide OMH clinical lab that, basically, handles routine tests for all of our hospitals. The downstate areas, basically, those hospitals -- oh, I apologize, the OMH lab is located on the grounds of Rockland Psychiatric Center and Nathan Klein Institute in Rockland. The downstate facilities and all the way up to Albany, but not inclusive of Albany, those labs are picked up in the morning and delivered to that lab that morning, and the results are available electronically in the afternoon. The upstate labs, those labs are picked up in the afternoon, delivered overnight and, basically, available to our clinicians in those hospitals the next morning. These are really routine laboratory tests. Obviously, if we had a patient who needed a stat test or something along those lines, by virtue of geography alone sometimes that wouldn't be

possible. So all of our hospitals, in addition to having the majority of their tests done at the lab, also have an agreement with a local lab or a local hospital to perform those immediate need tests, and it's really due to the fact that delivering those labs would be the most difficult process.

Our OMH clinical laboratory is licensed by the Department of Health; it's accredited by the American College of American Pathologists. It develops therapeutic drug tests and assays which are approved by the Department of Health and used in clinical settings. So our lab, in addition to providing basic services, actually does develop some of their own tests which are actually then submitted and approved by the Department of Health for use, but that really is a lot of our clinical drug testing that we do that's actually been developed at our lab.

As I had stated before, in Cerner Millennium software we've got linkages, as I've demonstrated, to MARS and Meds Manager. Order entry is done at the facility -- at stations and they are transmitted.

And, really, this is just a summary of the process itself. Our samples are drawn at the

facilities, shipped to the lab that day and analyzed upon receipt. The verified results are available immediately at the facility electronically. Critical values are actually reported to facilities via fax and telephone, and we've also been piloting some text and e-mail clinical alerts, as well, for critical values.

This, basically, is a summation of some of those processes we just discussed, and a number of reports. This is something -- and you'll see a lot of this in more depth as we look at these individual systems. But, really, once the lab results are available, they're available in our MHARS system. They're available in the Cerner system which some of our clinicians have access to, and they're even available in our pharmacy system, and we can, basically, track certain values, for instance, WBC, white blood cells, are very important in our agency with the amount of clozapine that we use.

Some other reports. Obviously, we have to report communicable diseases to the Department of Health, and the system allows us to generate reports for state reporting requirements.

I'm going to jump a little bit into our

pharmacy system, and again this will be gone over in much more depth, I believe, tomorrow afternoon. Meds Manager is a multi-facility, has decision supported order entry, allergy drug interaction screening clinical drug utilization reports, it has global administrative functions, browse capacity for non-pharmacy clinicians which allows, for instance, nurses, physicians, others, non-pharmacy people, to have access to the system for looking up data. Our lab data, we went over.

Outpatient functionality is another important point. Our pharmacy system is a hospital-based system, but we also do supply medications for our affiliated clinics in an outpatient environment. We supply discharge medications for some of our inpatients. We supply a number of outpatient prescriptions. So our system, which where VistA differs a little bit from that, is that we not only are operating in a hospital environment, but we also have a clinic environment where there are different regulations required.

This is just a sample of what the pharmacy sees in terms of medication profile.

Clinical decision support at the pharmacy

level. Rather than at the CPOE function.

This is really the first clinical decision support that happens in our current medication administration system is at the pharmacy. As these drugs are put in, if there are alerts, allergy checks, drug interactions, and so forth, these are done at that point. If there is a therapeutic intervention, it is done at this point. This is also recorded electronically so that we have that functionality, as well. Numerous reports, literally in the hundreds, that we can generate, both canned reports and custom reports through our current system. Many of these would obviously need to have some continuation as we move into another system.

Outpatient labels, again, this is really one of our key needs in terms of our outpatient environment in terms of how our pharmacy is set up. This is actually an outpatient label report. It's printed out on specialized paper, different than our inpatient systems, and I'll have to speak up a little bit here. The top part of this on the left is really a label that actually goes on to a medication bottle for our outpatient. It has all of the required information for a prescription that needs to go on a prescription bottle. This

second piece actually peels off itself. It goes on the back of the prescription that's filled. And the bottom piece goes to the patient, themselves, which actually has all of their prescription information. And this goes on sometimes for a few pages in terms of what the drug is used for. It's a clinical drug information pamphlet that goes with each medication that is dispensed.

Again, you know, we've got a number of reports that we utilize on a daily, monthly, weekly, annual basis that would have to be included. Meds Manager is used in all of our 25 OMH facilities. We are currently using version 8.1. We have been using some version of this system since 2000. And, actually, we've got an older system, a legacy system, that we still have data available from, even prior to 2000. That data, as we discussed, is put into the Meds Manager system, and we've got a history database, as well.

Besides the pharmacy, this data is used in PSYCKES. It's also used in some of our research database information. NIMRS, which you'll see, MHARS all rely on Meds Manager to supply THE patient medication information. Even Open Dental,

our dentists can actually go into their system and see the patient's current medication profile.

Our infection control program Hao discussed briefly, as well. But, really, you know, we've got some key goals with our infection control programs, and this we want to utilize technology to leverage this, as well. Obviously to protect the patient, to protect the health care workers and to provide cost-effective infection control. The primary functions, we're managing critical data information, reporting of infectious disease outbreaks which our system currently allows us to do. We have numerous statewide and federal requirements in terms of reporting infectious disease outbreaks, and our system allows us to collect that data and quickly make it available to the Department of Health.

Basically, we've included in here education and training health care workers, obviously, and employee health is also a requirement. Health information is collected not only for our patients, but also our employees. The infection control system also has the technology available to monitor employee health issues, whether they be vaccinations or other areas.

Infection control. A nurse at each facility manages the infection control program. I've listed some of their functions. I'm looking, really, at track one in the RFP, and what are some of our needs that we don't currently have? CPOE, computerized prescriber order entry with clinical decision support capability; nursing bar code medication administration which we currently do not have; provide E-prescribing capabilities at OMH hospitals and outpatient clinics, and that's really a key piece, as well. Not only are we looking at being able to fill prescriptions for our clinic patients, but, basically, there is New York State and federal initiatives that are really kind of forcing our hand in a good way to really go to E-prescribing using numerous different interfaces, but, basically, most prescriptions, or many prescriptions, now have the capability of being electronically prescribed through the doctor's office through CPOE and transmitted electronically to the pharmacy so that the patient doesn't even have to carry the prescription with them.

And one of our other challenges is

providing a complete electronic record for all laboratory tests. As I stated, we have the Cerner system which collects all of our tests that we currently do at the lab. Where we're lacking in our electronic environment is stat tests, those tests that are sent to our local hospitals, for instance. They are still on a paper record. Point-of-care tests, you know, I think mostly like the finger stick, blood glucose tests. Again, these are done at the point of care at the hospital. They are not entered into our Cerner system at this point. Again, if you're looking at a complete electronic record, you need to really have the capability to have all laboratory tests. And, actually, we have -- there are certain tests that we even have our own laboratory, either because of volume or because of the type of test that -- actually, our own lab will actually send those tests out because they don't have enough volume to do them themselves. That, again, is a paper process that goes back to the facility. So even though we do have a laboratory system that, basically, records all of the tests that we actually do at our lab, there are a significant number of tests that are not in that electronic

record and force us still to go back to the paper record as the record of record.

And that's all I have. Thank you very much. I appreciate it. And Scott Derby is the Director of Application Services who will be giving the next presentation. Thanks.

MR. DERBY: Is everybody still with us? It seems to be warm in here. It gets warmer as the day goes on, too.

So as Gerry and Greg and everybody before me has gone over, you know, what OMH is like. I'm here, particularly, for the technology folks to give you a little clue of not what is in the RFP because those words are cast in stone. I can't change them, nor would I want to at the moment, but it does lead to what does the next five years bring as far as other initiatives that OMH has going on technology-wise that would be handy for you to know now, not like a year from now when they just kind of pop up.

(Discussion was held off the record.)

MR. DERBY: So as you can see, your view for the hardware network configurations that are already in the RFP are pretty straight-forward and standard. It does describe the statewide

computer environment, and there's a couple of slides coming up that will touch on that in a little bit. OMH, again, is always in a state of flux. We have a joke. We always like to blame the network for all of our problems, but most of it is pretty solid and pretty stable; however, we are looking to always make it bigger and faster because everything we do always requires more bandwidth than what we had six months ago.

The state of the hardware software configuration, as far as this bid is accurate within the RFP, so we're not going to make any changes on that.

And the other deal that we're working on right now is virtualizing. That's the big word for everything. It's not cloud computing, but we do a lot of virtualization on the servers that we have here. And we're now looking strongly at desktops, okay? We have a large population of desktops out there. There's thousands of them. I think close to 10,000 that are out there, probably by now. As you saw earlier, there's about 9,000 clinical people that will touch this system. Our current inroads in that area is about 5,000 users in our system right now at

various times during the day or month. So, again, you have almost a doubling up of the number of people that will use the new system, mostly because the current systems don't actually penetrate down to that particular level that we have right now.

Okay, as you see, our virtual server and network configurations, if it's a T-1, it probably won't be a T-1 by the time this goes into place. It will be 10 meg, or they have like an E-port connection to the state servers that are provided to us, which is a similar deal. We do have fiber on a lot of the campuses that are like 10 gig or better. So everything is moving up. Everything is moving forward.

Our application layers, right now our technology is either what we call two-tier or three-tier. The two-tiers usually have an end user presentation layer and the database and the business layer are combined. That's a little bit more like a Vista implementation, so we're used to that; however, anything we've developed ourselves is a three-tier. We have an end-user layer, a business layer, or application layer as we call it, and then you also have your database layer in the background, okay? We usually have firewalls

between everything to protect, you know, stray eyes from running around electronically. But, you know, we're fairly secure. We're big on HIPAA. I'm not sure there's actually a security presentation that covers that, but HIPAA and high tech regulations are all over the place for us, so we really do want to keep everybody in their nice little box.

Server availability, again a lot of this is virtualized; however, that's what we have today. Actually, this slide is from last summer. We're already in another purchasing cycle to buy newer, bigger, faster hardware which goes all the way from the Microsoft environment all the way back to our SAN storage, which is EMC, or IBM, or HP I believe is still here, also.

Our program environment currently has our legacy applications and MHARS which has been talked about a little bit, which is our primary clinical reporting tool, is VB6. It's a Fat client, that has been around for about 10 years. I think it's got about a 20 meg client right now, which is part of the reason why later on in the presentation we'll talk about Agile and what that means to us now as far as moving forward. For this discussion, again, MHARS Classic, which is our VB6

environment, is different than our .Net environment, which we've combined under this also. So we're very agile in our .Net environment and we're a little of one foot in the concrete block on the VB6 side, but we do manage quite nicely.

Basically, VB6.net or C#.net is our programming choice for around here. As I say, MHARS does contain both VB6 and C#.Net and, again, that's one of the targets to be replaced - VB6 and the VB6.net combination, okay?

We do support Microsoft Biztalk 2008. Biztalk was originally brought in for our electronic data interface. We do a lot of billing to the feds, EDI transactions, and it does have an adapter to do that quite nicely. We have since expanded that to use the HL7 adapter for those non-HL7-compliant applications that need to talk somewhere else. That has shown up mostly in an ADT interface, an admission discharge and transfer interface, that we wrote to McKesson and Cerner already, but that's available to highjack and go other places. I think that is pointed out in the RFP where some data transfers have to take place with that, also.

We do have Share Point, Microsoft Share

Point, and a team site. Again, this is a new effort at OMH, so we would want you to work with us to use Share Point to do this collaborative effort. And as you can see, we do have some people on video here. This is probably the largest mixture of people that have come to together to work here at OMH in a long time, and e-mail I don't think is going to work too well.

The more documentation you put up and the more you can use video conferencing or I think we even talked about using Skype at one point, but some sort of that interactive stuff for that Agile development within the team building that has to go on here I think is going to be a good deal.

And then most of our applications, we've got Oracle as our main database provider at the moment. So we have DB links in Oracle for most of our standard database to database port connections; however, we also have an enterprise service bus. It is based on Biztalk and some other software that we have written here internally. We also have Health Share from InterSystems which will basically be our data interface out to the world, and whether it's a health organization or one of the

RHIOS, from a technical standpoint, it's just a data push and a data accept. That's what it kind of comes down to for us. So we're looking at that now, but it's really more important going forward with this whole RFP effort. And I say, we do have an admission discharge transfer which is available, so any information coming out of our existing MHARS application does fall downstream or run downstream into various other applications that are patient related.

Okay, so if you notice in the RFP, there is very slim mention to the Agile process. However, if you listened to Dr. Wang earlier and Gerry or Greg, Agile is all about being flexible; it's about being on time; it's about being able to cope with whatever changes come our way, and OMH has got a lot of changes coming on.

We do see this life cycle, this process, being used in both tracks, okay? We really see it in the track-two development, which is going to be a more traditional system development effort because there is so much that has to be replaced from our existing systems that VistA does not support at the moment; however, for one track one, even though we view it as a large configuration

effort, because they are kind of out of the box for pharmacy replacement, CPOE and bar-code administration, there's still a lot of end user interaction, so that Agile part of putting that team together to work with the subject-matter experts, to be quick, to be right the first time and to keep processes moving forward so they can be deployed, work well.

And I'll give you one little hint. Agile really didn't come as a brand new process to us. About, I want to say, two years ago we were in kind of a quandary about what to do about MHARS, okay, which is our main EMR system. We were not delivering on time; we were not delivering for quality for a short period of time, and we got together with our consulting crowd, and we decided that we would Agilize ourselves to move forward. I've got to tell you, it's worked well, okay. We've involved our users. We've streamlined our processes, and I think over the last two and a half years we have hit our targets. End user satisfaction is something that, across 25 hospitals, it's the 80/20 rule, and certainly it's also helped us on our implementation process with getting the information out to the users on time

and also actually putting the new software in place with some reliability.

So we're constantly refining that process because it is new to us. We have had an extra effort these last few months to build up the life cycle to add to that process in anticipation of this RFP. We expect you folks, whoever is the successful bidder, to work with us cooperatively. If you don't have one, we can certainly build ours out. If you have one, we'll take the best of both and find a solution.

We do expect the business process modeling effort, because it seems to be coming along now with Agile, to help us actually document what is going on. If you remember the RFP, if you've read it, the first three months the pilots are out there getting the lay of the land, okay, so that would be an excellent opportunity to document things that are a little bit different than what VistA is going to provide. I assume VistA has something out there in the thousands of pages of websites that have this information on it. However, those artifacts that come out of that are going to be important to us in the future, okay, moving forward. And we used Plainview as a compliant business processing

software. That means we haven't actually chosen one. We're looking at several right now. It could be something as simple as Visio 2010 which has a nice component in this, but I think we're open to suggestions at any point.

So we are using a team foundation server already in some of our applications in this Agile process moving forward. Team Foundation Server Version 11, by rumor, is supposed to be ready by 2012. All my staff likes to keep pushing forward on the software upgrades from Microsoft as they become available. There's, generally, newer and better things, and, if not, if something didn't work, it probably works better in the next release, anyways.

We do see TFS holding all of the documentation that comes out of this application effort, okay? So all of the source codes, all the documentation, all of the tests, all of the test strips, and the defect and requirement documentation is all going to be out there in the Team Foundation Server. So plan on using this as one of the bases of your source code or just your document depositories. And then, again, you know, business process mapping, we'll find some tool by

the time this starts.

So why is OMH committed to Agile? Okay, as I said, two and a half, three years ago, it was, you know, like a treadmill. We're working very hard, and we just want to see the gains that we think we should be seeing. So, you know, we did take the better parts of what we could with our existing system, but these are really the key indicators if you're moving in the right direction, okay? Faster time to market, okay? We generally like to have quarterly releases of these bigger, heavier systems that we have right now. I think by this, it speaks for itself. For major releases, that still may be true, but for defects and bug fixes and things like that, we want to be much more quick when getting into our end-user's hands, okay? So the days of waiting six months to get that one little quirky part of that screen fixed are probably not going to be a thing that we're looking for; it's going to be a thing of the past.

Okay, immediate business value, again deployment. If you develop something and it's available for somebody to use it, let's give it to them, okay? And we understand that that's not in a vacuum. It has to be coordinated with whatever is

going around it. But if you have users and you have teams and if they're looking for something at the end of the day, business value. It's all about giving something that's worth to make their job easier or more accurate, and actually sometimes it's both.

Okay, flexibility, we need to be flexible, all right? The days of rigid software development life cycle mentality or methodology and silos of thinking, they're gone. I think you'll see from this presentation, with Jerry and Greg up here, I mean they are right in the middle of all this thinking of what's going on, so it's a huge effort and advantage. It's actually a bigger advantage than an effort for the IT folks. It's a great collaboration that's going on at this time.

Customer satisfaction, happy customers don't ring my phone, okay? It's that simple, okay? It also makes our help desk happy because they're not getting inundated with help calls. It makes our IT staff be able to focus on new things. So, to me, customer satisfaction is not just giving something faster or that they can use, it's that you have reliability and some competence in making sure that it's going to work fine, okay.

And sustainability, as we said, this is a five-year project. In the bid it talks about this second phase, this extra five years that's on the outside. Make no mistake about it, this is a long term commitment for OMH, okay, both from an IT and from a functional standpoint for our users. If anybody looks, and EMR takes years to develop, so we've been at it since 1980 at different, various parts. We've built on, you know, our pharmacy system in the 90's; we built on a lab system around 2000; there's been various other systems that have been kind of built on top of this pyramid. So it's a long term effort, and this is going to take a big core of that and just replace it. So when you do something like that, it's not like you're going to take it out two years from now because you don't like what you're doing. So sustainability has to be accurate. You have to keep moving forward, and whoever takes this over -- because if you look at most of us, we're not young in this deal. So, you know, over the next 10 years our faces are going to be changing. This project doesn't change. It has to continue on.

So lower costs, that's why we committed to it because, you know, New York State's always

looking to save a penny. Just have got to pay attention to the news, so that kind of says for itself. If you don't have to repeat yourself, then you don't have to, you know, reinvest the same money twice.

So, again, this is a slide that we already covered. It's available to 2011; I go by that.

The master patient index, that's a new one. As Dr. Wang spoke, there is an effort to do a master data management, okay. For us, what that means immediately is a master patient index, okay? Now as you're aware, we have 25 hospitals. As Dr. Wang said, that number varies depending on what the legislature is doing this week; however, it's the one thing not to be missed because all of our hospitals operate within themselves and then they're just overlaying patient record that has to go on top of that. So if you can't identify your people individually, you have a problem with that. We do have one master key for our patients, but as with anything else, you should go back in time, take it to a week. The work we're doing right now, the work product will be available to the successful bidder on this, as far as integrating that into your solution if we're talking about the

OMH EMR solution, but it will really be your solution for us, and it is based on IBM's initiative, okay, so it's a little piece of homework for you.

Health exchanges, we do have them. We picked up HealthShare from InterSystems. It seems to fit the bill for us, as far as trying to hold and then exchange data with outside providers. Which there is a host of them, as everybody's described to you -- me, Greg and Hao. InterSystems also, you know, strange enough, has Cache which goes along with VistA, so you seem to get a couple of bangs for the buck on both sides as far as technology help. With VistA, we do have that ability to take our internal data, so I think it's still open as to how our data is actually positioned to be provided outside. It could be in a source system, if it's kind of liked not asked a lot. The best guess is probably HealthShare, itself, will hold some subset of data that we're making available to the public, just a nice easy place to keep it all together, and we'll have the mechanisms to update it as we move forward, along with correction processes. It's not just positioned there. You have to keep after it.

Okay? Now I can say we're also picking up the Ensemble software from InterSystems which will help greatly with just the overall back and forth between Oracle, and Cache and VistA.

Okay, tomorrow -- as Gerry said, you've had quite a few slides about the existing system. Tomorrow, you're in for a treat, okay? So bring your caffeine with you because it will be a tough road to go. But all of these people, Pete Carroll, who is the Manager of Patient Systems; Mark Scalzo, who is our business processing and user support; James Smith is one of our technical people who spent a lot of time recently with VistA and Cache just getting us up to speed on; Kay is our pharmacy lead, very important because we're swapping out our pharmacy system for VistA; Ginny is our laboratory lead with Cerner, which is an application that is staying with us. We do like that software very much. And then Ginny and James, together, will collaborate on the data interfaces that are numerous within the RFP. If you looked at the diagrams, going back and forth in there, we keep these two tracks moving and our own systems in place. We have data going all over the place, so we want to have our own little team of people to

know exactly what's going on so that when something happens we can help diagnose the problem. But they'll all be here tomorrow. Those day-two presenters will also be running through a whole series of video clips that we've done on our existing systems. Those clips will be made available on the website; correct, Joel?

MR. RUBIN: Yes.

MR. DERBY: Okay, if not today, at least by the end of tomorrow. You're free to download them and use them to match up with the PDFs and also all of the documentation of the examples in the back of the RFP appendices. That is pretty much the sum total of what we have currently going on.

The demonstrations also, just to point out, are based on the scenarios that are in there that you will be using to provide your own demos to us several months from now, so we have taken those things that are there that we can represent to show you what we're doing now. So if it's not shown, it probably isn't something that we have that is in those scenarios, so use your ability to be creative.

(Discussion was held off the record.)

MR. DERBY: Okay, so health information exchanges, we are actively pursuing HIE. Again, HealthShare is probably going to be the basis for that. These things come from state agencies; they come from local providers; they come from counties. There seems to be a never-ending question of what data can I get from OMH because I have these patients in front of me. I think at some point that will also turn around, and we're going to start asking questions out to local providers and to roll back information on the patients that we have because especially on the outpatient side because it's kind of an uncontrolled environment, once they get home and away from us.

So the challenges, okay, these are the IT challenges, but they also kind of underlie the challenges for OMH in general, too. This is a new database, new software technology for us -- Oracle, DB, C-Sharp type people, now Mumps and Cache and Delphi systems, so there's a learning curve on our part, but, trust me, we've already started learning so we'll be able to help there. My memory goes back 30 years, okay? I know I don't look it, but it goes back 30 years. This is the single largest IT project to replace so much at one time,

okay? So it's a big lift on our part. It's going to touch parts of our hospitals that we don't traditionally have in-roads in, okay? Our systems are everywhere, but they don't necessarily get touched by that, and that's represented because there's 9,000 people we expect to have using the new system, and we've only got about 5,000 with what we have now.

Reliable performance and consistency, to me, that's the IT challenge, okay? We are not going to succeed if we're out there stumbling and bumbling our way through day-to-day with poor performance or bugs coming out all over the place. So testing's important, functionality, definition's important. End-user training, there's a large section in the RFP that covers that. It's very important, okay? So good plans around that stuff will be received well. And it's just a huge coordination of training effort for everybody -- us, you, our users, across the board. So you've got 16,000 people in OMH and whatever number of people that are going to come to the vendor that are all going to learn something new over the next five years.

And here's the promise. The promise is

that it will be done, we're going to transform OMH, okay. Hopefully, it's for the good, okay? That would be the great thing, but it's going to change. The way OMH thinks about IT is going to change in the future, and the brilliance of this whole thing, so we'll see how well we do, okay?

I'm going to be here for a few more years, so you'll see my face. Most of my team will be here for a few more years, some longer. We've got some qualified people behind them, so transition is happening on our side, and we now have some good people to work with, and that's it. And like everybody else, you can't ask me any questions. So I think I've kept on time. I think you get a break for 15 minutes; you probably all need it, okay? Get some fresh air, and we'll be back in 15. Thank you.

(A brief recess was taken.)

MR. RUBIN: Good morning, again. I'm Joel Marshal. We find ourself -- Joel Rubin, my middle name is Joel Marshal. We find ourself ahead of schedule by about 15 minutes, so with any luck, if we keep up the pace, we should be able to get out a few minutes early today. I'd like to attempt to speak deliberately and slowly so that the

stenographer can keep up.

I've been with OMH for two years now. Year one, I did business analysis on some of the legacy mainframe billing systems, the inpatient and outpatient billing systems. In the past year, I've been working on the RFP with a team of contributors, including a lot of people you've met so far, and also our procurement office and counsel who provided the contract boilerplate you see in section 8. So my talk will have any needed color commentary with Scott Derby, our previous presenter.

Before we get into the section by section look at the RFP, and we're not going to go into such great detail; I know it would be a pretty tough slog to get through it in the time I have allotted. I just wanted to continue to define some of the key terms that you'll run into a lot. The as is VistA solution is whatever is available to us at the time when the project gets underway, with a minimum of configuration, no additional development.

Base VistA is the term we came up with to describe what we're putting in in that track-one implementation which includes the physician order

entry, the bar-code medication administration, replacing Meds Manager with the VistA pharmacy module, and I guess the CPRS module which is needed as a foundation for the other modules that we want to implement, in order for them to function.

The OMH EMR is the end product. That's what we're going to end up with at project end. So it consists of core functions or what we're calling the set of requirements that are presented with the RFP. So the EMR is those core functions. Base VistA, track one, has a portion of those functions. In track two, we implement the remaining core functions that we didn't put in track one and then any additional functionality, any additional enhancements that we uncovered during the project implementation.

Core functions, I just explained, that's what is available at the time of the RFP release.

Track one, you saw a few diagrams earlier. It's the base VistA implementation available to selected users just at the facilities, the inpatient facilities, and in this track the ADT feed comes in from MHARS to base VistA to get the admission, discharge, transfer information into VistA. And track two, MHARS is being replaced, and

so the OMH EMR will supply the ADT information to all of the other information systems that MHARS currently interfaces with.

So the RFP has nine sections. The introduction just gives you a little bit of the OMH background which was covered in some earlier presentations. We have the systems background in section 2, the mandatory contractor requirements for both the firm requirements for the bidder's firm and the key staff.

Four touches on the project scope and presents a proposed work plan.

Section 5 is a lot of the supporting information Scott Derby just presented just beforehand.

Six, a very short section on the change request management and enhancement request management process and it has the template you might use for the change request process.

Seven, we get into the RFP evaluation criteria and the bid submission requirements. We want to be as clear and unambiguous in this as possible. We want to see to it that you have everything you need to do to make it all the way through the process.

Contract boilerplates, the legalese that are required, provisions.

And, finally, the library of attachments and forms which we will supply and that you will need to fill out and submit with the bid.

So a few key points of section 1.4, the type of contract this is, is a fixed price bid to deliver the core functions and deliverables and then a flat hourly rate to carry out any additional functionality and additional deliverables. The base contract term is five years plus two optional one-year renewals.

Related procurements, we are working on a separate procurement to procure the services of an independent validation and verification vendor. They'll be on site to provide help with the project management, quality control, assurance oversight and risk mitigation, and they'll advise us when it comes time to sign off on the deliverables.

So you were introduced to several of the OMH patient systems this morning during the clinical overview presentation. You'll get a more detailed look at those tomorrow. We have some good video screen captures that are narrated that show you how a lot of those systems perform in the

scenarios that you'll be expected to demonstrate during the on-site demonstrations.

The EMR, these are two of the key systems we need to interface with, the inpatient and outpatient billing systems. The main difference between those two is inpatient is based on the patient census; we bill by a day in a facility. Outpatient billing systems is based on capturing billable direct services through CPT codes. So once MHARS is gone, the OMH EMR would pick up the slack there.

In section 3, we see the mandatory contractor requirements. Again, there's requirements for the firm which you will submit on the attachment S-1. I should point out, this is one of the updates to the RFP. It's available on the RFP web page now, which you should be checking. We require five years experience in implementing the VistA-based EMR solution at multiple facilities within a single hospital entity. We are requiring five years experience in using project management best practices. You need to show us that you've successfully managed and implemented multi-facility EMR projects. Demonstrate that you have used your firm's clinical and nursing expertise to drive

process re-engineering and training, and, finally, five years experience in software design, development, testing, all the stuff that goes along with systems integration, including integration of third-party software to solve business problems and meet business needs. And it's important to mention that if you plan on partnering with a subcontractor, or if you're a subcontractor partnering with a prime, you can use the subcontractor firm's experience to count towards the five year requirements.

So we will be conducting reference checks, both for the firm and the six proposed key staff positions, including any subcontractors. So the firm experience you'll deliver to us on attachment S-1. The references for the firm are on a separate form, Attachment Q, the project abstract form. So it's possible you're going to need multiple projects to meet the five-year requirement, so print out multiple copies of that Attachment Q to supply us with those. Additional mandatory requirements for the firm don't come in on either one of those two forms. We ask you to -- in the project approach, there's a section where we ask you to demonstrate your relationship with the

Veteran's Administration and describe to us your plans on how to keep the OMH EMR current with all VistA development and modifications, both with the application and the VA's planned move to a more modular, open VistA structure and they're starting an online open source community, and we would like to be involved with that with your help.

Here's the six key staff roles. Attachment S is one long form with six sections for each of the key staff -- the project manager, the technical solutions architect, someone with a clinical background to be the clinical solutions architect. A big piece of this effort is the implementation and training, also lead business analyst to provide business analysis and business process modeling, and the lead pharmacy expert because we're replacing our current pharmacy system. So Attachment S, Mandatory Qualifications Detail Form, has areas for each of those key staff positions and a place to put the two references, as well.

Exhibit 17, the requirements traceability matrix, it's quite a lengthy document. There is something like 610 requirements on there categorized. We'll get to it in a future slide.

So the scope of the project can be

described as the sum of these two things: Our set of requirements on the matrix and our project deliverables. There is a total of 56 of them. In all of these categories there's project management, testing, training, software and project closure towards the end of the project life cycle.

Just a good illustration of the nature of the two tracks:

Track one, MHARS, is still operating to supply the ADT data to the base Vista system. Here's the modules we expect to implement, and it's limited bunch of users here -- physicians, nurses, pharmacists, health information managers, also known as medical records.

In track one, base Vista is going into our 25 OMH facilities. In track two, MHARS is gone. The OMH Vista supplies the ADT feed, interfaces with our patient systems. A more extensive list of functionality we expect to implement. Some of it you may already have available. Some of it will need to be developed, as you go. There is a wider audience of end-users, too. So in addition to the inpatient facilities, each one of them has a number of outpatient locations. So you can see it's a much larger effort in terms of size and scope.

I'm not sure how I got all the way back there. I must have hit the home button instead of down. Let me just switch back to slide view, slide --

(Discussion was held off the record.)

MR. RUBIN: This further explains the two-track concept, and you can see there are a lot of parallel efforts going on within each track during the track-one base Vista implementation. The yellow blocks designate planning activities or review activities. You'll see after the four pilots wrap up, before we decide to roll out the remaining implementation sites, we're going to have a period of time to review and see what we've learned from that effort and what we need to change before we complete the implementation. And then in track two, before things get underway, there's a large design code and testing phase before we're ready to even go to that pilot. And then, again, as the pilots are being implemented, in parallel to that there is the data migration from the legacy system and the interfaces. Again, the pilot effort shows a little bit of review before we roll out to the remaining locations.

And throughout all of this effort we have

support and maintenance. There's pre Go-Live support, there's post Go-Live support, and the maintenance, not just maintaining the system, but also maintaining the most current version of Vista, as well.

And, finally, the end stage, the transition to the maintenance phase where you turn the system over to us and conduct a knowledge transfer so we can operate the system ourselves. I won't spend too much time on this other than to point out that certain of the deliverables are current fixed points and times. Certain of them might be designated milestone deliverables. Other deliverables, such as the project management plan, which we will have an early version of way back here, will be updated continuously.

The anticipated pilot sites for the track one and I believe the track two, too, were selected because each of them represents the different flavors of facilities that we operate here. For the track-one pilot, we would need a prototype of the system available in the central office probably before we even go out to whichever one of these ends up being the first pilot. So probably a little bit of travel involved down to Staten

Island, the Capital District Psychiatric Center; it's right around the corner from where you are now. Marcy, New York is Central, New York out near Utica and the Brooklyn Children's Center, a children's facility down in Brooklyn, New York.

On section 4, you were first introduced to the requirements traceability matrix. These are the categories of requirements contained in Exhibit 17. I've highlighted a few of them just to explain them a little better to you.

Document imaging would be scanning solution to allow us to convert both any historical patient data that's on paper, to scan them, attach them to a patient record and retrieve them electronically from within a patient record.

Inpatient program scheduling is something we need that only a handful of our facilities' program's treatment is available to inpatients. That system will resemble something you would use to schedule college classes. It's how people would register for programming individual and group counseling.

Interface migration is key. We've touched on that a lot to all systems, patient systems that MHARS currently supports.

And, finally, training. Some of those requirements involve the delivery method. It's a big challenge. All the end-users are going to have to receive this training and be certified in the training before we'll allow them to operate the system, so we're particularly interested in your approach to training. In fact, there are ten points available in the training approach section of the technical proposal.

In section 5, supporting information, just a bunch of diagrams and charts. You get the hardware, software configuration, the enterprise architecture.

Section 6, a very short section with a look at the enhanced request template and the process we'll use to manage these additional functionality and deliverables.

Section 7, that will be the presentation that follows mine, the evaluation and selection process, the series of hurdles you'll have to pass through. The first few stages are pass/fail where we just assess the bid to see, you know, whether it's complete, responsive, and then we get a little more into the demonstrations. And Sheila Long will also be talking about the bid documents in the

mandatory package.

Section 8 was compiled with help from Robin Goldman from the OMH Counsel's office, the conditions under which we can terminate the agreements, suspend the work. Hopefully, we won't need to, you know, do that. A dispute resolution, we would like to make a good-faith effort to settle amicably. It discusses the type of software licenses and the warranties which we are looking for, an 18-month warranty after we accept the final OMH implementation at the final implementation site; we accept the product, you sign off 18 months, the clock starts ticking from that point.

Section 9, the library of attachments and forms. This is what you'll be submitting with your proposal. Again, that will be covered in a subsequent presentation.

Now, is David here? Okay, I think because we're ahead of schedule, David Milstein, who was going to present this section earlier, I don't believe he's present yet, so we're going to ask Sheila Long to step in and handle this.

(Discussion was held off the record.)

MR. RUBIN: Okay, I'd like to introduce to you David Milstein. He helped develop

our evaluation process. And he's going to explain it to you in detail right now.

MR. MILSTEIN: Good afternoon or good morning, I suppose. Congratulations to the Giants fans out there. It was quite a night for me.

Okay, so a little background. We had a work group in place that we worked together very diligently, and one of the areas that I was involved in -- can you hear me okay? -- was the evaluation section. So I am going to walk you through today on how OMH will score your bid proposals, so keep your pens handy, please.

So my topic is the bid evaluation proposal. It's set forth in RFP section 7. Bidders are required to submit a bid proposal consisting of a technical proposal and a financial proposal. The total bid evaluation score is 100 points. Seventy points, or 70 percent, is assigned to the bidder's technical proposal, and 30 percent, or 30 points, is assigned to your financial proposal. The bidder with the highest combined technical score and financial score will be awarded the bid pending contract approval by the Attorney General and the Office of the State Comptroller.

Now the evaluation process consists of six

distinct evaluation levels by OMH. Each level is to be scored and evaluated separately by OMH.

Level 1. In level 1, the evaluation process for level 1, OMH will determine whether your bid submission proposals are complete; in other words, of all the documentation, has all the documentation and information which has been required to be submitted under the RFP been submitted? Take a look at section 7.4.1 and 7.4.2 which set forth the components, the requirements, to be submitted under both the technical and financial proposals. Now I believe, momentarily, Sheila Long is going to walk you through those particular requirements.

Now a bidder will either pass or fail evaluation level 1. No points are assigned to evaluation level 1. So assuming a bidder's technical and financial proposals are complete, it will pass to evaluation level 2. Now OMH may consider an incomplete submission, for instance, if a bidder forgot what might be deemed to be an immaterial submission. So if you do forget to submit a specific document, attachment, OMH will have the right to, perhaps, waive that late filing and provide you with an opportunity to submit it.

Okay, so assuming, as the bidder, your technical and financial proposals are complete, what will happen at that time? Well, you're going to advance to level 2. So you're now at a level out of 6. And during evaluation level 2, OMH will determine whether a bidder and its six key project staff meet mandatory experience requirements set forth in RFP section 3 of the RFP. And I believe that, Joel, you had mentioned a little bit about that previously, you and Scott. What bidders must do is complete Attachment S, which is the form used to show and confirm both the bidder's and its key staff experience. So, for instance, I'm just taking one example out of the RFP section 3, and I suggest you review that in detail. A bidder must have a minimum of five years, the actual bidder must have a minimum of five years experience implementing a Vista-based solution at multiple facilities within a hospital environment or within a state agency. In addition, staff in key six project positions must meet minimum levels of experience, and I believe they were mentioned previously: That's the project manager, the technical solutions architect, the clinical solutions architect, the implementation/training

manager, your pharmaceutical expert and your business analysis.

In RFP section 3, there are minimum requirements that are assigned to each of these specific project positions. Again, please make sure that when you complete your Attachment S that you meet those minimum requirements. We don't want to see bidders bounced or disqualified for failing to meet mandatories in evaluation level 1 or evaluation level 2.

So evaluation level 2 again, which is the experience requirements is, is also a pass fail. You will not receive any score for those two levels. So assuming your experience levels are met in Attachment S, you will advance to evaluation level 3.

Evaluation level 3 is where we begin to start scoring your evaluation. Evaluation 3 -- well, I should say the technical proposal consists of three components, which will be scored and evaluated separately. During level 3, evaluation 3, OMH will evaluate two out of three technical proposal requirements. The first is assigned 40 out of the total 70 points for the technical proposal. Bidders must obtain a minimum score of

30 out of 40 points for the technical proposal component 1 in order to advance to component 2.

So what do these 40 points consist of? Well, there are four separate parts. The first part is a bidder's description of its approach and methodologies to carry out the 56 deliverables set forth in RFP section 4. This part is assigned a maximum of 15 points, and I believe that's section 4.11, right, Joel?

MR. RUBIN: It sounds good.

MR. MILSTEIN: So I do highly recommend that you go through section 4.11 very closely to determine what the deliverable components are under the RFP.

Now, the second component, or the second part of component 1, of your technical proposal is a bidder's technical approach which is assigned a maximum of five points. Bidders must compile and complete Exhibit 6 and 8 which pertain to their technical solution, and OMH will score the answers provided. The third part of technical proposal component 1 is a bidder's training proposal which is assigned 10 points. Bidders must complete Exhibit 7, which pertains to its training proposal, which will then be scored by OMH. Now, the final

part of component 1 of the technical evaluation is the scoring of a bidder's requirements traceability matrix. Can you pull that up, Joel? Can you find it? And that's in Exhibit 17. Ten points are assigned to this part. Are you there? Okay.

MR. RUBIN: Yeah.

MR. MILSTEIN: So bidders must complete this Exhibit 7. I'm sorry, so bidders -- the matrix sets forth over 600 plus core functions which may be required for the OMH VistA solution. The bidders must fill in this matrix and indicate for each of the 600 plus core functions, whether it's as is a VistA solution. Joel, you may be able to get to that particular column.

MR. RUBIN: Yeah, that's right here. That's this column right here. Yup, it is the bidder acknowledgment.

MR. MILSTEIN: Okay, great, that's the bidder acknowledgment. Currently, performs the core function, or if it does not perform the function, whether a bidder will use a third-party solution to meet the function, or the function will be built by the bidder or the bidder does not agree to supply that function, okay? Now we're showing it over there in column F, right?

MR. RUBIN: Yeah. Here's where they fill it out. This explains the point system, too.

MR. MILSTEIN: Okay. Take a look at that point system. You're going to get a -- for instance, you'll get five points if you indicate that your as is Vista solution provides that core function. You'll obtain two points for each core function. We're going to add up each core function and assign each core function a number of points. So if you're core function -- if your as is Vista solution, which you bring in, provides that core function without anything additional, you'll get five points for that core function. If you're going to use a third-party solution to perform that core function, you'll get two points for that core function. If you're going to build that core function, then you're going to get one point for the core function. And if you do not agree to provide a core function, you're going to get zero points. So what will happen is we'll aggregate all of these points for each core function, and the bidder with the highest total, their score will be normalized to 10 points, and then all of the other bidders will be ranked accordingly and their scores will be normalized.

One very important point, take your pen out, write this in bold: If a bidder does not agree to supply any one of the 600 plus core functions, it will be disqualified. So be sure to indicate that you can provide all of the core functions. This is a mandatory requirement. Do not make a mistake, do not put a zero in that column unless you do not want to continue to advance in the evaluation process which, to me, sounds counterintuitive since you've already put all of this work into it.

So that is the fourth part of component 1 of your technical proposal. So OMH is going to score the four parts of component 1 and bidders achieving a score of 30 points or more will advance to the second component of the technical proposal.

What is the second component? Well, the second component is assigned a total of 20 technical points, 20 technical points consisting of a live, on-site presentation at OMH demonstrating the EMR functions set forth in Exhibit 1. Joel?

MR. RUBIN: Do you want to take a look at that?

MR. MILSTEIN: Yeah, let's take a look at that. Just so you know, the Exhibit 1 functions

that you're going to demonstrate as a bidder are a subset of the 600 plus core functions in the requirements traceability matrix. This may get a little confusing, but think of the requirements traceability matrix as the 600 plus core functions which may be used for the final OMH VistA solution, and you indicate in there whether you can provide that function, whether you're going to build it out, whether you're going to bring in a third-party vendor or software solution. Well, that's all good and fine. You're going to sign that Exhibit 17, but then we really want to see what it looks like live. So then you'll be coming in, and you'll be performing a live on-site demo.

Now, the subset that you will be performing will be 200 plus functions of the 600 plus core functions in the requirements traceability matrix. So your live on-site demo, which comes into this building to perform, is comprised of four separate parts. The first is an inpatient demo, a demonstration of your inpatient system, of about 215 functions including tasks such as admission. Joel?

MR. RUBIN: Yeah.

MR. MILSTEIN: Can you just --

MR. RUBIN: Yeah, I think we're there. These early ones are the admission.

MR. MILSTEIN: They're admission?

MR. RUBIN: Yeah.

MR. MILSTEIN: Just to give folks an idea. Including tasks such as admission, referral information, registration, treatment plans. This demo, I think there's 217 functions. Scroll down. So, okay, so you got your work cut out for you. This demo is to last no longer than five hours, and it includes a 60 minute -- which will include a 60 minute Q and A from the OMH evaluators. So that's the ATD, right?

MR. RUBIN: That's a part of it, yeah. The first column cross-references to Exhibit 17. It tells you exactly where this function occurs in Exhibit 17, and this is just a number. They're sequentially numbered.

MR. MILSTEIN: Okay, and then part of your on-site demonstration, again the second component -- as I mentioned, there's four separate parts to your on-site demonstration -- will be a demonstration of your outpatient system, and there are about 100 functions that are listed there. Joel, can you shoot down to that, please? There is

108?

MR. RUBIN: Yeah.

MR. MILSTEIN: Okay, and that will include processing referrals, treatment plans scheduling appointments, discharge. Again, review those very closely, and you'll have no longer than five hours to perform that demo including a 60 minute Q and A. The third demo is of your pharmacy solution, and that will consist of about 50 functions.

MR. RUBIN: Fifty-two.

MR. MILSTEIN: Fifty? Fifty-two, okay, such as processing prescriptions, detecting drug interactions, drug treatment monitoring, that demo is to last no more than two hours including 30 minutes of Qs and As. And the fourth demo is of your lab solution and that will include -- way down there?

MR. RUBIN: That's actually our timekeepers telling us you have about a minute left to go. Do you want to --

(Discussion was held off the record.)

MR. MILSTEIN: And the lab demo is no more than two hours including 30 minutes for Q and A. So at a bidder's demo presentation -- also, a bidder's demo presentation should generally follow

the order in which the Exhibit 1's functions are laid out for functions that have yet to be developed; meaning, you haven't developed them, bidder's can use wire frames, power points or other means to demonstrate a function. Now you must obtain a score of at least 40 out of 20 points for your live on-site demonstration of those four parts -- inpatient, outpatient, pharmacy, lab -- to advance to the next level.

MR. ENGEL: I think you just misspoke there for a second about the point values?

MR. MILSTEIN: Fourteen.

MR. ENGEL: Yeah, I think you said 40.

MR. MILSTEIN: Oh, 14, 14, excuse me, in order to advance to the next level in the evaluation process. Assuming you achieve 14 points, you're going to move on to level 4, which is your reference checks and interviews. So bidders must complete Attachment Q and S and enter two references for both the bidder and each of its six key project staff. OMH is going to check those references. OMH will also conduct live, on site-interviews of the bidders' six key project staff in Albany.

MR. GUILLES: Will that be nine hours

of demos, then? Over two days? I just wanted to be clear.

MR. MILSTEIN: So during the reference checks on evaluation level 4, assuming that the references and interviews are satisfactory, bidders will advance to evaluation level 5. And this is important level 5; it's a scoring of your financial proposal. It's a total of 30 points and consists of two components. The first is your fixed-price bid and assigned a maximum of 25 points. This is the bidder's fixed price cost to carry out the 56 project deliverables identified in section 4.11 of the RFP. These deliverables are defined as the fixed-price deliverables. When you see that term during the RFP, it means the fifty-six project deliverables set forth in section 4.11. Take out your pen again. Note that any task not described in a fixed-price deliverable but can be reasonably anticipated to carry out the deliverable, is within the scope of deliverable and will not result in a price increase. So when you go through those 56 deliverables, if you can reasonably determine that a task is required to carry out that deliverable, even though it's not stated in that deliverable, that will not result in a change order price

increase. So this provision was specifically included to limit change orders, so when you're pricing up your fixed-price bid, consider the tasks attributable to carrying out those deliverables, even though they're not specifically stated in the RFP. So then bidders are required to complete attachment 0, which is your financial proposal attachment, and enter in your fixed price to perform those 56 fixed-price deliverable.

Now note, the price, as provided for your fixed price to carry out those deliverables is not subject to increase, irrespective as to the length of time it takes the contractor to carry out those 56 fixed-price deliverables. Again, the fixed-price bid is worth 25 points.

Now, the second component of the financial proposal is your hourly-rate bid which is worth a maximum of five points. Your hourly-rate bid is the flat-rate-per-hour price for the contractor to carry out enhancements. What are enhancements? Well, they consist of additional deliverables beyond the 56 set forth in the RFP and, also functionality, additional functionality beyond the 600 plus core functions identified in your

requirements traceability matrix in Exhibit 17.

So let's take a quick example. You go out, you're the contractor, you win the bid, you go out and do a business analysis, gap analysis at OMH hospitals and outpatient clinics and elsewhere. And you determine that there are numerous functions beyond those described in Exhibit 17, the requirements traceability matrix, beyond the 600 plus core functions. You identify those to OMH. OMH and you agree that those should be built out. Those will be built out at a fixed price hourly rate, so they will be based upon your hourly rate bid.

Now how do you calculate and submit your hourly rate for enhancements? Can you pull out 0? This is important. I want you to see this. Okay, so here you have 11 categories, labor categories. You will put in an hourly rate for each of those labor categories, total it up and divide the total by 11. That will be your hourly rate bid. So for instance, if your hourly rate comes out to \$80, that means if an enhancement takes 10 hours, you'll be paid \$800, irrespective as to the job titles that you use. You may use job titles that are higher priced, but since it's 10 -- your average

hourly rate is \$80, it would still come out to \$800 irrespective as to the job titles you use.

And, finally, the level six, assuming once the financial proposal is scored, bidders will then advance to level six. This is the last component of the technical evaluation. It's the third component of the technical evaluation. It's worth a total of 10 points. It's the executive presentation. It's not to exceed four hours. This will be before OMH's executive committee on pertinent information in the RFP. It will include Q and As from the panel. So once that exhibit level 6 executive presentation is complete and that third component of your financial score is scored, a bidder's technical score and financial score will be added together, and that bidder will be the awardee awarded the contract, again pending the OSC approval and the Attorney General's approval.

One final topic I'm going to just spend a couple moments on this, and that's on the Minority and Women Business Enterprises. That's received an awful lot of attention lately. I hope many of you are aware of it. The Governor has mandated goals for state agencies at 20 percent. The MWBE goal for this procurement is 20 percent, 12 percent for

minority vendors, eight percent for woman vendors. This means that 20 percent of all expenditures for the EMR project are to be made to certified vendors. So all bidders are required to submit with their bid proposal what's called an "MWBE Utilization Plan" which shows the minority and women vendors which will be used as subcontractors during the project and the anticipated amount of expenditures to each MWBE vendor. MWBEs are listed in the directory retained by the Empire State Development Corporation. We will refer you to the website at ESDC. Make sure you do partner up with minority groups and women-owned businesses and attempt to achieve that 20 percent. In the event you're unable to achieve that 20 percent goal, you can submit a waiver requesting lower goals, provided that you show that you've made a good faith effort to achieve the 20 percent goal. The good faith effort requirements are identified and defined in the MWBE regulations, which you can obtain off of the Empire State Development Corporation's website. I highly recommend that you read those good faith effort requirements. So for instance, if after you make a good faith effort you realize that you are unable to meet the 20 percent

goal, you can submit a waiver. The waiver, for example, might say that you'll be able to achieve 10 percent for minority businesses and six percent for women-owned businesses for a total of 16 percent, and then there is a review process that OMH will go through and determine whether you've basically made a good effort to achieve your MWBE goals.

So that concludes the evaluation and the MWBE portion of this presentation today. Thank you.

MR. RUBIN: Thank you, David. I did want to point out that last point David made. We've attached and updated event dates, what we've updated on these event dates. They've been updated. We removed something earlier that stated the MWBE forms were due two days after the contract award. We've removed that. The RFP makes it clear, they are actually due with the bid and not only by the vendor.

This is Sheila Long, another member of the RFP work group. She's a Contract Management Specialist 3 with OMH, and she's here to talk about

the bid proposal submission requirements.

MS. LONG: Thank you, everyone. It was at the request of the Governor's office that for this bid, due to the size of the dollar values, that those MWBE forms be submitted with the proposal as opposed to after the bids and the contract is awarded. So that might be a different process than you may have had in dealing with other contracts with New York State. We will have those links provided on our website for you to the DED website, as well as to, more specifically, how you can get to the sites that David talked about in reading for good faith efforts.

There are a couple of really critical reminders that I want to point out in submitting your bids. It's crucial that you keep separate anything related to financial from technical. They must be kept in separate envelopes. I've seen several bids in my career here being non-responsive because, inadvertently, a piece of paper that discloses something related to cost or financial gets put in the technical portion, and we don't want to see that happen to any of you. That is why we developed the two checklists -- that's the first

two pages of your handouts -- to help you really differentiate. Even though it's pretty clearly spelled out within the RFP we thought that, perhaps, having an actual checklist that somebody can double check from your own company to say this is what goes in the financial and this is what goes in the technical, and you can literally check it off so that you can know that you have them in the right format, order and in the correct particular envelope.

It's also important to clearly reference the bid number as well as your company name on all boxes, envelopes, everything, because just in case you may have two boxes and one gets separated, and doesn't have that bid number or it doesn't have your company name, this delays things for us internally to make sure that everything is being matched up.

Another key point, the bids do not come to this building. The pre-bidder's conference is here, your demonstrations are going to be here, but the proposals, themselves, go to our Consolidated Business Office which is around the block from here in the Capital District Psychiatric Center, right next store to Albany Med. So it's very, very

important that the bids be delivered to the correct location. I have seen a couple of bids in my career here be delivered accidentally to this building as opposed to the correct location. And the reason for that is that's where our business office is located. It's to keep the integrity of the bid. They will hold on to all the financials over there. They will open it, log it, make sure that everything is received, then the technical will be distributed to those people that are part of the technical panel.

Please also make sure you allow sufficient time for the mandated 3 p.m. arrival date. That includes if you're Fed Ex'ing it, to make sure it's there ahead of time. If you're doing hand delivery, it can take a little bit of time to get into the parking garage there, to get through security and make change for you from your five dollar bill for the four singles. These things take time. Walking into the main entry, I would allow at least a good half hour to 45 minutes to get there -- pretend the bid is due at 2:00 or 2:30. Don't wait to deliver it at 3 p.m. I've seen a lot of delays because there's a traffic accident on Western Avenue. So it sounds very minor, but these

are concerns. This is a lot of work that all of you are going through, and it would be real shame to be DQ'd at the very end. And Joel made a nice aerial view. It's not that far. It's right around the block, but it takes more than 15 minutes if you accidentally send somebody to this building to go and deliver something around the block. So those are some key points that seem basic, but I've seen bids fail because of that.

Please only use the forms provided for in the bid as well as process in the specified formats. Don't substitute your own forms. Make sure that anything that needs to be signed and notarized is done, and make sure it's done by somebody who's authorized for your company to do so. That can be a problem, too, if you have the wrong person executing all of this on your company's behalf.

Try not to do any deviations from the bid, extraneous terms, etcetera, because it may DQ your bid as being non-responsive. Those are the types of things that you should bring up as part of your written questions. If you have any concerns about those terms, please bring them up during that question format, and we'll do our best to address

them. Don't wait until you're submitting your bid to tell us that you're taking exception to an RFP term because, chances are, we're going to view it as being non-responsive.

It's very important for everybody to realize that we are currently in the Restricted Period as per the New York State Procurement Lobby Act guidelines. There are only three people named as appropriate person to communicate for this bid. That's Scott Derby, myself and Joel Rubin. Our preferred source to get information has been, and remains, in writing to the EMR RFP mailbox. We are monitoring that several times a day. We're constantly in it. So it's very important to note that that's the form of communication. There is paperwork that you're being given today that lists a lot of other people's names. We're going to be posting this whole pre-bidder conference to the website. It's incorporated into the RFP. You're going to see a lot of other names. Please do not attempt to contact them, and we don't only mean contact via the work environment, but via LinkedIn and other social media sites, etcetera. Please, we really don't want to delay our agency to be able to make an award over inappropriate contact.

The technical proposal. We want the original and we want it to be unbound. The reason for that is if we do have to make additional copies, we can make additional copies here. It's a lot easier with an unbound set. We then want one bound copy. We also want two electronic copies on a USB flash drive. We've provided template labels. Label everything. Please also review section 7.4.1, as far as adhering to page limits and all the different topics that are defined for what goes into each section. For instance, the Executive Summary, it may say discuss item A, item B, item C. Make sure have you addressed item A, item B, and item C, because you can end up losing points if you don't.

The financial proposal. This could be a little bit complicated. David talked earlier about the Attachment O. Basically, there are going to be several envelopes here. You're going to have one sealed envelope, and that's going to have Attachment O, plus it's going to have all of the supporting documents for Attachment O which -- can you bring it up?

MR. RUBIN: Yup.

MS. LONG: -- which is all of this. So you have the original Attachment O, plus the

backup behind it is going to be in a sealed envelope. Then we're also going to have one clone copy of that, okay? These go in together in one envelope. Then you're going to have a second envelope which is going to have all the forms; consultant disclosure forms, procurement lobbying forms. Anything that we listed that's on this checklist now for the financial is going to go in a separate envelope. The reason for that is we're not going to look at the financials until later in the process; we can look at what's in that second envelope to see what forms are there. If one happens to be missing, we may be able to call and say we found Attachment A missing, we'll give you, maybe, 24 hours to provide it. But, in theory, we don't need to do that. We can DQ you as being non-responsive if those forms are missing. We want to make sure that everybody is submitting at the time of submission everything that is needed.

Then we want two USB flash drives. The flash drives can be a combination of what's in each of those two envelopes, so they're just going to be the same on each of the two flash drives. And I think it will make more sense when you actually look at the checklist and put your packets

together. Again, please use the template labels that we've provided in the RFP, and making sure that it has the contract number on it, as well as your company name, just in case, we have two people opening envelopes, flash drives may go flying on the floor, who do they belong to?

Okay, so we did develop technical and financial proposal checklists. We provided them as a handout with this presentation. Everything in this presentation is going to be put onto the website. We ask that you use the checklist as the cover page for each of the original sets that you're sending for both the financial and technical because it will also help our reviewers here in doing that packet.

And just in closing, Joel already alluded to it, we did update the event dates. The only change for that right now was in deleting the fact that those MWBE forms were due two days after OMH notified the selected bidder of award that's been changed because we want them all now with bid submission from all bidders submitting a bid. We ask that you please frequent the OMH website often for updates and any revisions to the RFP. We've made

several updates out there. One was posting the times for this conference, for instance.

We still see some questions that come through the EMR, and we know that we've been posting some of this stuff up there. So please, please make sure you go out there and look at that frequently.

That's going to be our main form of communication in updating when we can.

If you're not bidding, it would be of great value to us if you could please submit the Attachment B no-bid explanation as early in the process as possible with an explanation as why. For instance, if you're going through, as David and Scott and everybody had talked about earlier, the list of the mandatories that we're looking for, we would want to know. If we're seeing that several companies -- we're hearing that people aren't bidding because nobody can meet one particular mandatory requirement, we need to know that, because the only way a mandatory requirement can be eliminated after an RFP has been issued is if there is no bidder or no potential bidder out there that can meet it. So it's very, very important to us to let us know why you're not bidding, okay? Because that can really help us with the future development

of the RFP.

And we're not doing a working lunch. This is just to do a summary and clarification at the end. We thought we might be doing a working lunch when this was first developed, but we thought, perhaps, everybody would prefer to mingle on your own. I think that's it for us. We really didn't want this to be a main question and answer session. We would recommend that all of your questions, though, if you would please take the time to submit them to us. If you could just put in the subject line question, we'll be able to sort them. I know that several people have asked already about the list of attendees here. We are going to be providing, as part of the Q and As, the list of companies and who attended this pre-bid conference because we know that would assist with collaboration; it's a matter of public record, so we can certainly put that out there.

Are there any general questions, though, that we may be able to answer for you today? Yes.

MR. RUBIN: I just want to add, please state your name right before the question so the stenographer notate.

MS. LONG: Yes, we have a transcriber.

You have to bring him the microphone. I'm not entertaining technical questions.

MR. JACKOVICH: Brian Jackovich. You had mentioned that you're going to be using the website to post all of this stuff to. Does that include a transcription of what was said here today's and tomorrow's meeting as well, or is it going to be closed?

MS. LONG: It's public record. It is our intent to post what the transcriber is taking down, as well as our power points.

MR. DERBY: And the videos that you'll see tomorrow --

MS. LONG: She can't hear, Scott.

MR. DERBY: I'm sorry, and the videos will be posted tomorrow on the website, and you'll be able to download them, so you'll have any information that has been viewed here.

MR. JACKOVICH: And you had also mentioned that the Q and As, the responses, would only be available to bidders who are here today. So is that going to be public as well, or is that going to be closed?

MS. LONG: We're looking at that. We're probably going to post it because the RFP is

posted. There's nothing proprietary about what we've been speaking with today. The only people that are going to be able to submit a bid are those that attended today's meeting (full 2 day pre-bid conference), so we don't feel that there's anything negative in posting. We feel it actually could encourage participation for minority- and women-based entities, if they can read it and see it as well, and so we believe we're going to be able to post all of it, and if we can't it will be addressed. So I do want to reiterate that you're sitting there, if your name is not on that attendee list, you weren't here today and you can't submit a bid. So I really need to drive home, make sure that you're signed in, because that to us is the Bible and proof that you attended this conference. Any other clarifications?

MR. SANTANDREA: Hi, my name is Dan Santandrea, S-A-N-T-A-N-D-R-E-A. With regard to MWBE utilization, would it suffice -- does the MWBE have to be a direct subcontractor to the prime in order to meet the 20 percent goal, or can the subcontractor, the MWBE, be a subcontractor to a subcontractor to the prime?

MS. LONG: Well, first of all, that

would be a good question for you to put in writing because I would like to be able to post that. David, would you like to answer that or we can address later.

MR. MILSTEIN: Well, I think, first of all, we should say that any answers that we provide today can be amended in writing.

MS. LONG: All right, we'll get back to you with that.

MR. MILSTEIN: And the MWBE community, as to whether second-tier MWBEs can be counted. So for instance, if you hire an MWBE sub and that MWBE sub further hires another MWBE sub or you utilize MWBE subs to do other functions within your organization, accounting, janitorial, so these kinds of questions have not been fully answered, to my understanding. But I would very highly recommend you submit this question in writing, and we'll seek the answers from those people who are establishing the interpretations and the stat of the regulations.

MR. CAMPBELL: My name is Kyle Campbell. I'm with TIAG. Joel, when he was talking, he was referring to the vendors as the firm. And on slide 90, it addresses using some of the qualifications from the subs as representative

of the firm or the team to go along with the whole proposal. David, when he was talking, was referring as the bidder, and he said only the bidder could have the qualifications. Does that mean that the subs cannot put their "quals" in, or does that mean that the terminology of bidder and firm are the same, it's the team of the multiple vendors that make up that team or that firm or that bid?

MS. LONG: The terminology is the same, bidder versus vendor in this particular case. I would request also that you put that in writing, and we will clarify it. We are enabling subs that you are proposing to be part of your qualifications, but we will word that carefully.

MR. CAMPBELL: Right. This is Kyle Campbell again. Specifically, to the point of the qualifications for the five-year Vista experience, etcetera, if the prime does not have that, but the sub does then that's more pointed to my question?

MS. LONG: The answer to that is yes.

MS. CLARK: Deanne Clark from DSS.

I'm wondering if there's a mechanism for alternative solutioning, ideas that might be different than what was laid out, but are options, you know, how that response would be structured or

if it's strictly the format and forms that are within the RFP now?

MS. LONG: It's strictly the forms and the format that are in the RFP now. And are you talking alternative solutions other than Vista?

MS. CLARK: No, talking about maybe -- and I don't mean to be technical at all because I know this isn't -- I'm talking about ways of delivering the technical solution that may not have been pre thought out in the RFP.

MS. LONG: If you could put that in writing, and we'll discuss it internally and get a clear answer to you, and if you could give us an example.

MS. CLARK: Yeah.

MS. LONG: I don't want to put you on the spot. It sounds like a very generic question. If you can give me a sample or two, I think, that way we can give a good answer. Scott?

MR. DERBY: This is Scott Derby. Just to clarify a little bit. When you send that question in, okay, try to be as specific as possible of what those alternatives might be, so we have to be reactive. So if it's just you have them --

MS. LONG: No. Somebody over here had a hand up.

MR. RUBIN: Did someone have a hand up?

MS. LONG: I thought I saw somebody with a hand up. That's all I have.

MR. RUBIN: Is that everyone?

MS. LONG: I think so.

MR. RUBIN: Okay, I guess this concludes day one of the pre-bid conference. See you all back here tomorrow. Registration is at 8:30. We'll start fresh at 9:00 tomorrow. Thank you.