AGENDA

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE
BOARD OF DIRECTORS

Meeting Date: April 19, 2012
Time: 2:30 PM
Location: 125 Worth Street, Room 532

CALL TO ORDER — **DR. STOCKER**

ADOPTION OF MINUTES
-March 22, 2012

CHIEF MEDICAL OFFICER REPORT — **DR. WILSON**

METROPLUS HEALTH PLAN — **DR. SAPERSTEIN**

INFORMATIONAL ITEMS:

1. Supply Chain Management Technology Transformation — **MR. RAMLAKHAN/ MR. QUINONES**
2. Meaningful Use Update — **DR. CAPPONI**

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

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NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

MINUTES

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE BOARD OF DIRECTORS

Meeting Date: March 22, 2012

ATTENDEES

COMMITTEE MEMBERS:

Michael A. Stocker, MD, Chairman
Alan D. Aviles
Josephine Bolus, RN
Isaac Weisfuse, MD (representing Thomas A. Farley, MD)

HHC CENTRAL OFFICE STAFF:

Deborah Cates, Chief of Staff, Board Affairs
Louis Capponi, MD, Chief Medical Informatics Officer
Diane Conyers, Corporate Risk Manager
Juliet Gaengan, Senior Director, Clinical Affairs
Erin Hughes, Director, Media Relations
Caroline Jacobs, Senior Vice President, Safety & Human Development
Lauren Johnston, Senior Assistant Vice President/Chief Nursing Officer, Patient Centered Care
Irene Kaufmann, Senior Assistant Vice President, Community Physician Services
Mei Kong, Assistant Vice President, Patient Safety
Robert Kurtz, MD, Senior Clinical Advisor to Chief Medical Officer
Patricia Lockhart, Secretary to the Corporation
Ronald Low, MD, Senior Director, Office of Statistics and Data Analysis
Tamiru Mammo, Deputy Chief of Staff, Office of the President
Ana Marengo, Senior Vice President, Corporate Communication & Marketing
Susan Meehan, Assistant Vice President, Medical & Professional Affairs
John Morley, MD, Deputy Chief Medical Officer
Bert Robles, Senior Vice President, Information Technology/Corporate Chief Information Officer
Salvatore Russo, General Counsel, Legal Affairs
David Stevens, MD, Senior Director, Health Care Improvement
Steven Van Schultz, Director, Office of Internal Audits
Katie Walker, Assistant Vice President, Institute for Medical Simulation & Advanced Learning
Manasses Williams, Assistant Vice President, Affirmative Action/EEO
Ross Wilson, MD, Senior Vice President/Corporate Chief Medical Officer, Medical & Professional Affairs

FACILITY STAFF:

Machelle Allen, Interim Medical Director, Bellevue Hospital Center
Chris Constantino, MD, Executive Director, Elmhurst Hospital Center
Lynda D. Curtis, Senior Vice President, South Manhattan Network
Elizabeth Gerdts, Chief Nurse Executive, North Central Bronx Hospital
Iris Jimenez-Hernandez, Senior Vice President, Generations +/Northern Manhattan Network
Paulette McCullogh, Chief Nurse Executive, Renaissance Health Care Network Diagnostic & Treatment Center
George Proctor, Senior Vice President, Central & Northern Brooklyn Network
Arnold Saperstein, Executive Director, MetroPlus Health Plan, Inc.
Joseph Skarzynski, MD, Medical Director, North Bronx Healthcare Network
Arthur Wagner, Senior Vice President, Southern Brooklyn/SI Network
William Walsh, Senior Vice President, North Bronx Healthcare Network
Meryl Weinberg, Executive Director, Metropolitan Hospital Center
Reba Williams, Medical Director, Renaissance Health Care Network Diagnostic & Treatment Center
Julius Wool, Executive Director, Queens Hospital Center

OTHERS PRESENT:

Melissa Dubowski, Analyst, Office of Management and Budget
Scott Hill, Account Executive, QuadraMed Corp.
Richard McIntyre, Key Account Executive, Siemens
Megan Meagher, Analyst, Office of Management & Budget
Frank Proscia, MD, Doctor's Council

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE Thursday, March 22, 2012

Michael A. Stocker, MD, Chairman of the Board, called the meeting to order at 2:32 P.M. The minutes of the February 29, 2012 Medical & Professional Affairs/IT Committee meeting were adopted.

CHIEF MEDICAL OFFICER REPORT:

Ross Wilson, MD, Senior Vice President/Corporate Chief Medical Officer reported on the following initiatives:

1. Health Home Implementation Update

The process for COBRA and CIDP transition into HHC Health Home has been designed in collaboration with current providers and Office of Ambulatory Care Transformation; with identified capacity to absorb most of the initial group of Health Home patients with existing staff. At this time, NYSDOH focus and priority for Health Home roll-out is on the highest acuity patients with outreach services projected to begin sometime in April with small targeted groups of patients in the Brooklyn and the Bronx. We await the State's response to our application for Health Home designation in Manhattan and Queens.

2. Comprehensive Care Plan Information System

A Request for Proposals (RFP) was recently released to seek vendors to develop a comprehensive interoperable Care Planning System that would facilitate viewing and documentation access to all providers of a patients' care team, including those in and outside HHC. The system would provide a vehicle for capturing patients care needs and self-management goals, as well as the care teams activities and interventions supporting the patient's ability to meet those goals. In addition the system will support patient tracking, consent management and medical flags, triggers and alerts. The Care Plan Management System will be regarded as a component of the medical record with plans for creating bi-directional interfaces to the electronic health record (HER).

3. Panel Management System (PAMS)

PAMS was built by ICIS and designed to assist Patient Centered Medical Home (PCMH) practices to establish and maintain the integrity of physician panels, has been deployed to all PCMH sites. Training of PCMH practices on the use and application of the system has been completed, and all sites are currently using PAMS to reconcile physician panels and ensure that patients are accurately and reliably assigned to their physician panel.

4. HHC Connectx

Excellent progress continues. Currently there are 3,700 community providers using HHCAdvantage, HHC's web-based referral management system; 75% of referrals from community practices and organizations are being received on-line and managed by HHC Connectx Referral Services staff at each of our facilities. Use of HHCAdvantage has facilitated the exchange of patient referrals and consultation requests from community providers to HHC facilities in a secure HIE environment and has provided a tool for the safe and efficient management, processing, tracking and completion referral requests.

Dr. Stocker inquired as to whether the community physicians (non-HHC affiliated) with MetroPlus are connected with the HHC Connectx system. Dr. Saperstein responded that most of their physicians are connected to the HHC Connectx system to ensure continuity of care. Dr. Stocker further inquired as to what percentage of the MetroPlus community physicians are looped into the Connectx system. Dr. Saperstein responded that they have a total of 13,000 providers, so about one third of total providers are connected. In general if a patient is being seen by an HHC provider the inpatient admissions to HHC are about 80% for that group of member. For the community providers it was 60% at last look – but 55-60% of readmissions at last look are coming back from community referrals.

In the orientation and contracting process, they must commit to an HHC facility – once a quarter we review – and have terminated doctors as they did not meet in network referrals.

In general if a patient is being cared for by a primary care perspective from an HHC provider the inpatient admissions into HHC are about 80% for that group of members.

5. UHF Conference: İnnovations in Health Service Delivery

On March 1, 2012, HHC participated in the above conference that was facilitated by the United Hospital Fund (UHF) with sessions from the perspectives of health plan and then delivery systems. The keynote address was delivered by Dr. Don Berwick, past Administrator of Centers for Medicare and Medicaid.

6. Clinical Ethics Committees

With expert assistance from Ms. Nancy Dubler, there is further strengthening of the clinical ethics consultation service at each of our facilities. The Clinical Ethics Council is made up of the chairs of each of the facility committees, and this Council is guiding the ongoing education and training of their members and overseeing the peer review of the quality of the consultations being performed. This is a vital service to assist in timely resolution of clinical decision making, often at the end of life, to reduce suffering or anguish for patients and their families.

METROPLUS HEALTH PLAN, INC.

Dr. Arnold Saperstein, Executive Director, MetroPlus Health Plan, Inc. presented to the Committee.
Dr. Saperstein informed the Committee that the total plan enrollment as of March 1, 2012 was 425,439. Breakdown of plan enrollment by line of business is as follows:

Medicaid	356,923
Child Health Plus	17,823
Family Health Plus	36,265
MetroPlus Gold	3,089
Partnership in Care (HIV/SNP)	5,693
Medicare	5,646

Dr. Saperstein provided the Committee with reports of members disenrolled from MetroPlus due to transfer to other health plans, as well as a report of new members transferred to MetroPlus from other plans. In addition, he provided a graph showing net transfers for the month of February 2012 for Medicaid and Family Health Plus (FHP). Dr. Saperstein informed the Committee that over the last year, 5,662 members left MetroPlus to go to Health First. He conducted a collaborative study with Maxine Katz, Senior Assistant Vice President, Revenue Management, to ascertain how many of the members stayed at HHC. The last time this

study was conducted it showed that 19% remained at HHC – the preliminary number for the most current year is 20.8% - therefore 80% of the population that leaves MetroPlus goes to Health First and does leave the HHC system. Committee members inquired as to whether these patients leave HHC due to access issues. Dr. Saperstein stated that in the past, access was not noted as an issue, that those members wanted to see a doctor outside of HHC. Dr. Saperstein will try to survey the members that recently left to ascertain the reason (s).

Dr. Saperstein provided the Committee with the new population carve in timeline from the Medicaid Redesign Teams Managed Care Benefit and Population Expansion. This report summarizes all of the current fee for service populations that are being carved into Medicaid managed care programs in the next nine months. Below are brief summaries of these populations, which are all effective April 1, 2012:

- *Individuals with End Stage Renal Disease (ESRD)*: Recipients with ESRD will no longer be exempt from enrolling in a Medicaid managed care plan. Current Medicaid recipients with ESRD will have 30 days to choose a Medicaid managed care plan. Anyone who fails to choose a plan within 30 days will be automatically assigned to a plan.
- *Homeless individuals***:** Where identifiable, SDOH will make an effort to target families with children prior to enrolling single individuals and childless couples. Individuals who are living on the street will be targeted last to allow sufficient time to educate this harder to locate population.
- *Individuals receiving services through the Chronic Illness Demonstration Program (CIDP)***:** CIDP providers will be assisting recipients in choosing a health plan that includes the providers that the individual is currently seeing.
- *Infants born under 1200 grams or disabled under 6 months of age:* Infants born on or after April 1, 2012 with a birth weight of less than 1200 grams and infants under six months of age who are disabled will no longer be excluded from enrolling in a Medicaid managed care plan. Infants born prior to April 1st that are already enrolled in fee-for-service will remain in fee-for-service until they are six months old, at which time their guardians will be required to choose a plan.
- *Individuals with characteristics and needs similar to those receiving services through an Long Term Home Health Care Program (LTHHCP), Care at Home (CAH) program, Traumatic Brain Injury (TBI) program, Nursing Home Transition and Diversion (NHTD) waiver program and the Intermediate Care Facilities for the developmentally disabled program (ICF/DD):* Beginning in April 2012, the state will begin to enroll individuals who "look like" participants in the LTHHCP waiver program and are not currently enrolled in the program.

There are additional benefits and populations that are being carved into Medicaid managed care, and those include:

- *Dental:* Effective July 1, 2012 plans will be responsible for dental benefits.
- *Skilled Nursing Facility services:* Effective October, 2012 plans will provide benefits for residents of residential health care facilities – nursing homes.
- *Early Intervention services:* Effective January 1, 2013, plans will provide benefits for individuals in the Long Term Home Health Care Program. These individuals will have the ability to opt out of mainstream managed care and enroll in the managed long term care program.
- *Consumer Directed Personal Assistance Program (CDPAP):* This program is designed for elderly or disabled residents that require and are eligible to receive home care, personal care or skilled nursing services and wish to maintain control over whom provides these services. SDOH just informed plans that this change was postponed for the time being.

The U.S. Centers for Medicare and Medicaid Services (CMS) has informed the Plan that they will perform a financial audit for contract year 2010. MetroPlus, within the last year, completed a successful audit for 2008 in which the auditors reported no material findings and three minor observations, all related to true out-of-pocket costs (TrOOP) that should not occur again since CMS has now automated these TrOOP processes.

CMS has not yet provided a start date for the audit. The 2008 audit took about six months for the auditors to complete.

The New York State Department of Health (SDOH) issued a revised date for requiring dual-eligible individuals, 21 and older, who need more than 120 days of non-institutional long term care services to enroll into a managed long term care (MLTC) plan. The implementation date, originally scheduled for April 1, 2012, is now July 1, 2012. This revised schedule is subject to receiving approval from CMS.

The SDOH is requiring that all Medicaid Health Plans transition coverage of dental services into the benefit packages by July 1, 2012. MetroPlus has been engaged in a Negotiated Acquisition for an appropriate vendor to cover our dental benefit. Two vendors pre-qualified, DentaQuest, MetroPlus' current vendor, and Healthplex. Both vendors were carefully reviewed and Healthplex was chosen as the vendor. The annual estimated costs will be approximately $56 million for dental services and up to $5 million for administrative costs. This contract was approved by the MetroPlus Finance Committee in February and MetroPlus Board on March 13th. It is being presented today to the HHC Board of Directors for approval.

CHIEF INFORMATION OFFICER REPORT:

Bert Robles, Chief Information Officer provided the Committee with an update on the Networking Infrastructure Refresh Program. In February 2011 the Board of Directors approved a capital spend of $25.3 million for a network infrastructure refresh program. This funding was to be used to upgrade and maintain Phase I of a five (5) year network infrastructure refresh program which will assist the Corporation in accommodating application growth, increasing bandwidth for faster application response times and maintaining stability.

The components of this upgrade include (but are not limited to) routers, switches, wireless access points, IPT phones, network cabling and uninterrupted power supplies. All of these networking components interconnect together allowing hospital Local Area Networks (LAN) the ability to share various different business, clinical and data applications over the Wide Area Network (WAN) both within HHC and over the Internet.

Applications such as Quadramed (QCPR), Siemens (Unity) and the Corporate messaging system (GroupWise email) would not be able to function unless these networking components are functioning and in place. This infrastructure upgrade is also required in order for the Corporation to communicate with our patients and business partners. In addition, this hardware is required to support new technologies for such initiatives as a new clinical Electronic Medical Record (EMR) and payroll/ time keeping systems. These systems and several others all require a robust data communication system in order to operate efficiently.

As of today, Enterprise Information Technology Services (EITS) has encumbered $12.1 million and has another $7.9 million of pending purchases orders associated with this upgrade. EITS is on track to use remaining balance by the end of Fiscal Year 12 and we will be requesting additional funding to start Phase II.

We have completed upgrading the network and wireless infrastructure at Gouverneur Healthcare Services, Queens Hospital Center and Coney Island Hospital. Work is underway at Elmhurst Hospital Center, Lincoln Medical & Mental Health Center, Harlem Hospital Center, Metropolitan Hospital Center, Segundo Ruiz Belvis Diagnostic & Treatment Center, Morrisania Diagnostic & Treatment Center, Woodhull Medical & Mental Health Center and Cumberland Diagnostic & Treatment Center. EITS projects that by the end of Calendar Year 2012 the upgrade will be completed at all 8 locations.

One factor impacting the progress of this project has been the readiness of the environmentals (power and cooling) at the facilities. We are now taking a joint approach with the Office of Facilities Development (OFD) to engage architectural/engineering resources to address this in a more comprehensive, Corporation-wide way, rather than the site-by-site approach which was not proving to be efficient or effective.

This past winter, the issue of Public CIO which is technology leadership in the public sector publication, there is an article in which two of the IT employees are featured. The article is titled "Duty calls: Balancing Military Service and a Civilian Career Pays Off for These IT Professionals" and features Craig Franklin. Deputy CIO at North Bronx Healthcare Network, who has served in the Air Force Reserve for 23 years and Corey Cush, Assistant Vice President, Infrastructure Services who was an active-duty soldier and has served 22 years in the Army National Guard. Both Mr. Franklin and Mr. Cush are outstanding individuals at HHC who have been able to balance both serving in the military and working at HHC.

INFORMATION ITEMS:

1. Update on Research at HHC

Presenting to the Committee was Ross Wilson, MD, Senior Vice President/Corporate Chief Medical Officer and Christiana Coiro, Director, Office of Research Administration. Ms. Coiro began her presentation by stating why research should be supported at HHC. It is critical to our mission: "*To join with other health workers and with communities in a partnership which will enable each of our institutions to promote and protect health in its fullest sense -- the total physical, mental and social well-being of the people.*" by matching the health services research body of knowledge to the needs of HHC's patients.

Ms. Coiro then presented a snapshot of HHC's research activity to the Committee as follows: 402 protocols approved in 2010; 425 protocols approved in 2011; as of March 9, 2012, 79 protocols were approved; there are active protocols at 10 facilities; and 67 federal grants were received in FY 2011 with total award funding of $6.5 million.

Starting in 2012 for the first time we started coding studies to capture the different types of research being conducted at HHC. The categories are: Chart review and data runs; questionnaires, survey's and interviews; health services research; and clinical trials, interventions, medication intervention and devices. Ms. Coiro shared the January and February 2012 types of studies with the Committee, along with a chart demonstrating the types of research per facility.

Starting in 2010, research has under gone many changes. The HHC research approval process was streamlined, the application was shortened, made certain steps of approval process concurrent, and added a pre-approval step; enhanced research administration office; formed a HHC Research Council comprised of experts throughout HHC to guide the research agenda; contracted with Biomedical Research Alliance of New York (BRANY) to be the Corporate Institutional Review Board (IRB); embarked in a five year partnership with the New York University (NYU) called the NYU-HHC Clinical Translational Science Institute (CTSI) whose focus is on translational research engaging the community in some of the clinical research activities and to train and groom a new generation of clinical and translational researchers. There are eight HHC facilities involved: Bellevue Hospital Center; Coler-Goldwater Specialty Hospital and Nursing Facility; Coney Island Hospital Center; Gouverneur Healthcare Services; Kings County Hospital Center; Lincoln Medical and Mental Health Center; Metropolitan Hospital Center; and Woodhull Medical and Mental Health Center; and received a Agency for Healthcare Research and Quality (AHRQ) grant in 2010 which funded Corporate-wide research conference that was held in October 2010 at Lincoln.

As we move forward we are taking on even more: a strategic research plan was draft with the following goal: "to enhance HHC's infrastructure and processes to support financially sustainable research in collaboration

with regional academic partners, industry and other sponsors, as well as the communities served by HHC facilities; in the process of upgrading the electronic research approval system; strengthening CTSI partnership with NYU; revising the Corporate research operating procedure; developing a public website for research; and enhanced educational offerings.

Ms. Coiro described the following short-term goals that will be achieved over the next one to three years: to develop HHC research infrastructure, with streamlined resources and easy and efficient processes to maximize quantity and quality of research programs; a set of HHC research priority areas based on the priorities and health needs of NYC communities, including identifying opportunities unique and specific to HHC in areas such as health services delivery, cost effectiveness, comparative effectiveness and clinical translational research in collaboration with research stakeholders; community-based and translational research collaborations with academic and community partners; an assessment of barriers to participation in clinical research at HHC sites; a mechanism for dissemination, presentation and publication of results; put in place an evaluation plan to evaluate the impact of the Strategic Research Plan; and develop a mechanism to identify strengths and weaknesses in existing HHC systems and rapidly implement changes to advance the successful implementation of research opportunities.

Ms. Coiro concluded her presentation by describing the long-term goals that will be achieved in years three through five: increased funding to sustain the research infrastructure, creation of research centers of excellence and expertise in specific research areas based on health needs of New Yorkers; the establishment of a human research protections program at HHC and the Association for the Accreditation of Human Research Protection Programs (AAHRPP) accreditation; an evaluation of the impact of HHC research on health outcomes and public health of New Yorkers and patients generally; and a culture that values and maximizes human research subject protection and creates mechanisms to facilitate, monitor and enhance research compliance and human research participant protections.

Dr. Isaac Weisfuse, Deputy Commissioner, NYC Department of Health and Mental Hygiene, inquired as to whether research is conducted at multiple HHC sites and whether the researchers conduct the research on HHC time, and is it grant funded. Ms. Coiro responded that yes, the graph previously displayed included multiple site research. Dr. Wilson responded that there is funded and un-funded research currently occurring at HHC. Un-funded research is whereby residents doing projects that associated with their residency program which are in essence the chart review project Ms. Coiro noted earlier. On the funded research side, part of the researcher's time is funded, but there are multiple difficulties such as how we track and monitor their time especially when they already have a full-time job. We used the Office of Internal Audits in 2010-2011 to understand where there were difficulties in the process and documentation and we found that things were in pretty good shape and deficiencies were corrected. In response to Dr. Stocker's inquiry, Ms. Coiro explained that research projects being done at one facility go through that Affiliate IRB for approval. In a the case when there is no Affiliate IRB associated with a facility, the BRANY IRB would be used. When a research project is being conducted at multiple HHC sites, it would go to the BRANY IRB for approval.

2. Chronic Disease Management and Preventive Services at HHC

Presenting to the Committee was Ross Wilson, MD, Senior Vice President/Corporate Chief Medical Officer and David Stevens, MD, Senior Director, Office of Healthcare Improvement. The current state chronic illness control can be summarized as: we have accurate data in some metrics which has driven sustained improvement in a number of areas; improvements have reached a 'plateau'; control rates vary across facilities; and we need more data in order to expand the scope of improvements. The two aims are: 1) accurate and timely data in all priority areas to drive improvement efforts and reduce disparities; and 2) dissemination of best practices such as Patient Centered Medical Home (teamwork, training, coordination of care), information technology (registries and decision support), and advances in healthy lifestyle support.

In terms of reporting the data there are two definitions: 1) standard is the National Average Performance for Commercial HMOs nationwide; and 2) a benchmark is the 90th percentile of National Commercial HMOs. Dr. Stevens described the slide that contains the Corporate-wide preventive services and chronic illness control dashboard. Across the top of the table the columns illustrate the standard, the benchmark, percentage of HHC patients at target in 2011 & 2010, percentage of facilities at standard in 2011 & 2010, and the percentage of facilities at benchmark in 2011 & 2010 with the chronic disease condition listed on the left side of the table. Dr. Stevens highlighted some of the dashboard components. HHC's rate for blood pressure control in diabetes management was at 36% in both 2010 and 2011, compared to the Standard of 33% and the benchmark of 42%. Eight-two percent of HHC facilities met the standard in 2011 compared to 64.7% in 2010. In 2011, 12% of the facilities met the benchmark compared to 24% in 2010. For LDL control the standard is 48% and the benchmark is 57%. In 2010, 70.6% of HHC facilities met the standard compared to 88.2% in 2011. In 2010, 24% of HHC facilities met the benchmark compared to 47% in 2011. For mammography screening the standard is 71% and the benchmark is 80%. In 2011, 71% of HHC facilities met the standard and 12% met the benchmark. The newer data components that will be added to the dashboard include: non-cancer prevention such as HIV/know your status; behavioral health screening such as depression, tobacco use; and other chronic illness control such as asthma control and depression management.

Dr. Steven then presented histograms that drill down the performance of individual facilities. For blood pressure control, the facilities that improved were Cumberland D&TC, Bellevue Hospital Center, Lincoln Medical and Mental Health Center and East NY D&TC – the remaining facilities either remained flat or slightly worsened. For LDL eight out of the fifteen HHC facilities improved, the others remained flat or slightly worsened.

Moving beyond the plateau: bring lowest performers into the 'Pack' by adoption of readily available best practices and identify unique challenges; and moving up the whole 'Pack' where the bell curve is pretty tight already by targeting different barriers with new tools such as the PCMH model ("It takes a village" – enlist all team members); proven approaches to lifestyle change; and closer follow-up of uncontrolled patients (care management, non-physician driven pathways). Using the data to drive improvement by identifying disparities and variations - facility-to-facility, subpopulations within a facility, and provider-to-provider within a facility- and by measuring the impact of interventions

The new areas of focus in prevention and chronic illness in 2012 include heart failure (reduce readmissions); geriatric syndromes (fall risk, dementia); adolescent wellness (obesity, reproductive health); drug/alcohol "hazardous" use; and obesity/overweight (children, adolescent, adult). The 2012 priority areas for improved data collection/reporting are: depression management in primary care; preventive measures in diabetes mellitus (eye/kidney/ feet); colorectal screening (screening/quality rate); and prevention composite (vaccines, screening).

There being no further business the meeting adjourned at 3:42 P.M.

MetroPlus Health Plan, Inc.
Report to the
HHC Medical and Professional Affairs Committee
April 19, 2012

Total plan enrollment as of March 27, 2012 was 426,364. Breakdown of plan enrollment by line of business is as follows:

Medicaid	358,149
Child Health Plus	17,538
Family Health Plus	36,182
MetroPlus Gold	3,078
Partnership in Care (HIV/SNP)	5,713
Medicare	5,704

Attached are reports of members disenrolled from MetroPlus due to transfer to other health plans, as well as a report of new members transferred to MetroPlus from other plans. In addition, I have attached a graph showing net transfers for the month of March 2012 for Medicaid and Family Health Plus (FHP).

At each meeting I report on the number of members that transfer in and out of MetroPlus every month. An analysis of the 5,870 members that transferred from MetroPlus to Health First in 2011 revealed that only 21.8% of these continued to receive their care at HHC.

The New York State Department of Health (SDOH) sponsors a Consumer Satisfaction Survey every two years. This year, it was performed by DataStat in the late fall of 2011, and we recently received our results. The survey was performed on adult Medicaid members of each plan. Fifteen hundred surveys were sent out for each plan with multiple mailings and follow up phone calls, of which MetroPlus had a 36.9% response rate. The good news is that, as compared to 2009, we had improvements in the indicators measuring the provider's screening and intervention to assist members in quitting smoking. We also improved in the rate of flu vaccines, and whether members would recommend the health plan to family and friends, which is now up to 91.9%. Our problem areas continue to be measures of access including getting needed care, getting care quickly, and access to specialist appointments. The results of this survey will be used in the ranking of health plans for the quality incentives and the Consumer Guide. We are addressing the results and will be making appropriate interventions to improve our results.

In the recent New York State Budget negotiations several groups were pushing for the introduction of "Prescriber Prevails" language related to the Medicaid managed care prescription benefit. The prescriber prevails coverage was previously included in the fee-for-service Medicaid pharmacy benefit. Prescriber prevails allows the prescribing provider to determine what drug/medication their patient would receive, regardless of any authorization or formulary requirements required by the patient's managed care plan. Member advocates and certain groups funded by the pharmaceutical industry argued that providers should have final say in what medications members receive. The coalition of health plans argued that implementing prescriber prevails undercuts the appropriate review and screening of prescription and drug use. The Health Plan Association had reviewed claims data, and found that many of the denials made

by plans are for issues related to inappropriate and potentially harmful prescribing. The MetroPlus Prior Approval process, Step Therapy, and Quantity Limits are in place to ensure that medications are being prescribed and dispensed in a safe, appropriate manner. The State also already considers certain drug classes "protected" and not subject to plan formulary or prior authorization requirements. As of the writing of this report, there was an agreement at the State level to include prescriber prevails language for antipsychotics.

KPMG has completed the Plan's annual audit for 2011. There were no findings identified by KPMG. In 2011, the Plan received $1,465 million in premiums; had medical expenses of $1,284 million (a medical expense ratio of 88%) and administrative expenses of $113 million (admin expense ratio of 8%).

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 03/14/2012

Other Plan Name	Category	2011_04		2011_05		2011_06		2011_07		2011_08		2011_09		2011_10		2011_11		2011_12		2012_01		2012_02		2012_03		TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
Affinity Health Plan	INVOLUNTARY	0	5	0	2	0	3	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	13
	VOLUNTARY	11	122	12	139	11	143	18	97	10	126	14	99	10	138	22	124	19	99	10	108	15	90	6	69	1,512
	TOTAL	11	127	12	141	11	146	19	99	10	126	14	99	10	138	22	124	19	99	10	108	15	90	6	69	1,525
CarePlus Health Plan	INVOLUNTARY	1	3	0	4	1	5	2	5	0	0	0	0	0	0	2	1	0	0	0	0	0	0	0	0	24
	VOLUNTARY	1	39	2	29	6	33	2	34	4	26	3	34	2	24	5	43	2	42	1	27	3	25	3	19	409
	TOTAL	2	42	2	33	7	38	4	39	4	26	3	34	2	24	7	44	2	42	1	27	3	25	3	19	433
Fidelis Care	INVOLUNTARY	0	7	0	8	1	3	0	3	0	0	0	0	1	1	0	1	0	0	0	1	0	2	0	0	28
	VOLUNTARY	21	227	27	196	32	280	27	211	42	252	20	176	22	201	27	257	27	234	25	223	33	267	17	146	2,990
	TOTAL	21	234	27	204	33	283	27	214	42	252	20	176	23	202	27	258	27	234	25	224	33	269	17	146	3,018
Health First	INVOLUNTARY	2	22	3	13	2	2	0	1	0	0	0	0	0	1	0	2	0	0	1	5	0	1	1	0	56
	UNKNOWN	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	VOLUNTARY	42	397	29	465	45	538	35	419	44	500	35	412	39	407	43	488	40	462	26	514	43	550	28	296	5,897
	TOTAL	44	419	32	479	47	540	35	420	44	500	35	412	39	408	43	490	40	462	27	519	43	551	29	296	5,954
Health Plus	INVOLUNTARY	4	13	1	6	2	4	2	5	0	0	0	0	0	0	0	7	0	1	0	1	0	0	0	0	46
	VOLUNTARY	17	176	18	191	13	208	13	160	22	208	18	185	20	145	24	216	25	188	10	175	14	241	11	107	2,405
	TOTAL	21	189	19	197	15	212	15	165	22	208	18	185	20	145	24	223	25	189	10	176	14	241	11	107	2,451
HIP/NYC	INVOLUNTARY	1	2	1	3	0	1	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	12
	VOLUNTARY	13	59	9	75	3	102	10	72	8	83	6	90	11	55	12	77	12	86	10	92	8	91	8	52	1,044
	TOTAL	14	61	10	78	3	103	10	75	8	83	6	90	11	55	12	77	12	86	10	92	8	92	8	52	1,056
Neighborhood	INVOLUNTARY	0	6	1	3	0	0	2	2	0	0	0	0	0	0	0	1	0	1	0	2	0	1	0	0	19

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 03/14/2012

		2011_04		2011_05		2011_06		2011_07		2011_08		2011_09		2011_10		2011_11		2011_12		2012_01		2012_02		2012_03		TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
Neighborhood Health Provider	VOLUNTARY	10	128	11	118	12	124	21	115	8	169	8	120	7	114	15	144	14	131	15	94	11	122	8	75	1,594
	TOTAL	10	134	12	121	12	124	23	117	8	169	8	120	7	114	15	145	14	132	15	96	11	123	8	75	1,613
United Healthcare of NY	INVOLUNTARY	1	4	1	3	1	0	0	1	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	13
	VOLUNTARY	14	53	5	74	11	107	11	69	14	68	10	72	7	48	18	111	16	74	14	70	8	81	7	51	1,013
	TOTAL	15	57	6	77	12	107	11	70	14	68	10	72	7	48	18	112	16	74	14	71	8	81	7	51	1,026
Wellcare of NY	INVOLUNTARY	1	5	1	2	0	3	0	5	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	18
	VOLUNTARY	2	15	1	29	4	26	2	33	2	27	3	22	8	18	0	10	2	29	0	20	2	26	1	13	295
	TOTAL	3	20	2	31	4	29	2	38	2	27	3	22	8	18	0	10	2	29	0	21	2	26	1	13	313
Disenrolled Plan Transfers	INVOLUNTARY	10	67	8	44	7	21	7	27	0	0	0	0	1	2	2	13	0	2	1	11	0	5	1	0	229
	UNKNOWN	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	VOLUNTARY	131	1,216	114	1,316	137	1,561	139	1,210	154	1,459	117	1,210	126	1,150	166	1,470	157	1,345	111	1,323	137	1,493	89	828	17,159
	TOTAL	141	1,283	122	1,361	144	1,582	146	1,237	154	1,459	117	1,210	127	1,152	168	1,483	157	1,347	112	1,334	137	1,498	90	828	17,389
Disenrolled Unknown Plan Transfers	INVOLUNTARY	2	39	1	67	4	51	6	46	5	47	3	35	7	53	5	36	3	27	2	37	1	30	2	13	522
	UNKNOWN	0	0	1	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
	VOLUNTARY	1	43	0	21	0	24	3	40	5	49	4	61	5	53	19	96	16	116	9	56	8	83	19	50	781
	TOTAL	3	82	2	89	4	75	9	86	10	97	7	96	12	106	24	132	19	143	11	93	9	113	21	63	1,306
Non-Transfer Disenroll Total	INVOLUNTARY	1,475	11,150	1,235	9,826	1,176	8,727	1,359	10,100	1,033	9,713	1,112	10,295	1,011	9,917	1,031	9,854	1,159	10,194	1,161	10,307	1,020	10,266	1,289	10,674	135,084
	UNKNOWN	0	2	0	7	1	1	1	0	1	2	1	3	1	3	1	4	1	3	1	5	1	6	2	2	49
	VOLUNTARY	0	83	0	67	0	61	0	42	0	52	0	52	1	55	252	387	2	59	2	80	1	59	79	781	2,115
	TOTAL	1,475	11,235	1,235	9,900	1,177	8,789	1,360	10,142	1,034	9,767	1,113	10,350	1,013	9,975	1,284	10,245	1,162	10,256	1,164	10,392	1,022	10,331	1,370	11,457	137,248

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 03/14/2012

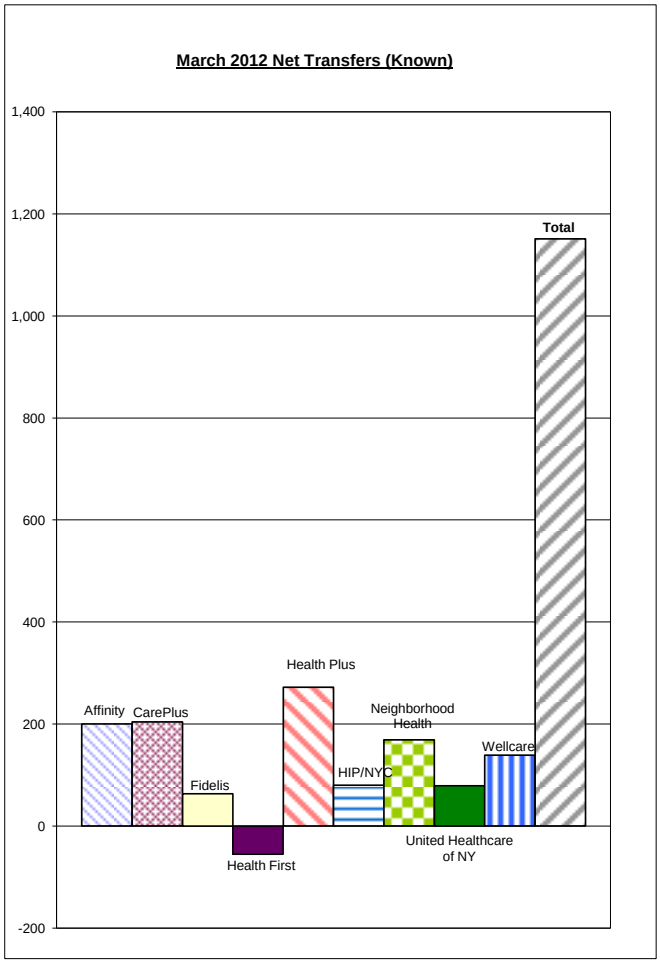
		2011_04		2011_05		2011_06		2011_07		2011_08		2011_09		2011_10		2011_11		2011_12		2012_01		2012_02		2012_03		TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
Total MetroPlus Disenrollment	**INVOLUNTARY**	1,487	11,256	1,244	9,937	1,187	8,799	1,372	10,173	1,038	9,760	1,115	10,330	1,019	9,972	1,038	9,903	1,162	10,223	1,164	10,355	1,021	10,301	1,292	10,687	135,835
	UNKNOWN	0	2	1	9	1	1	1	0	1	3	1	3	1	3	1	4	1	3	1	5	1	6	2	2	53
	VOLUNTARY	132	1,342	114	1,404	137	1,646	142	1,292	159	1,560	121	1,323	132	1,258	437	1,953	175	1,520	122	1,459	146	1,635	187	1,659	20,055
	TOTAL	1,619	12,600	1,359	11,350	1,325	10,446	1,515	11,465	1,198	11,323	1,237	11,656	1,152	11,233	1,476	11,860	1,338	11,746	1,287	11,819	1,168	11,942	1,481	12,348	155,943

Disenrollments TO Other Plans		Mar-12			Apr-11 to Mar-12		
		FHP	MCAD	Total	FHP	MCAD	Total
	INVOL.	0	0	0	1	12	13
	VOL.	6	69	75	158	1,354	1,512
Affinity Health Plan	TOTAL	6	69	75	159	1,366	1,525
	INVOL.	0	0	0	6	18	24
	VOL.	3	19	22	34	375	409
CarePlus Health Plan	TOTAL	3	19	22	40	393	433
	INVOL.	0	0	0	2	26	28
	VOL.	17	146	163	320	2,670	2,990
Fidelis Care	TOTAL	17	146	163	322	2,696	3,018
	INVOL.	1	0	1	9	47	56
	VOL.	28	296	324	449	5,448	5,897
Health First	TOTAL	29	296	325	458	5,496	5,954
	INVOL.	0	0	0	9	37	46
	VOL.	11	107	118	205	2,200	2,405
Health Plus	TOTAL	11	107	118	214	2,237	2,451
	INVOL.	0	0	0	2	10	12
	VOL.	8	52	60	110	934	1,044
HIP/NYC	TOTAL	8	52	60	112	944	1,056
	INVOL.	0	0	0	3	16	19
	VOL.	8	75	83	140	1,454	1,594
Neighborhood Health	TOTAL	8	75	83	143	1,470	1,613
	INVOL.	0	0	0	3	10	13
	VOL.	7	51	58	135	878	1,013
United Healthcare of NY	TOTAL	7	51	58	138	888	1,026
	INVOL.	0	0	0	2	16	18
	VOL.	1	13	14	27	268	295
Wellcare of NY	TOTAL	1	13	14	29	284	313
	INVOL.	1	0	1	37	192	229
	VOL.	89	828	917	1,578	15,581	17,159
Disenrolled Plan Transfers:	TOTAL	90	828	918	1,615	15,774	17,389
	INVOL.	2	13	15	41	481	522
	VOL.	19	50	69	89	692	781
Disenrolled Unknown Plan Transfers:	TOTAL	21	63	84	131	1,175	1,306
	INVOL.	1,289	10,674	11,963	14,061	121,023	135,084
	UNK.	2	2	4	11	38	49
	VOL.	79	781	860	337	1,778	2,115
Non-Transfer Disenroll Total:	TOTAL	1,370	11,457	12,827	14,409	122,839	137,248
	INVOL.	1,292	10,687	11,979	14,139	121,696	135,835
	UNK.	2	2	4	12	41	53
	VOL.	187	1,659	1,846	2,004	18,051	20,055
Total MetroPlus Disenrollment:	**TOTAL**	**1,481**	**12,348**	**13,829**	**16,155**	**139,788**	**155,943**

Disenrollments FROM Other Plans	Mar-12			Apr-11 to Mar-12		
	FHP	MCAD	Total	FHP	MCAD	Total
Affinity Health Plan	20	255	275	313	2,637	2,950
CarePlus Health Plan	22	204	226	290	2,073	2,363
Fidelis Care	16	210	226	234	2,581	2,815
Health First	17	253	270	230	2,473	2,703
Health Plus	33	357	390	396	3,419	3,815
HIP/NYC	10	130	140	116	1,352	1,468
Neighborhood Health	18	234	252	260	2,117	2,377
United Healthcare of NY	10	127	137	131	1,061	1,192
Wellcare of NY	31	122	153	233	1,636	1,869
Total	177	1,892	2,069	2,203	19,349	21,552
Unknown (not in total)	2,066	11,401	13,467	25,357	134,047	159,404

Data Source: RDS Report 1268a&c Updated 03/19/2012

Net Difference	Mar-12			Apr-11 to Mar-12		
	FHP	MCAD	Total	FHP	MCAD	Total
Affinity Health Plan	14	186	200	154	1,271	1,425
CarePlus Health Plan	19	185	204	250	1,680	1,930
Fidelis Care	-1	64	63	-88	-115	-203
Health First	-12	-43	-55	-228	-3,023	-3,251
Health Plus	22	250	272	182	1,182	1,364
HIP/NYC	2	78	80	4	408	412
Neighborhood Health	10	159	169	117	647	764
United Healthcare of NY	3	76	79	-7	173	166
Wellcare of NY	30	109	139	204	1,352	1,556
Total	87	1,064	1,151	588	3,575	4,163



New Member Transfer From Other Plans

	2011_04		2011_05		2011_06		2011_07		2011_08		2011_09		2011_10		2011_11		2011_12		2012_01		2012_02		2012_03		TOTAL
	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
Affinity Health Plan	19	209	35	241	42	273	37	231	51	264	16	194	21	175	23	203	17	191	13	207	19	194	20	255	2,950
CarePlus Health Plan	33	202	20	172	23	203	35	137	29	223	25	198	25	135	28	177	12	147	13	145	25	130	22	204	2,363
Fidelis Care	14	207	25	201	29	260	17	200	26	293	19	234	24	173	19	232	18	217	17	183	10	171	16	210	2,815
Health First	14	185	18	225	25	248	22	219	26	242	25	148	14	186	26	217	13	198	22	165	8	187	17	253	2,703
Health Plus	42	299	33	238	51	349	29	273	30	343	34	258	38	255	32	254	29	275	26	300	19	218	33	357	3,815
HIP/NYC	12	125	12	133	10	126	10	122	15	113	10	117	6	94	7	102	5	104	11	97	8	89	10	130	1,468
Neighborhood Health Pr	25	196	14	181	32	213	16	162	15	175	25	139	26	149	24	171	31	126	16	206	18	165	18	234	2,377
United Healthcare of NY	12	75	17	59	13	72	12	76	11	77	10	83	6	72	8	103	10	125	8	101	14	91	10	127	1,192
Unknown PLan	2,014	9,445	2,171	9,838	2,527	13,610	2,160	10,215	2,145	11,424	2,022	9,708	1,927	9,393	2,190	12,782	1,820	11,452	2,162	11,739	2,153	13,040	2,066	11,401	159,404
Wellcare of NY	16	157	19	132	24	157	15	123	21	157	11	127	20	146	28	145	15	126	19	144	14	100	31	122	1,869
TOTAL	2,201	11,100	2,364	11,420	2,776	15,511	2,353	11,758	2,369	13,311	2,197	11,206	2,107	10,778	2,385	14,386	1,970	12,961	2,307	13,287	2,288	14,385	2,243	13,293	180,956

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

March-2012

		Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12
Total Members	Prior Month	418,371	418,502	418,636	421,659	423,123	424,610	426,777
	New Member	15,582	15,103	19,144	17,026	17,905	18,053	16,279
	Voluntary Disenroll	1,627	1,560	2,591	1,854	2,045	1,992	1,991
	Involuntary Disenroll	13,824	13,409	13,530	13,708	14,373	13,894	14,701
	Adjusted	9	13	-11	39	-31	1,341	0
	Net Change	131	134	3,023	1,464	1,487	2,167	-413
	Current Month	418,502	418,636	421,659	423,123	424,610	426,777	426,364
Medicaid	Prior Month	351,041	350,765	350,524	353,227	354,757	356,153	358,206
	New Member	12,298	11,923	15,546	14,101	14,324	14,971	13,220
	Voluntary Disenroll	1,320	1,258	1,953	1,520	1,459	1,635	1,657
	Involuntary Disenroll	11,254	10,906	10,890	11,051	11,469	11,283	11,620
	Adjusted	10	17	-8	50	41	1,283	0
	Net Change	-276	-241	2,703	1,530	1,396	2,053	-57
	Current Month	350,765	350,524	353,227	354,757	356,153	358,206	358,149
Child Health Plus	Prior Month	18,784	18,855	18,896	18,875	18,701	18,207	17,812
	New Member	726	713	775	573	431	436	522
	Voluntary Disenroll	43	45	43	36	21	36	29
	Involuntary Disenroll	612	627	753	711	904	795	767
	Adjusted	-1	-3	-3	-11	-9	-11	0
	Net Change	71	41	-21	-174	-494	-395	-274
	Current Month	18,855	18,896	18,875	18,701	18,207	17,812	17,538
Family Health Plus	Prior Month	34,914	35,115	35,349	35,561	35,554	35,864	36,287
	New Member	2,168	2,092	2,360	1,939	2,282	2,262	2,221
	Voluntary Disenroll	121	132	437	175	122	146	187
	Involuntary Disenroll	1,846	1,726	1,711	1,771	1,850	1,693	2,139
	Adjusted	1	1	0	0	-70	22	0
	Net Change	201	234	212	-7	310	423	-105
	Current Month	35,115	35,349	35,561	35,554	35,864	36,287	36,182

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

March-2012

		Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12
HHC	Prior Month	2,980	2,986	2,976	2,999	2,990	3,091	3,102
	New Member	25	20	42	20	273	12	6
	Voluntary Disenroll	0	3	2	0	153	0	0
	Involuntary Disenroll	19	27	17	29	19	1	30
	Adjusted	0	0	1	1	9	13	0
	Net Change	6	-10	23	-9	101	11	-24
	Current Month	2,986	2,976	2,999	2,990	3,091	3,102	3,078
SNP	Prior Month	5,377	5,397	5,431	5,499	5,546	5,670	5,723
	New Member	125	142	208	165	243	187	116
	Voluntary Disenroll	47	31	39	37	36	41	20
	Involuntary Disenroll	58	77	101	81	83	93	106
	Adjusted	-1	-1	0	-1	-2	30	0
	Net Change	20	34	68	47	124	53	-10
	Current Month	5,397	5,431	5,499	5,546	5,670	5,723	5,713
Medicare	Prior Month	5,275	5,384	5,460	5,498	5,575	5,625	5,647
	New Member	240	213	213	228	352	185	194
	Voluntary Disenroll	96	91	117	86	254	134	98
	Involuntary Disenroll	35	46	58	65	48	29	39
	Adjusted	0	-1	-1	0	0	4	0
	Net Change	109	76	38	77	50	22	57
	Current Month	5,384	5,460	5,498	5,575	5,625	5,647	5,704

"Supply Chain Management Technology Transformation"

Enrick Ramlakhan
Joseph Quinones

NYC Health and Hospitals Corporation

April 19, 2012

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

History: HHC Supply Chain Management

- Decentralized contracting and management practices
- Operational inefficiencies
- Lack of
  - Transparency
  - Accountability

The Road Ahead: psBlue

HHC Supply Chain Council used Breakthrough to improve medical supply purchasing process

Selected “psBlue” (i.e. GHX) suite of applications resulting in improved:

- Transparency of spend – contracting and standardization savings
- User compliance – Amazon.com experience
- Sustained performance – accountability
- Productivity gains
- Multi-disciplinary collaboration

psBlue

Cost Savings

To Date: $9 million in annualized savings

FY13 Target: $14 million

Vendor	Savings
Contracting	
Iv pumps, supplies, and services	$1,471,603
GE 2nd year maintanence contract	$717,641
Citi Storage (repository med records)	$650,000
HWS Waste Amendment	$215,000
NY blood & Service	$3,422,631
Subtotal	$6,476,875
Standardization	
GE preventive services maintanence contract	$715,963
Hill Rom Rebate (bed supplies)	$38,000
Assorted Medical supplies	$278,385
Distributor costs (Cardinal)	$1,430,981
Central Poly Savings Plastic (biohazard supplies)	$281,782
Subtotal	$2,745,111
Total:	**$9,221,986**

Staff Productivity Gains

Standard of work was changed

- Developed a contract repository and item master
- Reduced processing errors for requisitions, POs and vendor invoicing.
- Ordering process no longer relies on faxes and phone calls.

Purchasing Staff	Bellevue & Metro	Coler, Goldwater, Gouverneur	North Bklyn	Central Bklyn	South Bklyn	Gen Plus	Queens	North Bronx	Total
Current Staffing	12	8	8	9	8	21	12	7	85
Recommended staffing(based on industry Benchmarking)	9	5	4	5	6	8	8	5	50
Adjusted staffing (w/ facility feedback)	9	5	5	5	6	13	9	5	57
Staff Attrition by June 30, 2012	3	3	3	4	2	8	3	2	28

Validation: Tracking Product Purchases

Transparency allows for monitoring of implementation

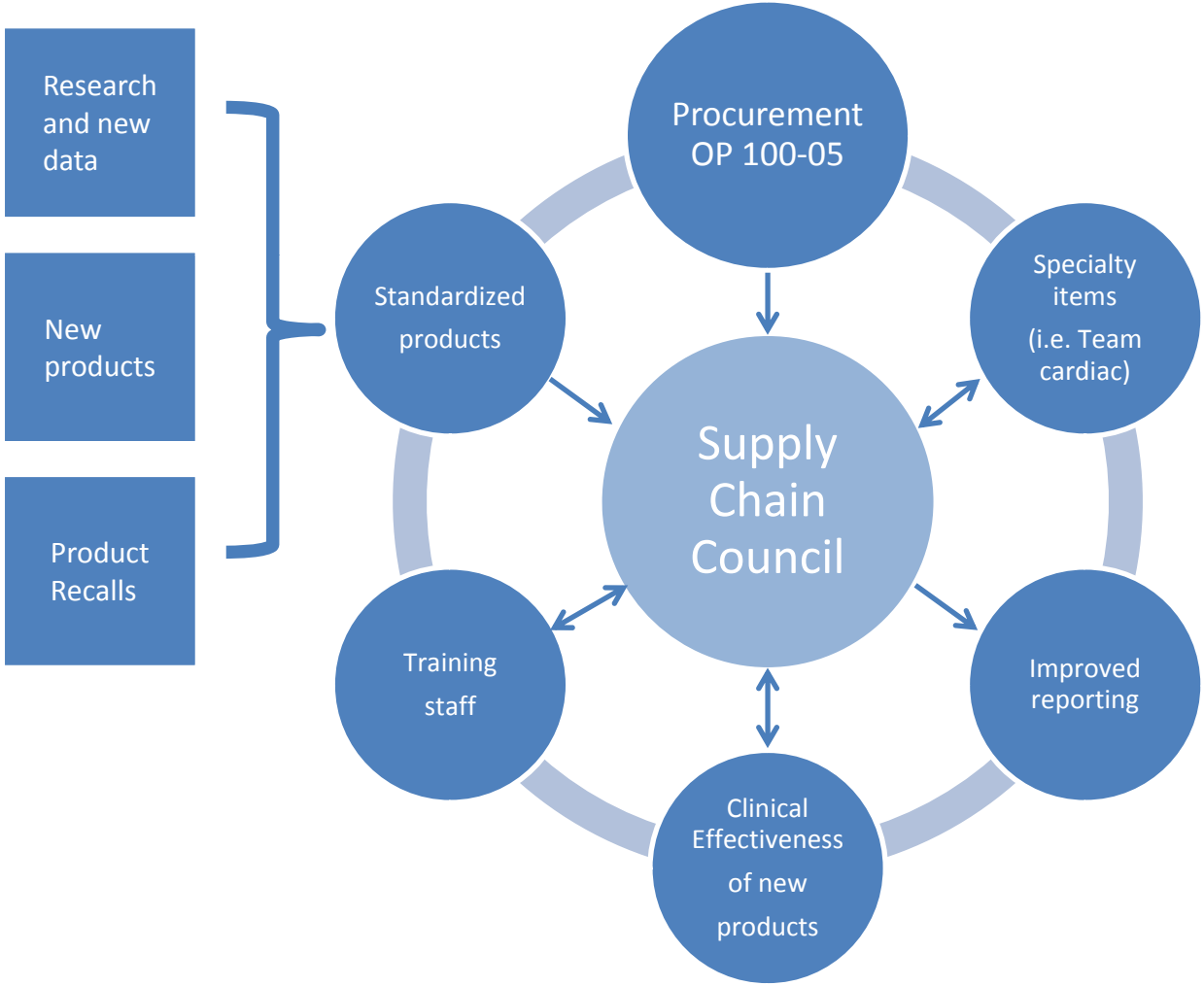
- High User Acceptability = High Compliance Rate (i.e. orders from the contract)
  - 40% of orders are on contract for ALL GHX customers (National Avg.)
  - 70% of HHC orders are on contract
  - HHC sets the benchmark for the National GHX customer base

- Reduction of Special Purchase Requests (SPRs) = Cost Savings
  - After seven months of full implementation we have achieved 50% of HHC item master purchases (approved catalogue)

- Increased Transactions through psBlue system
  - As of February 2012 monthly transactions total $41M

Multidisciplinary Team Approach

Item Review / Standardization



User Acceptance and Satisfaction

* What is your primary role as a psBlue (GHX Procurement Suite) user?

Requestor	237	73%
Approver	65	20%
Buyer	20	6%
Other	4	1%
Total	326	100%

* Is psBlue (GHX Procurement Suite) a valuable tool?

Yes	289	89%
No	37	11%
Total	326	100%

* Does psBlue (GHX Procurement Suite) help you do your job more easily?

Yes	240	74%
No	86	26%
Total	326	100%

Survey conducted November 2011
326 respondents (12% total population)
Reponses are reflective of feedback received at facility based Town Hall Meetings.

psBlue: Sustaining Transformation

Collaboration

- Alignment of IT / Supply Chain Management
- Engage staff to use the tool
- Leverage GNYHA resources/expertise
- Leverage group purchasing

Communication

- Message to staff
- Purchasing Collaborative
- Obtain employee feedback

Reporting on compliance

- One source = price accuracy
- Scheduled data collection
- Information is actionable


THANK
YOU!

HHC
Meaningful Use Update

Medical & Professional Affairs / IT Committee

Board of Directors

April, 2012

Purpose of Meaningful Use

1. Improve quality, safety, efficiency, and reduce health disparities
2. Engage Patients and Families
3. Improve Care Coordination
4. Protect Privacy and Security of Personal Health Information
5. Improve Population and Public Health

Key Applications Needed to Meet Stage 1 Meaningful Use Requirements

- Core HIS System with Clinical Data Repository
- Clinical Documentation
- Clinical Decision Support
- Computerized Physician Order Entry
- Medication Management
- ED System or Module

Meaningful Use…

1. Use a Certified EHR – QuadraMed version 5.2
2. Use it in a meaningful way:
   - **15 Core objectives-criteria** (**14** for Hospitals)
   - **5 Menu objectives-criteria** are required for hospitals (out of a total of **10** objectives)
3. Quality Measures or criterion

   need to show a percentage of patients
4. ED processes (POS 23) are included along with inpatient processes (POS 21)

Stage 1
15 Core Objectives/Criteria:

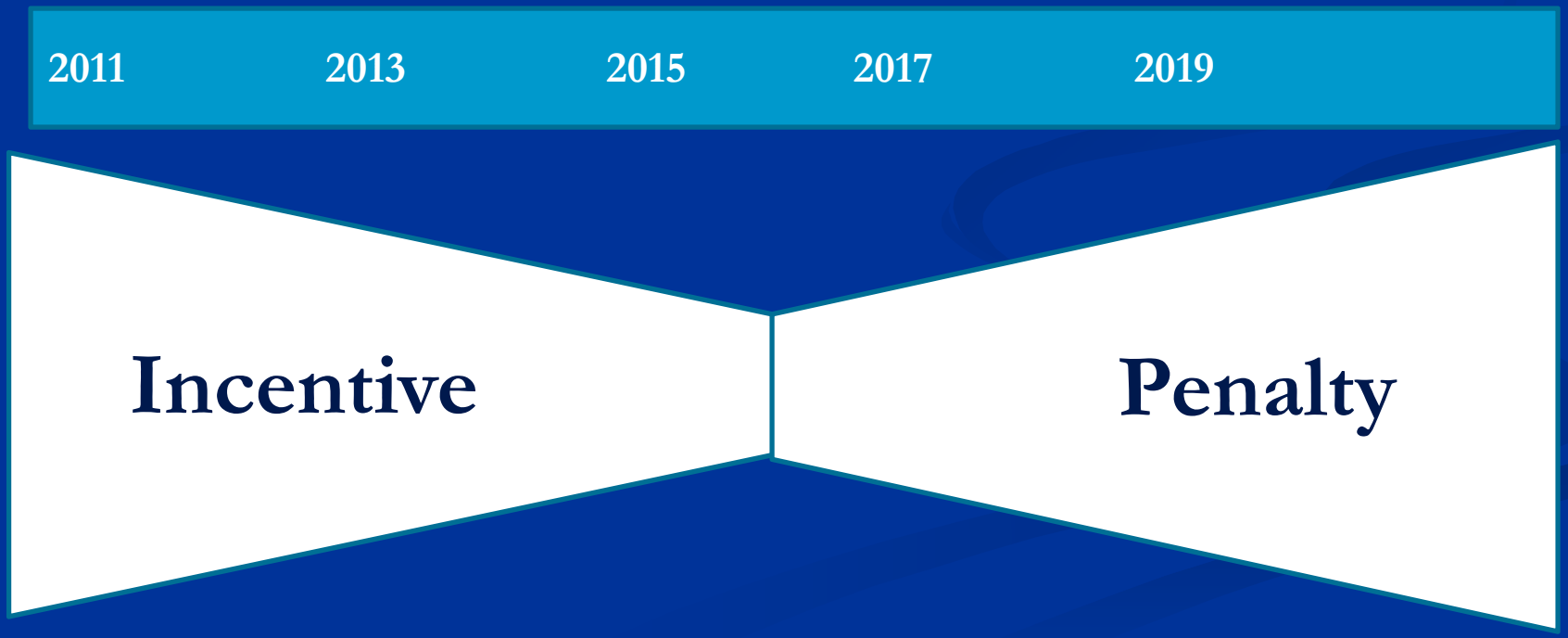
- Demographics
- Vital signs, BMI, growth
- Problem List
- Medication List
- Allergy List
- Smoking status
- Give pts clinical encounter summaries
- Give pts health summary
- Transmit prescriptions (eRx)
- CPOE for med orders
- Drug-drug and drug-allergy checks
- Test ability to exchange clinical information (***HIE/RHIO***)
- Implement one clinical decision support rule – and track it
- Security risk analysis
- Report quality measures

10 Menu Objectives/Criteria: must select 5

- ✓ ***Formulary checking***
- ✓ ***Clinical lab test results***
- ✓ ***List of pts with specific conditions***
- ✓ ***Send data to immunization registry***
- ✓ ***Advance directives for pts => 65***
- Use EHR to identify educational resources specific to patient
- Med reconciliation
- Send syndromic surveillance data (test)
- Reportable labs to public health (H)
- Send preventive care reminders (EP)
- Give pts access to problems/meds/labs (EP)
- Pts get summaries for use in referrals

Financial Incentives

- Max, HHC Hospitals $120,000,000
- Max, HHC Ambulatory $ 70,000,000 **(estimated)**



Project Status

Task	CIH	LHC	HLM	MHC	BHC	WHH	JMC	NCB	KCH	EHC	QHN
Cache Upgrade	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
5.1 Upgrade	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
5.2 Upgrade	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Registration	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Exchange Key Clinical Information	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending
Security Assessment	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending	Pending
Attestation Period Start	1/13/12	1/30/12	2/8/12	1/30/12	1/27/12	1/27/12	1/25/12	1/25/12	1/25/12	1/16/12	1/16/12
Attestation Period End	4/12/12	4/29/12	5/8/12	4/29/12	4/26/12	4/26/12	4/24/12	4/24/12	4/24/12	4/15/12	4/15/12

Timeframe Payment Year

First Payment Year	Payment Year				
	FFY/2011 10/1/2010-9/30/2011	FFY/2012 10/1/2011-9/30/2012	FFY/2013 10/1/2012-9/30/2013	FFY/2014 10/1/2013-9/30/2014	FFY2015+
2011	Stage 1	Stage 1	Stage 2	Stage 2	TBD
2012		**Stage 1** HHC	**Stage 1** HHC	Stage 2	TBD
2013			Stage 1	Stage 2	TBD
2014				Stage 1	TBD
2015+					TBD

MU Stage 2 Overview

On February 23, CMS released the NPRM (proposed rule) for meeting meaningful use in Stage 2

- New Stage 2 measures
- Additional important changes in the rule

1. In 2014, meaningful use will require electronic reporting of new (2014) quality requirements
2. To avoid penalties in 2015, you must be a meaningful user in 2013 and must have attested by July 1, 2014 (hospitals) or October 1, 2014 (physicians)

MU Stage 2 Overview

The thresholds for Stage 2 of MU are much more aggressive

- ***Thresholds will be increased***

~ Example: Demographics must be recorded for 80% of patients (was 50%)

- ***Almost all Stage 1 Menu requirements will be core***

These include the items that were often deferred by organizations during Stage 1

Summary of care at transitions (92% deferred)
Syndromic surveillance (82% *deferred*)
Reportable lab results for public health (77% *deferred*)
Medication reconciliation (74% *deferred*),
Provide educational resources (62% *deferred*)

- ***Hospitals will have 16 core items and can pick 2 of 4 menu items***

- ***EPs have 17 core and can pick 3 of 5 menu items***

MU Stage 2 Overview

- Problem lists, medication lists, and allergy lists are no longer separate measures
- Vital signs recorded for 80% of patients (was 50%)
  - Blood pressure for over 3 years old (was over 2)
  - Separate exemptions for BP and height/weight
- Smoking status for 80% of patients over 13 (was 50%)
- CPOE for 60% of medication, lab, and radiology orders (was one med order for 30% of patients)
  Note change in measure from patients to orders
- Drug-drug and drug-allergy checking no longer separate measures, still required˜ part of CDS
- Drug formulary checking no longer a separate measure now˜ required part of eRx
- Security analysis (includes encryption of data at rest)

MU Stage 2 Overview

- Medication reconciliation for 65% of patients (was 50%)

- Summary-of-care record at 65% of transitions in care (was 50%). 10% must be electronic transfer; many required data elements

- 55% of lab results recorded as structured data (was 40%)

- Identify and provide educational materials to 10% of all patients using the EHR. (Note: materials can be stored elsewhere)

- Implement drug-drug and drug-allergy checking *and implement 5 decision* interventions related to quality measures (combined recommendations, increased from 1 rule to 5)

- Generate list of patients for quality improvement (from menu to core)

- Submit immunization data (from menu to core)