

NEW YORK STATE OFFICE OF MENTAL HEALTH

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BIDDER'S CONFERENCE

Day 1

Electronic Medical Record

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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 Froetz  
Hao Wang  
Gerald Engel  
Dr. Greg Miller  
Scott Derby  
Dave Milstein  
Sheila Long

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

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

25 I'd like to bring up now the acting

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1 director of the project management office, Sue  
2 Froetz.

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

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

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

1 track today.

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

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

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

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

1 again, myself, just giving you these ground rules.  
2 We also have Gerald Engel, who is our Director of  
3 Health Services; and Greg Miller, Dr. Greg Miller,  
4 who is our Medical Director of Adult Services.

5 Following that will be Scott Derby, who is our  
6 Director of Application Services. Joel Rubin will  
7 be providing a brief presentation from the PMO.

8 David Milstein from the Consolidated Business  
9 Office will be giving us an overview of the RFP,  
10 and Sheila Long will be giving some additional  
11 information. And these folks are people who you're  
12 probably going to meet in your day-to-day work  
13 within OMH. These are people who have subject  
14 matter expertise and do play a role in our  
15 facilities and in the RFP.

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

1 who is our Director of Adult Operations here at  
2 central office; and, finally, Mari Pirie-St.  
3 Pierre, who is our Health Information Management  
4 Director at St. Lawrence.

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

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

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

21 DR. WANG: Good morning, everyone. We  
22 are -- thanks, Sue. We are way ahead of schedule,  
23 so we hope to keep it that way today. Right? So,  
24 you know, for those of you who are having Superbowl  
25 hangovers, we have coffee out there. And I know

1 that whenever our transcriber needs to stop me, you  
2 know, when I talk too fast, feel free to ask me.

3 So I would like to introduce the broader  
4 mission of OMH Electronic Medical Records. It's  
5 been in the making in the past many years. For  
6 those of you who know -- I think most of you know  
7 about OMH, right? So I was pretty encouraged that  
8 when I saw the list of the vendors. We have about  
9 28 vendors, probably more than that that officially  
10 responded that they wanted to be here today or  
11 received information about this pre-bidder's  
12 conference. So one of the things that we know we  
13 needed, we need to help you today and tomorrow to  
14 prepare a better RFP response. So that's why Sue  
15 and the team, they put together a good agenda. You  
16 know, my role is to introduce to you what OMH does,  
17 why we need EMR and how we expect EMR to roll out  
18 and implement in the next few years.

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

1 behind only the Columbian Presbyterian Hospital  
2 system and Long Island Jewish system. We are the  
3 third largest, and we are subject to CMS and the  
4 Joint Commission of Regulatory Compliance, just  
5 like any other health care provider. So that's  
6 also for the EMR, so our EMR has to be compliant  
7 with CMS requirement and the Joint Commission  
8 requirement.

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

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

21 This is a map that shows us the  
22 distribution across the State, all of our  
23 psychiatric hospitals. The total number of  
24 hospitals may change over time, but right now there  
25 are 25 hospitals, and we also have, approximately,

1 310 outpatient facilities. And during our adult  
2 medical director's, Dr. Greg Miller, presentation  
3 you'll learn what kind of adult facilities of  
4 outpatient settings we have.

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

1           So those, among other key reasons, our  
2           transformation is determined that we are going to  
3           get to more of a supportive, continuous,  
4           accountable and early intervention model. And we  
5           also emphasize our collaboration with the community  
6           providers because mental illness needs to be dealt  
7           with at the onset, or at the beginning, and no  
8           matter if the patient is at their primary  
9           physician's office or at school or at their  
10          employment place. Right? So whenever the early  
11          indication, the risk factor is high, we hope the  
12          patients are being supported -- I'm sorry, before  
13          they become patients, we hope New Yorker's are  
14          being supported and so that they can have  
15          resilience in their life.

16                 Like I mentioned earlier, we will  
17          restructure our care from an episodic,  
18          volume-driven model towards this effective support  
19          model, which is highly dependent on a successful  
20          electronic medical records system to better  
21          interact with the community, to better conduct care  
22          for the nation. Our early intervention model for  
23          people and their families is closely aligned with  
24          the primary care setting, with our and the  
25          community's quality management system, and we need

1 to align them with a social utilization management  
2 system, align them to the school system, education  
3 system and the employment support system. And EMR,  
4 again, is one of the key links in that entire chain  
5 of services.

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

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

20 As some of you know, OMH, for many years,  
21 has been working with the community providers,  
22 developing very good quality metrics and delivers  
23 those quality metrics and associated data to the  
24 community providers who help provide and better  
25 manage their care delivery and help the performance

1 of the whole system. I'll just give you one  
2 example. Our psyches, you know, is one of the  
3 division's support tools that's based on quality  
4 metrics. The two first indicators for psyches, one  
5 was the polypharmacy, the quality indicator for  
6 medication management for our patients, we  
7 developed in-house for our inpatients, then we  
8 applied that to the Medicaid population and applied  
9 to the outpatient community and hand that tool to a  
10 lot of the outside providers, the community  
11 providers, help them to identify the risk of  
12 polypharmacy and help them procure -- not procure,  
13 help them deliver better care. And we are going to  
14 strive to do so continuously, all right? So we  
15 want to deliver the data to clinicians, to the  
16 providers, to the policy-makers and to health care  
17 policy administrators, as well, for them to better  
18 manage the entire care ecosystem.

19 EMR, needless to say for all of us here who  
20 are familiar with Electronic Medical Records, we  
21 know is the key ingredient to the solution for all  
22 of those above requirements. At the core and  
23 foundation of our outside key, EMR, first and most,  
24 is digitizing and electronically capturing data  
25 about our health care delivery and about our

1 patients and our services. And those data are  
2 being used, subsequently, to direct the care  
3 coordination to better make an evidence-based  
4 health care decision, as well as a health care  
5 policy decisions. And throughout the study of the  
6 VA Vista system, over the years we know that the  
7 Vista system has EMR for all VA hospitals developed  
8 about more than ten years ago. After it was  
9 installed in the VA system, the operating  
10 efficiency for running that health care system was  
11 remarkable. The study showed that yearly  
12 efficiency gain, because of EMR, was about six  
13 percent per year for veteran affairs and for their  
14 hospital systems. You know, what that means is  
15 throughout about a six- or seven-year period, the  
16 VA's clinicians, the head counts, stayed flat,  
17 about 200,000 people delivering direct care;  
18 however, the ability for VA to take care of the  
19 population that's 67 percent larger six years later  
20 is remarkable without increasing the head count of  
21 the health care professionals, and equivalent  
22 efficiency gain is about six percent. We want to  
23 duplicate that in OMH, as well. Eventually, it  
24 will reduce the burden on taxpayers and, hopefully,  
25 improve the care and quality of care, as well.

1           Because when you have the EMR, we're not treating  
2 patients blindly because we will have more  
3 information, hopefully all of the information  
4 necessary, and all of the information available,  
5 and the care delivered to the patient will be more  
6 appropriate than otherwise. And the EMR will  
7 modernize our system, and we hope it will modernize  
8 our community provider system. Many of our larger  
9 providers have already installed their EMR. And  
10 for a smaller sized provider, they do not have the  
11 financial ability or sophistication for technology  
12 to install and develop their own EMR system. And  
13 the choice of an open source, public domain based  
14 EMR, like the Vista, is a smart choice in my view.  
15 It's because the open source portion of Vista plus  
16 the work-to-hire portion of this EMR implementation  
17 that, with your help, we will wire the Medicaid  
18 rules and wire those evidence-based, division  
19 support rules into the EMR for behavioral health.  
20 That work-to-hire portion, in conjunction with the  
21 Vista based system, will be made available to  
22 community providers if they need it to practice  
23 behavioral health care in New York State. Now they  
24 have a functional EMR that can -- not only can it  
25 be used in the hospital system, but also it can be

1 used in the outpatient clinic system, and it will  
2 have a lot of the customization needed to function  
3 in New York State automatically available for our  
4 community providers. And I think if we realize  
5 that, this project will not only transfer our own  
6 state-round operation to a modern care system, but  
7 also transforming health, transforming our  
8 community providers' practice and their systems.

9 Like we mentioned earlier, OMH will  
10 strictly adhere to the regulatory compliance with  
11 CMS and the Joint Commission. And it is my wish  
12 that the demanders, when you do EMR implementation  
13 elsewhere, you will have your best practice to help  
14 the provider adhere to that regulatory compliance,  
15 and we want to do the same. Right? So this chart  
16 actually shows where we are today. OMH, actually,  
17 is at stage one of the three stage CMS meaningful  
18 use of EMR model. OMH is capturing health  
19 information in a coded format already. We have our  
20 in-house built MHARS; that's in-house EMR  
21 equivalent. You know, somebody will give you a  
22 demonstration on day two, right? You will see that  
23 we are capturing a lot of the data in a coded  
24 format, and we are using those coded data to make  
25 decisions for care coordination publicists, even

1           though we believe we are not doing it in the full  
2           extent, but we have the foundation, and we hope  
3           that foundation can be expanded through the EMR  
4           implementation project.

5           The decision for tools, such as our psyches  
6           tool and our, I believe, shape mats in our  
7           facility, those tools are developing in the last  
8           few years and are being used today, and we are  
9           continuing to, you know, make it a more perfection  
10          tool for our operation. And we are reporting  
11          quality measures. You know, even CMS, even if we  
12          use arena, there are at least six behavioral health  
13          quality measures that I know of that are built into  
14          our requirements, and I believe there will be --  
15          more quality measurement needs to be built into our  
16          EMR system; you know, that's our goal.

17          Then stage two, we wanted to go to stage  
18          two fairly quickly in 2013. One of the reasons  
19          that in the EMR RFP, you'll see that we had a  
20          two-track strategy. The first track was developed,  
21          actually deployed, largely out-of-box CPOE  
22          functionality and bar-code medication  
23          administration functionality, that's because we  
24          wanted to achieve that stage two in 2013. And we  
25          believe that out-of-box functionality of Vista can

1 largely meet our needs, and we can transform our  
2 internal operation to adapt to that. And with  
3 minimal configuration customization, we wanted to  
4 deliver that functionality fairly quickly.

5 Then broader user interface for clinicians  
6 in the work flows will be done in the subsequent  
7 years in parallel. Hopefully by 2013, we will  
8 achieve stage three goal by CMS.

9 And this is a broader OMH health care IT  
10 roadmap we develop two or three years ago. It's  
11 been a long way, but it's still valid. We keep  
12 refining it. As you can see, EMR is a core part of  
13 that health IT road map. On the top portion is our  
14 platform selection. We already concluded, we  
15 selected Vista. And we planned our work, the  
16 result of this RFP -- as a result of the work is  
17 this RFP. And we did have our EMR strategic  
18 roadmap, we also have our health information  
19 exchange roadmap, to communicate any problems,  
20 operated as community providers. And outside EMR,  
21 we wanted to build a solid foundation for the EMR  
22 system and for our whole health care delivery.

23 You know, the foundation includes things as  
24 master patient index, using industry leading master  
25 data management solutions, and we wanted to make

1 that MPI ready before vendors started working on  
2 EMR implementation, and we are well ahead of the  
3 schedule to deliver that piece.

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

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

23 The bottom half of that blue box, largely,  
24 are existing today. Like I mentioned earlier, we  
25 are at stage one. We are doing clinical

1 documentation. We are doing decision support, but  
2 we need to do it better, right? So that's the  
3 track two work, is that, in parallel with track  
4 one, we wanted to be with all of these  
5 functionalities and make that adapt to the New York  
6 State Health Care Policy reimbursement rules and  
7 make it available very quickly for our facilities,  
8 eventually to the communities.

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

17 I believe our director of health services,  
18 Jerry Engel, will give you more of a broader view  
19 of our clinical environment later, but, really,  
20 this chart shows our major existing clinical system  
21 in our facilities today. And you can see that  
22 green box is those systems function that --  
23 functionally will be replaced by Vista. And those  
24 white boxes will coexist with Vista going forward,  
25 and they have been integrated with the Vista

1 solution that, hopefully, some of you will help us  
2 implement.

3 And to integrate our health care system  
4 with broader communities in New York State, I just  
5 want to give you a context where the EMR fits in.  
6 The EMR is not only a software system, it's one of  
7 the components of the broader strategy for us to  
8 better service New Yorker's through closer  
9 interaction and integration as community providers.  
10 As you can see on this chart, we are, in parallel  
11 to EMR, doing a number of things, you know,  
12 information exchange with state agencies,  
13 information exchange change with the local  
14 agencies, the counties and information exchange  
15 with the local WIAs are all happening at the same  
16 time. And they are done by a standard-based,  
17 intra-operable approach, and we heavily emphasize  
18 data and records initiative. In conjunction to  
19 health information exchange, we work with long  
20 Island community providers in the past three or  
21 four years to standardize what we call the clinical  
22 records for New York State. Essentially, I  
23 believe, approximately, 12 programs, more than two  
24 or three dozen forms are standardized across the  
25 entire community in Long Island. And about a year

1 ago, we wrote out that to statewide. Hopefully,  
2 eventually, we standardize the clinical records for  
3 the entire state for behavioral health. This is a  
4 project we are doing in conjunction with OASAS for  
5 the substance-abuse population, as well. Like what  
6 I mentioned earlier, we are doing master data  
7 management, not only creating the master patient  
8 index, we are creating a master provider index and  
9 a master employee index. You actually will have a  
10 master services index. And we are doing --  
11 vocabularies. CSM, ICD, CPT, all of those clinical  
12 terminology relevant to mental health care will be  
13 standardized across our facility, eventually. So  
14 all of those will be working in conjunction with  
15 EMR. So your RFP development, I know that not  
16 everything will be rated or scored. We're going to  
17 strictly adhere to the state procurement practice,  
18 but keep in mind the EMR is not an isolated system.  
19 The ability to integrate with our existing system,  
20 our existing initiatives and the ability to  
21 integrate and inter-operate with the community  
22 providers, EMR, it is critical for our broader  
23 success, and that the more you can help us, the  
24 better value our system will be. And the  
25 Electronic Medical Records that you help us

1           implement will help transform our business  
2           entirely, that entire OMH, as an agency, as a  
3           hospital provider system, will be engaged and will  
4           be mobilized to participate in this particular  
5           project. As you can see, essentially, all borders  
6           of OMH will be part of our team. We not only have  
7           a steering committee that's chaired by our CMO, the  
8           medical director and me, but also we will have an  
9           operating committee that will be, you know, formed  
10          by the hospital CEOs, hospital COOs, nursing  
11          directors because EMR, quote, unquote, -- the  
12          implementation of EMR, quote, unquote, can be very  
13          intrusive to their day-to-day operation. We have  
14          to have a well organized and well coordinated  
15          project working with the people running the  
16          hospitals and the clinics on a daily basis to get  
17          this done in the next few years, and the operation  
18          committee is very essential to the success of this  
19          project, and we realize that. And most  
20          importantly, we will have a clinical transformation  
21          team that will be headed by Dr. Greg Miller and  
22          Dr. Stewart Gabel, Dr. Grace Lee and Gerry Engel,  
23          and many others that will help us redesign our  
24          clinical work flow which is largely based on paper  
25          today. So with a new EMR system developed and

1 implemented a lot of this clinical work flow has to  
2 change, and we have to move away from paper entry  
3 of clinical care delivery, and we have to move to a  
4 more electronic and automated fashion, and we have  
5 to standardize that automated electronic-based  
6 clinical delivery across the entire spectrum of our  
7 facilities; the 25 or 26 hospitals, the 300 plus  
8 outpatient facilities have to adopt the standard  
9 treatment plan and the standard work flow. So the  
10 close interaction with our clinical leadership is a  
11 must for this project to succeed. And we expect --  
12 I think it's evident in that RFP, we expect the  
13 firm or the vendor bring to the table the clinical  
14 champions who've had a similar experience in  
15 transforming the clinical work flow in other  
16 provider system in the past, and only that will,  
17 you know, help us better interact with our clinical  
18 leadership and better persuade our users, the 9,000  
19 plus caregivers, to adopt to the model.

20 In addition to that, we will have a  
21 clinical advisory committee that will have leaders  
22 not only in to the statewide system, but also from  
23 the academia environment who know what research  
24 tells us about evidence-based medicine, who can  
25 tell us what's the best practice today and how do

1 we closely integrate our system to the research  
2 community to help the translation on research. And  
3 we need to have participation from the local and  
4 community providers who are working, you know, with  
5 us for our patients together, so our system, even  
6 though it's for statewide hospitals, and they  
7 should be acceptable and should be friendly with  
8 our community providers. So we'll have additional  
9 clinical expertise and leadership in our advisory  
10 capacity to help guide this initiative. You know,  
11 further down the chart, you will see that our  
12 billing operation, our facility operation, our  
13 quality management will all be involved, and we  
14 have to deliver a far-reaching system than just in  
15 solving software, per say, right?

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

1 talking to the community providers for mental  
2 health and behavioral health care. And we have to  
3 focus on not only the inpatients but also the  
4 outpatients. I believe the Vista is proven, it's  
5 well known, it works for the inpatient environment.  
6 It will be able to support our inpatient operation  
7 in New York State, but what most importantly is, it  
8 has a significant gap to support outpatient  
9 facilities, and that needs to be one of the focuses  
10 in this project. So the more best practice and  
11 clinical leadership and transformational leadership  
12 you could bring to the table, the better off we  
13 are. And it has to be conducive and enabling to  
14 our business and clinical transformation. Like I  
15 said, it is not a simple system installation. It  
16 has to fundamentally transform how we deliver and  
17 manage our care, and clinical work flow  
18 transformation is important and other business work  
19 flow is equally important. And one of the Vista  
20 shortcomings is, because it was developed for VA it  
21 did not have a institute billing component that's,  
22 you know, closer to our reimbursement and Medicaid  
23 environment in New York State, we have to have  
24 that, because not only the state needs the  
25 reimbursement capabilities to bring the revenue to

1 the state health care system, but also when we  
2 release some of our component in this system to the  
3 community providers, and they -- you know, I think  
4 the most value to them is that reimbursement rule,  
5 a service capturing, coding and all of those things  
6 need to be automated. It will make their life much  
7 easier, so we have focus on -- one of the focuses  
8 is really the physical functionality. We have to  
9 supplement the Vista out of the box.

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

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

4 Then, lastly, we want to be agile, right?  
5 So what we don't want to see is we hire talented  
6 vendors to, you know, work on the system for three  
7 years, with all the contact with us, and come back  
8 three years later and deliver a system that may not  
9 fit our needs then, right? So the more frequent  
10 and the earlier we can deliver the use of the  
11 components to our user community, the better off we  
12 are. That's why we always hope that you bring to  
13 us your expertise in an agile approach in system  
14 development and implementation. If not, you know,  
15 we have -- OMH has identified this as an initiative  
16 about half a year ago. We've already developed our  
17 methodology, we'll share with you if you don't have  
18 one, but the key is we need to stay agile and  
19 deliver on a periodic basis rather than, you know,  
20 wait for six or nine months before the clinician  
21 can see the -- and we hope that, you know, if they  
22 request something, they need to see it in a matter  
23 of a few weeks. I wouldn't dictate the frequency,  
24 but we have to be much more agile than conventional  
25 methodology. The two-track model in our track one

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

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

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

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

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

1 who have created some very advanced approaches at  
2 their individual facilities, and some of them who  
3 are strong clinicians and have, like me, a good  
4 working knowledge of the context of EMR, but who  
5 are not informatics specialists, ourselves. I  
6 think you'll see, over the course of the RFP review  
7 process, that group of clinicians who will move on  
8 to be very crucial people and partners for the  
9 implementation process as this goes forward. Some  
10 of them are actually here today, so I think that  
11 you will see that there is a very strong component  
12 of people who are going to be partners around the  
13 clinical process of this to make it be a successful  
14 process. Dr. Gerry Engel, who is our director of  
15 health services, is going to present on some of the  
16 functionality issues around the medical  
17 functionality, that's for the CPOE, that's  
18 physician order entry, lab, pharmacy components;  
19 the track one, if you will. I'm going to talk a  
20 little bit around some of the ideas that will  
21 impact the functionality of the core behavioral  
22 health product. And I will tell you that I've been  
23 involved in an implementation in an EMR at an  
24 institutional level twice in my career, and I know  
25 it to be a fact that whatever product you end up

1 going with that, perhaps, the core behavioral  
2 health component is always the component that is --  
3 it's hard to fit the peg into the hole, harder than  
4 it is with some of the other specialty components  
5 of an EMR. We have a wide variety of clinical  
6 arenas, and we have a wide variety of both  
7 community services and inpatient services. We have  
8 done a tremendous amount of work to try to pull  
9 that clinical flow together. It will be reflected  
10 in the RFP. We also know that the work is a work  
11 in process and that some of the functionality  
12 issues will emerge on the ground as we go. So it's  
13 been a process for us to try to create an RFP that  
14 covers all of the requirements but also recognizes  
15 that we want to have this process be a  
16 transformative process. We want to ride the  
17 bicycle while we build a brand new one, if you  
18 will.

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

24 Just a little tiny bit of history. We are  
25 a strong, central, state-operated, mental health

1 system compared to most of the other large states  
2 where you will see that there's more local control,  
3 county control, local control. New York State, in  
4 its state operated mental health system, very early  
5 on, back in 1800s, early 1900s, became a system  
6 that's centralized especially in its state operated  
7 services. So the state hospitals have always been  
8 operated strongly with a strong central governance,  
9 but prior to that, those hospitals came together in  
10 multiple different directions so they were spread  
11 across wide geography. Many of them were private  
12 hospitals before they became public hospitals.  
13 Many of them were public county hospitals before  
14 they became state hospitals. So while we have a  
15 very large, state operated system with a very  
16 strong central core of governance, these hospitals  
17 are also local hospitals. They're part of their  
18 communities. They have strong leadership at each  
19 one of the 25 sites across the state, and they have  
20 developed solutions to their clinical process that  
21 reflects the environment in which they live in and  
22 the history that has gone into their own particular  
23 facility and their partners around clinical care  
24 and the particular leadership. So you will see  
25 those nuances across our state. And part of the

1 process of our clinical implementation is going to  
2 be integrating the strengths that we have across  
3 the State with our goal of consistency across the  
4 State in this process.

5 So the first axis I'm going to talk about  
6 with functionality will be our divisions, our  
7 clinical divisions. We have three: Adult  
8 services, child and adolescent services and  
9 forensic services. All of these services, to some  
10 degree, interdigitate but have strong core services  
11 separately. Across the State, we have -- I'm  
12 sorry, it's not 25 psychiatric centers in the adult  
13 service. We have a total of 25 psychiatric centers  
14 across New York State, each one a hospital with  
15 inpatient and outpatient care. That number may  
16 change because we are finding that, as clinical  
17 services transform across the state, capacity is  
18 changing. One of our hospitals just closed this  
19 year and the services merged into another one.  
20 That may happen with other hospitals over the  
21 course of this long implementation. I would  
22 venture to say that it will. Our psychiatric  
23 centers in the adult services vary from greater  
24 than 500 beds to less than 100 beds. On the  
25 inpatient side, there is about 3,000 to 3,500 bed

1 capacity of patients, and the majority of those  
2 patients within the state adult division are  
3 transferred to our state hospitals for inpatient  
4 care after having had rather lengthy attempts to  
5 stabilize their issues in acute care settings. By  
6 and large, there are exceptions to every rule, but  
7 in the adult system, by and large, we don't admit  
8 directly. That's different from some state  
9 systems. We see our purview for the adult system  
10 to be to manage people who are not able to be  
11 stabilized and released into the community, but who  
12 do have community integration potential and remain  
13 seriously ill at a hospital level of care despite a  
14 lengthy acute stay. Those patients we see as  
15 needing a higher specialized level of care in a  
16 longer stay hospital. It's not the idea anymore of  
17 the old state hospital where you send patients to  
18 stay for the rest of their lives. It's an idea  
19 that we have a longer length of stay focused on  
20 aggressive more specialized attempts to help people  
21 who have not gotten better in acute care to be  
22 mobilized into the community. A few PCs have  
23 accommodated to community standards, and they do  
24 acute care inpatient psychiatry. I think these are  
25 two completely different clinical missions and

1 often require different clinical components that  
2 will impact on our core behavioral health EMR when  
3 we have it.

4 We have two research institutes within the  
5 system where clinical research is done, both  
6 inpatient and outpatient clinical research. The  
7 Nathan Klein down near Rockland Psychiatric Center,  
8 as well as the New York State Psychiatric  
9 Institute, which is near Columbia. Research,  
10 obviously, has impacts around functionality that  
11 will have to be incorporated within the system.

12 Our outpatient, and as Dr. Wang had  
13 stressed, outpatient is really becoming more and  
14 more focused around how mental health care is  
15 transformed. We have a very large adult outpatient  
16 service, over 20,000 patients. We have clinic, we  
17 have specialized outpatient services like ACT,  
18 Aggressive Community Treatment, family care where  
19 patients are taken of within families. We have  
20 case management. We have peer supported services  
21 at some of our facilities. Not all of these will  
22 be in the first round of EMR. The core component  
23 for EMR is going to be our clinics, obviously, and  
24 that will stretch across all three divisions. The  
25 clinic, by the way, NYSCRI that Dr. Wang referred

1 to, that has standardized clinical documentation  
2 across the State that is being implemented in Long  
3 Island and being integrated into some outpatient  
4 EMR products at this point in time, is a set of  
5 records that came from compiling all of the  
6 requirements for outpatient care and developing the  
7 minimum standard templates and documents that were  
8 required for clinic level of care. So we do have a  
9 standard that we have supported as the outpatient  
10 standard in New York State, and that is the NYSCRI.  
11 The NYSCRI project did not involve inpatient care,  
12 so that's an important fact.

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

25 The child and Adolescent is a little bit

1 different from adult in that they do have a greater  
2 mission towards acute care, so about a third of our  
3 clinical inpatients and child psychiatric centers  
4 are admitted directly. They are not transfers for  
5 longer term treatment. Two thirds are referrals.  
6 The child PCs work together with the adult PCs  
7 around the mission of Child and Adolescent  
8 Services, and there are some documentation  
9 differences. So for those facilities that have  
10 child and adolescent outpatient services, there are  
11 sort of clinical requirements for documentation  
12 that differs somewhat from the adult requirements.  
13 Obviously, the Child and Adolescent Services, we  
14 all think of ourselves as looking at age  
15 appropriate in developmentally focused clinical  
16 assessment and interventions. In the child and  
17 adolescent, this is, of course, a very top  
18 priority. Developmental assessment is a crucial  
19 component to all of the child and adolescent  
20 services. And their array of community services  
21 include day hospital, children's day hospitals  
22 clinic, residential treatment facilities across the  
23 state which are different from congregant care  
24 residential services for adult in that they really  
25 -- many of the child and adolescent residential

1 facilities rise to nearly the level of a hospital.  
2 They have nurses, they have medication  
3 administration, they have a higher involvement of  
4 doctors. We don't run any of those, so the EMR  
5 won't directly involve those services, but the  
6 interaction with those services is crucial to our  
7 child and adolescent hospitals.

8 And one of the more complicated services in  
9 terms of how care gets given is our forensic  
10 services. So, obviously, in our forensic  
11 hospitals, people come to those hospitals by virtue  
12 of some legal problem. They are not admitted  
13 because they meet criteria for a clinical  
14 hospitalization. They are sent there because they  
15 come through the law, through the legal system in  
16 some way, and are, by virtue of the legal process,  
17 determined to need some sort of service out of our  
18 mental health services. Again, like with child,  
19 even though we have some three separate forensic  
20 psychiatric centers in New York State and one very  
21 large and vast outpatient service that operates  
22 within the Department of Corrections in prisons,  
23 much of the forensic domain of care occurs within  
24 adult settings and child settings. So this is one  
25 of the more complicated ways in which patients come

1 to us in terms of how they are legally admitted to  
2 the hospitals. There are multiple -- you know, in  
3 the child and adult, you're either sort of  
4 voluntary or one of two or three, but mainly two  
5 and, particularly, one form of involuntary  
6 admission, all of the details of which are easy to  
7 learn; whereas, in the forensic system there can be  
8 multiple ways in which legally patients come. So  
9 there can be an unfit to stand trial designation,  
10 which can lead to someone being admitted to one of  
11 our forensic psychiatric centers or one of our  
12 civil psychiatric centers if it's simply for  
13 assessment and determination of whether further  
14 inpatient care is needed. We have people that are  
15 acquitted by reason of insanity and, therefore,  
16 they have to go to a psychiatric facility until the  
17 legal process determines that they are able, in a  
18 very structured and sometimes lengthy process, to  
19 move back out toward community integrated care.  
20 And those insanity acquittees, called 33020s,  
21 actually can be seen in either forensic facilities  
22 or in our state-operated facilities. And, of  
23 course, those people in our system who are there by  
24 acquittal by reason of insanity, obviously, require  
25 a tremendous amount of partnership with the legal

1 system. Every step of the way with moving those  
2 people through to being out of the hospital and in  
3 community care, requires collateral work with the  
4 legal system in order to move them. When we have  
5 patients in the civil hospitals who are determined  
6 to require being in a forensic setting because the  
7 behavior they're exhibiting within the civil  
8 setting is dangerous, and we mean the bar is pretty  
9 high because the civil hospitals are already  
10 hospitals designed to manage high levels of  
11 potentially aggressive behavior, sometimes those  
12 patients are transferred on what is called a par 57  
13 into a forensic facility. They remain a civil  
14 patient. They have been designated in need of a  
15 forensic facility, so we have patients, many times,  
16 who belong to one of the civil hospitals who get  
17 transferred to a forensic hospital, the goal of  
18 which is being to get them ready to go back to that  
19 civil hospital as soon as possible. When state  
20 prisoners require inpatient care, they will be  
21 transferred to one of our state hospitals to  
22 receive that inpatient care. This is one incident  
23 in which we will be doing acute inpatient care in  
24 our state hospitals. And often, when county jail  
25 inmates are in need of inpatient psychiatric care,

1 they would be transferred into one of our forensic  
2 hospitals to receive that.

3 We also run what is called -- we call it  
4 SOTP, it's S-O-T-P, Sexual Offender's Treatment  
5 Program. You may or may not know that across all  
6 the states, how to deal with sexual offenders has  
7 been a major source of controversy and a major  
8 source of public concern. The program within  
9 New -- and a large part of this concern is what  
10 happens when people are nearing the end of their  
11 sentence in jail that are deemed -- but there's a  
12 question about whether they still remain highly and  
13 potentially dangerous for further offense if they  
14 were released. And we have a very complex  
15 mechanism for evaluating the level of risk and  
16 dangerousness in that population in deciding  
17 whether or not they are safe enough or at low  
18 enough risk to be released. And, if not, they turn  
19 into long term psychiatric patients in our civil  
20 psychiatric hospitals. There are designated  
21 hospitals that have specialized programs for sexual  
22 offenders who have been designated to be too much  
23 at risk to be released. The process for their  
24 moving into the community is, like with the  
25 insanity acquittees, often slow and arduous and in

1 strong collaboration with the civil services. And  
2 others, we do have sexual offenders that come into  
3 our system in other directions and may move into  
4 and out of the system.

5 I'm going to move faster for the sake of  
6 time, but the next axis I would focus around our  
7 clinical domains is our clinical process. Now in  
8 many ways on the inpatient side, these processes  
9 are going to look similar to what they do  
10 everywhere. We bring patients in, we assess them,  
11 we do medical evaluations, we decide on a treatment  
12 plan, we create interventions that are geared  
13 towards helping them out into the community. And  
14 one of the biggest things that we need to look at  
15 in how we do that across our system that I would  
16 say is most universal is how do we create a system  
17 within our inpatient services that really kind of  
18 organizes and integrates how we provide that care?  
19 So if you think of the treatment plan as the core  
20 functional component of what we're going to do with  
21 patients in the hospital, how does that treatment  
22 plan interdigitate with all aspects of care? How  
23 do those nursing assessments, doctor assessments,  
24 medical assessments, psychology assessments all  
25 come together in a way to create a good treatment

1 plan? And then how do the interventions, the  
2 groups, you know, the recovery-based services, how  
3 do those all come together in a treatment plan that  
4 allows a team to see how's this patient doing, are  
5 they getting what they need, and is what they need  
6 doing what it needs to do in order for us to move  
7 forward? And we need data, so we need this system  
8 to help provide us data that will evaluate this  
9 process. So we need text, but we also need a whole  
10 lot of data that comes into our system from this.

11 In the community-based services, we need to  
12 focus on some of the integration across broad  
13 community spectrums of care. For the sake of time,  
14 again I'm going to move forward. Integration is a  
15 big issue. We need integrated services on both of  
16 our inpatient and outpatient. On the data side, I  
17 can't emphasize enough how we are currently using  
18 our more rudimentary mental record service, EMR  
19 services, to begin to collect data about our  
20 population. We have a huge population of people,  
21 and we need to use the data that we can get to tell  
22 us how we're doing and to tell us about the  
23 quality. So Hao mentioned, for example, our shaped  
24 meds project. We have a project that is a clinical  
25 tool across all inpatient and outpatient services

1 that looks at people that are antipsychotic  
2 medications and ask our providers to answer  
3 electronically a set of questions about how that  
4 choice was made, whether or not they're on more  
5 than one antipsychotic, whether they've thought of  
6 better, more healthy medical antipsychotic choices,  
7 whether they've thought about the use of Clozaril.  
8 That data, once we get it, will be able to help us  
9 understand how we're prescribing. We have a lot of  
10 handicaps. We don't have a good database in our  
11 outpatient services around who is taking what  
12 medications. In some places we have, essentially,  
13 no database, so we're kind of using this shaped  
14 meds to create a database. It's kind of the proxy  
15 for a database, so we're having to identify if  
16 patients are on antipsychotics and then do the  
17 shaped meds. If we easily add a database around  
18 medications in our outpatient services, we would be  
19 starting at a much higher level. Inpatient, that's  
20 not a problem, obviously. We have other quality  
21 improvement projects, psyches, Hao mentioned, but  
22 we are moving forward a project at a time, and we  
23 are continuing to now with clinical care, quality  
24 implementations in the electronic medical  
25 environment that we currently have, those things we

1           need to try to incorporate into what we have as we  
2           move forward. We have a huge discrepancy across  
3           the facility regarding technical sophistication, so  
4           we have some facilities that have already created  
5           some incredibly brilliant interfaces with high  
6           utility and with a lot of user friendliness, and  
7           the users like them. We're going to need to try to  
8           see how we can take those advances into account.  
9           We have other facilities where that has not been a  
10          priority, and they're just looking for something to  
11          come in and create an environment for them. So we  
12          need to try to maintain individual facility gains  
13          as much as possible. We have got to attract our  
14          physicians and our clinical leaders, our nurses.  
15          We've got to try to find something that is going to  
16          be efficient for them over time. I know that,  
17          initially, it's not going to be efficient, no  
18          implementation is, but it should quickly be  
19          efficient, and it should hold the promise for  
20          efficiency for our clinicians in order to be  
21          something that they see as likeable.

22                   And, finally, I would talk about this is --  
23          you know, it's really a co-mutual process. There  
24          is no degree to which for this particular track we  
25          would be able to tell you exactly what the end

1 product is going to look like in every detail. We  
2 have collated a huge amount of clinical  
3 requirements across our system, it's in the RFP,  
4 but we also are going to need to have a process  
5 that, as we go on to the ground, we sort of find  
6 out, learn, modify, you know, and create and  
7 innovate at each one of the particular facility  
8 implementations. I think you'll find strong  
9 clinical leaders that will be in an active part of  
10 that process. We're looking to collaborate with  
11 clinical and informatic expertise in our vendor to  
12 make that process doable.

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

20 MR. ENGEL: Hi, thank you. Thanks,  
21 Greg. I'd have to say that in terms of the EMR  
22 environment and the behavioral health sides, Greg  
23 has the much more difficult side of the job, so I'm  
24 glad --

25 THE STENOGRAPHER: Could you use the

1 microphone, please?

2 MR. ENGEL: Oh, sure. Sorry, I tend  
3 to move around a lot. What are the OMH EMR  
4 clinical goals? Some of these are obvious:  
5 Enhanced communication, monitoring of care, reduce  
6 adverse stroke events, reduce medical errors,  
7 reduce or eliminate unfit or unnecessary test or  
8 tests, eliminate redundancies, increase clinician  
9 efficiencies in medication administration and  
10 monitoring processes, documentation and  
11 communication, replacing legacy systems, and the  
12 bottom line sums it up, as Dr. Wang talked about,  
13 is the Vista the VA environment. Basically, our  
14 goals are to increase the quality of care while, at  
15 the same time, reducing costs of providing care and  
16 leveraging technology to do so.

17 Current clinical systems, which you will be  
18 seeing throughout the two days, which there will be  
19 much more detail concerning those systems, and this  
20 is really an overview of how they kind of fit  
21 together in our current environment. We've got the  
22 pharmacy, the lab system, the dental, infection  
23 control, our Mental Health Automated Record System,  
24 or MHARS, and PSYCKES.

25 (Discussion was held off the record.)

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

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

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

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

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

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

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

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

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

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

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

21 Some other reports. Obviously, we have  
22 to report communicable diseases to the Department  
23 of Health, and the system allows us to generate  
24 reports for reporting purposes.

25 I'm going to jump a little bit into our

1 pharmacy system, and again this will be gone over  
2 in much more depth, I believe, tomorrow afternoon.  
3 Meds Manager, multi-facility, decision supported  
4 order entry, allergy drug interaction screening,  
5 clinical drug utilization reports, it's really big  
6 global administrative functions, browsed capacity  
7 for non-pharmacy clinicians which allows, for  
8 instance, nurses, physicians, others, non-pharmacy  
9 people, to have access to the system for looking up  
10 data. Our lab data, we went over.

11 Outpatient functionality is another  
12 important point. Our pharmacy system is a  
13 hospital-based system, but we also do supply  
14 medications for our affiliated clinics in an  
15 outpatient environment. We supply discharge  
16 medications for some of our inpatients. We supply  
17 a number of outpatient prescriptions. So our  
18 system, which where Vista differs a little bit from  
19 that is that we not only are operating in a  
20 hospital environment, but we also have a clinic  
21 environment where there are different regulations  
22 required.

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

25 Clinical decision support. Rather than at

1 the CPOE function, really, the first clinical  
2 decision support that happens in our current  
3 medication administration system is at the  
4 pharmacy. As these drugs are put in, if there are  
5 alerts, allergy checks, drug interactions, and so  
6 forth, these are done at that point. If there is a  
7 therapeutic intervention that is done at this  
8 point, this is also recorded electronically so that  
9 we have that functionality, as well. Numerous  
10 reports, literally in the hundreds, that we can  
11 generate both canned reports and custom reports  
12 through our current system. Many of these would  
13 obviously need to have some continuation as we move  
14 into another system.

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

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

10 Again, you know, we've got a number of  
11 reports that we utilize on a daily, monthly,  
12 weekly, annual basis that would have to be  
13 included. Meds Manager is used in all of our 25  
14 OMH facilities. We are currently using version  
15 8.1. We have been using some version of this  
16 system since 2000. And, actually, we've got an  
17 older system, a legacy system, that we still have  
18 data available from, even prior to 2000. That  
19 data, as we discussed, is put into the Meds Manager  
20 system, and we've got a history database, as well.

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

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

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

19 Basically, we've included in here education  
20 and training health care workers, obviously, and  
21 employee health is also -- and not only for our  
22 patients, but also our infection control system  
23 also has the technology available to monitor  
24 employee health issues, whether they be  
25 vaccinations or other areas.

1                   Infection control. A nurse at each  
2                   facility manages the infection control program, you  
3                   know, basically, some of their functions. And  
4                   this, really -- you know, I'm looking, really, at  
5                   track one in the RFP, and what are -- you know,  
6                   what are some of our needs that we don't currently  
7                   have? CPOE, computerized prescriber order entry  
8                   with clinical decision support capability; nursing  
9                   bar code medication administration which we  
10                  currently do not have; provide E-prescribing  
11                  capabilities at OMH hospitals and outpatient  
12                  clinics, and that's really a key piece, as well.  
13                  Not only are we looking at being able to fill  
14                  prescriptions for our clinic patients, but,  
15                  basically, there is New York State and federal  
16                  initiatives that are really kind of forcing our  
17                  hand in a good way to really go to E-prescribing  
18                  using numerous different interfaces, but,  
19                  basically, most prescriptions, or many  
20                  prescriptions, now have the capability of being  
21                  electronically prescribed through the doctor's  
22                  office through CPOE and transmitted electronically  
23                  to the pharmacy so that the patient doesn't even  
24                  have to carry the prescription with them.

25                   And one of our other challenges is

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

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

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

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

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

21 (Discussion was held off the record.)

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

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

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

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

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

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

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

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

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

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

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

6 Basically, DB6.net or CSharp.net is our  
7 programming choice for around here. As I say,  
8 MHARS does contain -- and, again, that's one of the  
9 targets to be replaced -- VB6 and the VB6.net  
10 combination, okay?

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

25 We do have Share Point, Microsoft Share

1 Point, at the team site. Again, this is a new  
2 effort at OMH, so we would want you to work with us  
3 to use Share Point to do this collaborative effort.  
4 And as you can see, we do have some people on video  
5 here. This is probably the largest mixture of  
6 people that have come to together to work here at  
7 OMH in a long time, and e-mail I don't think is  
8 going to work too well. Personality parts kind of  
9 get lost in that; however, the more documentation  
10 you put up and the more you can use video  
11 conferencing or I think we even talked about using  
12 Skype at one point, but some sort of that  
13 interactive stuff for that Agile development within  
14 the team building that has to go on here I think is  
15 going to be a good deal.

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

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

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

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

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

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

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

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

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

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

6 So we are using a team foundation server  
7 already in some of our applications in this Agile  
8 process moving forward. Team Foundation Server  
9 Version 11, by rumor, is supposed to be ready by  
10 2012. All my staff likes to keep pushing forward  
11 on the software upgrades from Microsoft as they  
12 become available. There's, generally, newer and  
13 better things, and, if not, if something didn't  
14 work, it probably works better in the next release,  
15 anyways.

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

1 the time this starts.

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

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

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

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

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

1           And sustainability, as we said, this is a  
2 five-year project. In the bid it talks about this  
3 second phase, this extra five years that's on the  
4 outside. Make no mistake about it, this is a long  
5 term commitment for OMH, okay, both from an IT and  
6 from a functional standpoint for our users. If  
7 anybody looks, and EMR takes years to develop, so  
8 we've been at it since 1980 at different, various  
9 parts. We've built on, you know, our pharmacy  
10 system in the '90s; we built on a lab system around  
11 2000; there's been various other systems that have  
12 been kind of built on top of this pyramid. So it's  
13 a long term effort, and this is going to take a big  
14 core of that and just replace it. So when you do  
15 something like that, it's not like you're going to  
16 take it out two years from now because you don't  
17 like what you're doing. So sustainability has to  
18 be accurate. You have to keep moving forward, and  
19 whoever takes this over -- because if you look at  
20 most of us, we're not young in this deal. So, you  
21 know, over the next 10 years our faces are going to  
22 be changing. This project doesn't change. It has  
23 to continue on.

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

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

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

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

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

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

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

5                     Okay, tomorrow -- as Gerry said, you've had  
6           quite a few slides about the existing system.

7           Tomorrow, you're in for a treat, okay? So bring  
8           your caffeine with you because it will be a tough  
9           hoe to go. But all of these people, Pete Carroll,  
10          who is the Manager of Patient Systems; Mark Scalzo,  
11          who is our business processing and user support;  
12          James Smith is one of our technical people who  
13          spent a lot of time recently with Vista and Cache  
14          just getting us up to speed on; Kay is our pharmacy  
15          lead, very important because we're swapping out our  
16          pharmacy system for Vista; Ginny is our laboratory  
17          lead with Cerner, which is an application that is  
18          staying with us. We do like that software very  
19          much. And then Ginny and James, together, will  
20          collaborate on the data interfaces that are  
21          numerous within the RFP. If you looked at the  
22          diagrams, going back and forth in there, we keep  
23          these two tracks moving and our own systems in  
24          place. We have data going all over the place, so  
25          we want to have our own little team of people to

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

8 MR. RUBIN: Yes.

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

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

25 (Discussion was held off the record.)

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

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

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

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

25                         And here's the promise. The promise is

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

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

18 (A brief recess was taken.)

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

1 stenographer can keep up.

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

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

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

1 entry, the bar-code medication administration,  
2 replacing Meds Manager with the Vista pharmacy  
3 module, and I guess the CPRS module, as needed, as  
4 a foundation for the other modules that we want to  
5 implement, in order for them to function.

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

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

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

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

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

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

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

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

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

1           Contract boilerplates, the legalese that  
2           are required, provisions.

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

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

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

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

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

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

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

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

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

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

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

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

25 So the scope of the project can be

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

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

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

15 In track one, base Vista is going into our  
16 25 OMH facilities. In track two, MHARS is gone.  
17 The OMH Vista supplies the ADT feed, interfaces  
18 with our patient systems. A more extensive list of  
19 functionality we expect to implement. Some of it  
20 you may already have available. Some of it will  
21 need to be developed, as you go. There is a wider  
22 audience of end-users, too. So in addition to the  
23 inpatient facilities, each one of them has a number  
24 of outpatient locations. So you can see it's a  
25 much larger effort in terms of size and scope.

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

5 (Discussion was held off the record.)

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

25 And throughout all of this effort we have

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

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

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

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

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

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

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

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

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

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

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

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

1 mandatory package.

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

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

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

23 (Discussion was held off the record.)

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

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

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

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

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

25 Now the evaluation process consists of six

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

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

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

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

1 manager, your pharmaceutical expert and your  
2 business analysis.

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

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

17 Evaluation level 3 is where we begin to  
18 start scoring your evaluation. Evaluation 3 --  
19 well, I should say the technical proposal consists  
20 of three components, which will be scored and  
21 evaluated separately. During level 3, evaluation  
22 3, OMH will evaluate two out of three technical  
23 proposal requirements. The first is assigned 40  
24 out of the total 70 points for the technical  
25 proposal. Bidders must obtain a minimum score of

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

3 So what do these 40 points consist of?

4 Well, there are four separate parts. The first  
5 part is a bidder's description of its approach and  
6 methodologies to carry out the 56 deliverables set  
7 forth in RFP section 4. This part is assigned a  
8 maximum of 15 points, and I believe that's section  
9 4.11, right, Joel?

10 MR. RUBIN: It sounds good.

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

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

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

6 MR. RUBIN: Yeah.

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

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

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

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

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

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

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

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

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

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

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

15 Now, the subset that you will be performing  
16 will be 200 plus functions of the 600 plus core  
17 functions in the requirements traceability matrix.  
18 So your live on-site demo, which comes into this  
19 building to perform, is comprised of four separate  
20 parts. The first is an inpatient demo, a  
21 demonstration of your inpatient system, of about  
22 215 functions including tasks such as admission.  
23 Joel?

24 MR. RUBIN: Yeah.

25 MR. MILSTEIN: Can you just --

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

3 MR. MILSTEIN: They're admission?

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

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

18 MR. MILSTEIN: Okay, and then part of  
19 your on-site demonstration, again the second  
20 component -- as I mentioned, there's four separate  
21 parts to your on-site demonstration -- will be a  
22 demonstration of your outpatient system, and there  
23 are about 100 functions that are listed there.  
24 Joel, can you shoot down to that, please? There is  
25 108?

1 MR. RUBIN: Yeah.

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

10 MR. RUBIN: Fifty-two.

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

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

21 (Discussion was held off the record.)

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

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

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

12 MR. MILSTEIN: Fourteen.

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

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

25 MR. GUILLES: Will that be nine hours

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

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

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

10 Now note, the 50 -- the price, as provided  
11 for your fixed price to carry out those  
12 deliverables is not subject to increase,  
13 irrespective as to the length of time it takes the  
14 contractor to carry out those 56 fixed-price  
15 deliverables. Again, the fixed-price bid is worth  
16 25 points.

17 Now, the second component of the financial  
18 proposal is your hourly-rate bid which is worth a  
19 maximum of five points. Your hourly-rate bid is  
20 the flat-rate-per-hour price for the contractor to  
21 carry out enhancements. What are enhancements?  
22 Well, they consist of additional deliverables  
23 beyond the 56 set forth in the RFP and, also  
24 functionality, additional functionality beyond the  
25 600 plus core functions identified in your

1 requirements traceability matrix in Exhibit 17.

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

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

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

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

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

1 minority vendors, eight percent for woman vendors.  
2 This means that 20 percent of all expenditures for  
3 the EMR project are to be made certified vendors.  
4 So all bidders are required to submit with their  
5 bid proposal what's called an "MWBE Utilization  
6 Plan" which shows the minority and women vendors  
7 which will be used as subcontractors during the  
8 project and the anticipated amount of spenders to  
9 each MWBE vendor. MWBEs are listed in the  
10 directory retained by the Empire State Development  
11 Corporation. We will refer you to the website out  
12 to that ESBC. Make sure you do partner up with  
13 minority groups and women-owned businesses and  
14 attempt to achieve that 20 percent. In the event  
15 you're unable to achieve that 20 percent goal, you  
16 can submit a waiver requesting lower goals,  
17 provided that you show that you've made a good  
18 faith effort to achieve the 20 percent goal. The  
19 good faith effort requirements are identified and  
20 defined in the MWBE regulations, which you can  
21 obtain off of the Empire State Development  
22 Corporation's website. I highly recommend that you  
23 read those good faith effort requirements. So for  
24 instance, if after you make a good faith effort you  
25 realize that you are unable to meet the 20 percent

1 goal, you can submit a waiver. The waiver, for  
2 example, might say that you'll be able to achieve  
3 10 percent for minority businesses and six percent  
4 for women-owned businesses for a total of 16  
5 percent, and then there is a review process that  
6 OMH will go through and determine whether you've  
7 basically made a good effort to achieve your MWBE  
8 goals.

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

12 MR. RUBIN: Thank you, David. I did  
13 want to point out that last point David made.  
14 We've attached and updated event dates, what we've  
15 updated on these event dates. They've been  
16 updated. We removed something earlier that stated  
17 the MWBE forms were due --

18 MS. LONG: Two days after --

19 MR. RUBIN: -- after the contract  
20 award. We've removed that. The RFP makes it  
21 clear, they are actually due with the bid and not  
22 only by the vendor.

23 This is Sheila Long, another member of the  
24 RFP work group. She's a contract management  
25 specialist 3 with OMH, and she's here to talk about

1 the bid proposal submission requirements.

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

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

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

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

19 Another key point, the bids do not come to  
20 this building. The pre-bidder's conference is  
21 here, your demonstrations are going to be here, but  
22 the proposals, themselves, go to our consolidated  
23 business office which is around the block from here  
24 in the Capital District Psychiatric Center, right  
25 next store to Albany Med. So it's very, very

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

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

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

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

18 Try not to do any deviations from the bid,  
19 extraneous terms, etcetera, because it may DQ your  
20 bid as being non-responsive. Those are the types  
21 of things that you should bring up as part of your  
22 questions to us in a written question. If you have  
23 any concerns about those terms, please bring them  
24 up during that question format, and we'll do our  
25 best. Don't wait until you're submitting your bid

1 to tell us that you're taking exception to an RFP  
2 term because, chances are, we're going to view it  
3 as being non-responsive.

4 It's very important for everybody to  
5 realize that we are currently in the New York State  
6 Procurement Lobby Act guidelines. We're in a  
7 restricted period. There are only three people  
8 named as appropriate people to communicate for this  
9 bid. That's Scott Derby, myself and Joel Rubin.  
10 Our preferred source to get information has been,  
11 and remains, in writing to that EMR RFP mailbox.  
12 We are monitoring that several times a day. We're  
13 constantly in it. So it's very important to note  
14 that that's the form of communication. There is  
15 paperwork that you're being given today that lists  
16 a lot of other people's names. We're going to be  
17 posting this whole pre-bidder conference. It's all  
18 going to be out there. It's incorporated into the  
19 RFP. You're going to see a lot of other names.  
20 Please do not attempt to contact them, and we don't  
21 only mean contact via the work environment, but  
22 linked in, etcetera. Please, we really want to --  
23 we don't want to delay our agency to be able to  
24 make an award over inappropriate contact.

25 The technical proposal. Basically, we want

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1 the original and we want it to be unbound. The  
2 reason for that is if we do have to make additional  
3 copies, we can make additional copies here. It's a  
4 lot easier with an unbound. We then want one bound  
5 copy. We also want two electronics. That would be  
6 on a USB flash drive. We've provided template  
7 labels. Label everything. Please also review  
8 section 7.4.1, as far as adhering to page limits  
9 and all the different topics that are defined for  
10 what goes into each section. For instance, the  
11 executive summary, it may say discuss item A, item  
12 B, item C. Make sure have you address item A, item  
13 B, item C, because you can end up losing a lot of  
14 points if you don't.

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

23 MR. RUBIN: Yup.

24 MS. LONG: -- which is all of this.

25 So you have the original Attachment O, plus the

1 backup behind it is going to be in a sealed  
2 envelope. Then we're also going to have one clone  
3 copy of that, okay? That goes in together in one  
4 envelope. Then you're going to have a second  
5 envelope which is going to have all the forms;  
6 consultant disclosure forms, procurement lobbying  
7 forms. Anything that we listed that's on this  
8 checklist now for the financial is going to go in a  
9 separate envelope. The reason for that is we're  
10 not going to look at the financials; we can look at  
11 what's in that second envelope to see what forms  
12 are there. If one happens to be missing, we may be  
13 able to call and say we found Attachment A missing,  
14 we'll give you, maybe, 24 hours to provide it.  
15 But, in theory, we don't need to do that. We can  
16 DQ you as being non-responsive if those forms are  
17 missing. We want to jump on this, so we really  
18 want to make sure that everybody is submitting at  
19 the time of submission everything that is needed.

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

1 together. Again, please use the template labels  
2 that we've provided in the RFP, as making sure that  
3 it's got the contract number on it, as well as your  
4 company name, just in case, we have two people  
5 opening envelopes, flash drives go flying on the  
6 floor, what are they and who do they belong to,  
7 okay?

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

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

1 updates out there. One was posting the times, once  
2 we knew the time for this conference, for instance.  
3 We still see some questions that come through the  
4 EMR, and we know that we've been posting some of  
5 this stuff up there. So please, please make sure  
6 you go out there and look at that frequently.  
7 That's going to be our main form of communication  
8 is updating when we can.

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

1 of the RFP.

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

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

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

25 MS. LONG: Yes, we have a transcriber.

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

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

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

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

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

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

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

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

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

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

24 MS. LONG: Well, first of all, that  
25 would be a good question for you to put in writing

1 because I would like to be able to post that.

2 David, would you like to answer that or we can --

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

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

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

20 MR. CAMPBELL: My name is Kyle  
21 Campbell. I'm with TIAG. Joel, when he was  
22 talking, he was referring to the vendors as the  
23 firm. And on slide 90, it addresses using some of  
24 the qualifications from the subs as representative  
25 of the firm or the team to go along with the whole

1 proposal. David, when he was talking, was  
2 referring as the bidder, and he said only the  
3 bidder could have the qualifications. Does that  
4 mean that the subs cannot put their "quals" in, or  
5 does that mean that the terminology of bidder and  
6 firm are the same, it's the team of the multiple  
7 vendors that make up that team or that firm or that  
8 bid?

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

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

20 MS. LONG: The answer to that is yes.

21 MS. CLARK: Deanne Clark from DSS.  
22 I'm wondering if there's a mechanism for  
23 alternative solutioning, ideas that might be  
24 different than what was laid out, but are options,  
25 you know, how that response would be structured or

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

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

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

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

14 MS. CLARK: Yeah.

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

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

25 MS. LONG: No. Somebody over here had

1 a --

2 MR. RUBIN: Did someone have a hand  
3 up?

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

6 MR. RUBIN: Is that everyone?

7 MS. LONG: I think so.

8 MR. RUBIN: Okay, I guess this  
9 concludes day one of the pre-bid conference. See  
10 you all back here tomorrow. Registration is at  
11 8:30. We'll start fresh at 9:00 tomorrow. Thank  
12 you.

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## C E R T I F I C A T E

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

Kyle Alexy

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Kyle Alexy

DATE: February 24, 2012

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