AGENDA

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE

Meeting Date: March 14, 2013
Time: 12:00 PM
Location: 125 Worth Street, Room 532

BOARD OF DIRECTORS

CALL TO ORDER — **DR. STOCKER**

ADOPTION OF MINUTES
-February 14, 2013

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

CHIEF INFORMATION OFFICER REPORT — **MR. ROBLES**

METROPLUS HEALTH PLAN — **DR. SAPERSTEIN**

ACTION ITEMS:

1. Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate a contract with CyraCom International, Inc., Language Line Services, and Pacific Interpreters, Inc. to provide over-the-phone-medical interpreting (OPI) services to the Corporation to meet the patient care needs of its limited English proficient patient population and comply with external review agency requirements for a term of three years with two-one year options to renew, solely exercisable by the Corporation, for an amount not to exceed $30,853, 396. — **MS. JACOBS**

2. Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate and enter into a sole source contract with Microsoft Corporation to purchase software licenses and related maintenance and support on an on-going basis in an amount not to exceed $34,500,000 for a three year period. — **MR. ROBLES**

3. Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and execute a contract and related agreements with North Shore-Long Island Jewish Health Systems, Inc. ("NSLIJ) (i) to establish a jointly controlled not-for-profit hospitals cooperative ("CoOpLab") that will provide laboratory services at cost to NSLIJ's and the Corporation's respective health systems in a new cooperative laboratory facility to be located within the City of New York for this purpose; (ii) for the period prior to CoOpLab obtaining the requisite licenses to provide such laboratory services to have NSLIJ's existing not-for-profit corporation, which operates its core laboratory perform the Corporation's reference laboratory work that is now sent to commercial vendors at cost and have the Corporation join such not-for-profit corporation as a member; and (iii) to provide for NSLIJ to indemnify the Corporation for any cost, damage or liability arising out of its laboratory activities prior to launch of the cooperative venture and out of any ongoing laboratory activities unrelated to the cooperative venture and for CoOpLab to purchase liability insurance to cover any claims that may arise in the conduct of CoOpLab's cooperative business.
AND
Authorizing the President of the Corporation to effectuate the establishment of CoOpLab and take such other actions as he/she deems appropriate to establish the cooperative laboratory structure described below consistent with these Resolutions. — **MS. ZURACK**

INFORMATION ITEM:

1. **Chronic Illness Improvement at HHC: Hypertension** — **DR. STEVENS**

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

MINUTES

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE BOARD OF DIRECTORS

Meeting Date: February 14, 2013

ATTENDEES

COMMITTEE MEMBERS:

Michael A. Stocker, MD, Chairman
Alan D. Aviles
Josephine Bolus, RN
Christina Jenkins, MD
Amanda Parsons, MD (representing Thomas Farley, MD)

HHC CENTRAL OFFICE STAFF:

Louis Capponi, MD, Chief Medical Informatics Officer
Deborah Cates, Chief of Staff, Board Affairs
Paul Contino, Chief Technology Officer
Mary-Ann Etiebet, Director, Ambulatory Care Transformation
Juliet Gaengan, Senior Director, Clinical Affairs
Marisa Salamone-Greason, Assistant Vice President, EITS
Terry Hamilton, Assistant Vice President, Corporate Planning Services
Caroline Jacobs, Senior Vice President, Safety and Human Development
Lauren Johnston, Senior Assistant Vice President/Chief Nursing Officer, Patient Centered Care
Irene Kaufman, Senior Assistant Vice President, Ambulatory Care Transformation
Patricia Lockhart, Secretary to the Corporation
Tamiru Mammo, Chief of Staff, Office of the President
Ana Marengo, Senior Vice President, Communications & Marketing
Antonio D. Martin, Executive Vice President/Corporate Chief Operating Officer
John Morley, MD, Deputy Chief Medical Officer
Charlotte Neuhaus, Senior Management Consultant, Corporate Planning Services
Bert Robles, Senior Vice President, Chief Information Officer
Salvatore Russo, Senior Vice President & General Counsel, Legal Affairs
David Stevens, MD, Senior Director, Office of Healthcare Improvement
Melville Sylvester, Assistant Director, Communications & Marketing
Joyce Wale, Senior Assistant Vice President, Office of Behavioral Health
Ross Wilson, MD, Senior Vice President/Corporate Chief Medical Officer

FACILITY STAFF:

Ernest Baptiste, Executive Director, King County Hospital Center
Lynda D. Curtis, Senior Vice President, South Manhattan Network
Arnold Saperstein, MD, Executive Director, MetroPlus Health Plan
Denise Soares, Executive Director, Harlem Hospital Center

OTHERS PRESENT:

Moira Dolan, Senior Assistant Director, DC 37, Research & Negotiations Department
Scott Hill, Account Executive, QuadraMed
Richard McIntyre, Key Account Executive, Siemens
Megan Meagher, Analyst, Office of Management and Budget

**MEDICAL AND PROFESSIONAL AFFAIRS/
INFORMATION TECHNOLOGY COMMITTEE
Thursday, February 14, 2013**

Michael A. Stocker, MD, Chairman of the Board, called the meeting to order at 10:17 A.M. The minutes of the January 24, 2013 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

Since the Health Home soft launch in August 2012, enrollment activity in Phase l HHC facilities continued at a steady pace for targeted eligible populations. HHC COBRA and CIDP care coordinators have worked to outreach and enroll their legacy patients and succeeded in enrolling 70% of their assigned patients. Outreach workers, using the roster of newly eligible patients provided by NYSDOH, sought to locate these individuals and initiate community-based enrollment. Of approximately 1,600 eligibles, 616 were contacted with 74 agreeing to enroll in HHC Health Home. Through these combined outreach and enrollment strategies, HHC Health Homes have enrolled 558 patients.

Since Phase II sites in Queens and Manhattan were approved in December 2012, NYSDOH issued a new roster of patients on January 21, 2013. This roster is comprehensive, representing 3,900 eligible FFS and MetroPlus-managed patients from both Phase l and Phase II regions. Importantly, the quality and accuracy of the patient information is much improved and supersedes the previous roster that had been provided. An analysis of the roster again shows a population of high acuity with 67% of the population having composite scores 125-149 or low high acuity; 20% having a composite score of 150-174 (similar to the CIDP patient population); and finally 13% with the highest acuity and complexity and composite scores in the 175-200 range. The boroughs of Queens and Brooklyn have the majority share of this roster with 2,381 patients linked to their facilities where outreach activities have been initiated in February. CIDP and COBRA programs in Phase II boroughs have a total of 802 active legacy patients. Care coordinators have also initiated engagement and enrollment of these patients this month.

To help guide the enrollment process, the HHC Health Home Office has been holding training sessions on the use of health Home enrollment and consent. Staff from legacy programs at Queens and Elmhurst Hospitals has already been trained; training for Bellevue, Harlem and Metropolitan is scheduled to take place this month.

Infrastructure for HHC's Health Home is being developed in a number of ways. The prototype for an interoperable Care Plan Management System (CPMS) will be ready for launch in March with user testing and training scheduled beginning in February and continuing through March. The web-based CPMS will be available to care team members via password; members of the Interboro RHIO will have view access to the care plans developed in the in the CPMS later this year. The Health Home Network is being developed through a phased-in strategy beginning with executing Data Exchange Application and Agreements (DEAAs) for the community-based organizations that were vetted and prioritized by HHC facility leadership in May 2012. We currently have completed DEAAs with 24 unique organizations and 16 additional DEAs are in progress. HHC Health Home will begin to develop contracts with community providers who are currently providing COBRA services to HHC patients who are eligible for Health Home services.

2. Dialysis Transition Project Report

- Project Manager for Transition has commenced – David Veras from Woodhull MMHC
- HHC / Atlantic Dialysis Contract has been signed
  - PAGNY Contract to be signed soon (by 2/15/2013).
- Transition Schedule:
  - Woodhull Medical Center by March 4, 2013
  - Queens Medical Center by March 11, 2013
  - Coney Island Hospital by June, 2013
  - North Central Bronx Hospital by July, 2013
  - Jacobi Medical Center by August, 2013
  - Lincoln Medical Center tentatively by September, 2013
- Standardized flow sheet has been developed for utilization at all sites
- IT Risk Assessment being conducted by HHC IT Security Dept. preparing for software integration between EPIC & QMS (Atlantic Dialysis EMR Software)
- ADMS is finalizing Policy & Procedure Manual to be distributed to each hospital for review and input.
- Fresenius Medical Care has been notified of transition and impending supplies & water testing contracts being phased out facility by facility at the point of their scheduled transition.
- Dialysis Equipment to be sold has been identified. Relinquishment & Depreciation is being conducted and will be produced to ADMS for purchase by Friday 2/15/2013 for Woodhull & Queens. Other facilities by April 2013.
- Working on standardizing and streamlining the HR & Nursing Onboarding process throughout HHC for all ADMS staff. Working closely with HR Directors and Nursing Directors.
- ADMS has updated their Liability Insurance Policy to cover Acute Facilities.
- ADMS Architect has visited NCB (2/6/13) & Lincoln (tentatively scheduled for 2/15 @2pm) to view space for new Chronic unit.
- Transition process to be presented at HR Directors, CNO Council and Chiefs of Internal Medicine – scheduled for Supply Chain Council and the CFO Council

3. HHC'S Teen Health Improvement Program

The Mayor's Young Men's Initiative funded HHC's Teen Health Improvement program that began in April 2012. The program's mission is to improve population health outcomes among HHC's adolescent patients by ensuring the accessibility and quality of health services HHC provides with a focus on sexual and reproductive health.

The Teen Health Improvement program has completed a needs assessment, and has a Health Improvement Panel at all 17 facilities. Supplies of contraceptives and patient education materials have been distributed to all facilities. In addition, the Standardized Patient program for pediatricians won 3rd prize among over 1,000 entrants at the International Meeting for Simulation in Healthcare. Adolescent Patient Satisfaction Survey is underway at all open facilities (not yet at Coney Island or Bellevue).

Future work includes:

- develop and deliver a multi-faceted provider training program;
- expand adolescent Standardized Patient program throughout HHC;
- assist pediatric/adolescent clinics qualify to be listed in widely-distributed DOHMH teen clinic listing;

- develop teen-friendly web page promoting HHC's services;
- investigate opportunities for increasing revenue for adolescent care (e.g. via use of the Family Planning Benefit Program, a little-known Medicaid program that covers sexual health care, or better financial practices; and
- support inter-facility collaboration regarding adolescent health quality improvement work.

4. Improving Access to Primary Care

As has been previously discussed providing adequate access to primary care is an essential component of the future HHC healthcare delivery system. It directly impacts many areas which include the capacity to enroll and maintain managed care patients as well as to attract beneficiaries to our new ACO. Current performance in providing adequate access and satisfying the needs of our patients needs to be improved. In order to progress this issue, an engagement with McKinsey & Co is commencing this month to assist the corporation to meet the needs of our current and future patients. This is a large and complex task and will be reported further in detail to the Committee as the work progresses.

CHIEF INFORMATION OFFICER REPORT

Bert Robles, Senior Vice President/Chief Information Officer provided the Committee with updates on the following initiatives:

Meaningful Use (MU) Stage 2 :

This morning we have a Meaningful Use presentation for the committee but I also wanted to briefly update the members as to the Corporation's status to meet Meaningful Use Stage II.

The Corporation continues efforts to meet requirements under the American Recovery and Reinvestment Acts (ARRA) program for Meaningful use of Electronic Health Records. This national program aims to increase the prevalence of electronic health record use across all providers of care including hospitals and community practitioners with the aim of forming a more connected healthcare system that is necessary to coordinate care, improve efficiency, decrease cost, and improve quality. This multi-year program has several Stages which will evolve over the coming years. Each Stage contains new requirements and providers are rewarded with incentive funds for achieving and sustaining each Stage.

In the fall of 2012, all eleven HHC facilities attested to achieving Stage 1 Meaningful Use. As a result, HHC received $17million of incentive funding under the Medicare portion of the Program and another $43.5 Million in Medicaid incentive dollars. In Stage 1 of the program, Hospitals need to meet minimum thresholds with fourteen core program measures as well as five menu measures. This stage continues for another year. HHC will receive additional incentives in 2013, provided Hospitals continue to meet these minimum thresholds. HHC is currently on track to do so and we continue to monitor performance across the system. To monitor for ongoing compliance all eleven hospitals run monthly reports on these performance measures.

Even as HHC remains focus on sustaining Stage 1, the Corporation is preparing for Stage 2 of the program. Stage 2 of the program includes both new requirements not previously part of Stage 1, as well as increased achievement thresholds for existing requirements. Among the changes are the requirements for Bar Coding of medications as well as the ability for a patient to download an admission summary within 36 hours of hospital discharge. In addition, several of the measures, which were optional in Stage 1, are now required in stage 2, including transition of data to immunization registries, medication reconciliation, and patient specific

education resources. In addition to meeting the Meaningful Use Criteria described above, each hospital will need to electronically transmit sixteen Quality measures to CMS.

As was the case in preparing for Meaningful Use Stage 1, Stage 2 will require several major software upgrades. These include moving from the current QuadraMed software version of 5.2, first to version 5.4 and ultimately to version 6.0. QuadraMed has advised HHC that the 6.0 version will not be generally available until the third quarter of calendar year 2013. However, it is anticipated that several HHC facilities will participate in the Beta release of this version which will give HHC an opportunity to test the system and test the features and functions in the release. All facilities are expected to be on version 5.4 by June 30, 2013. In addition to these software upgrades, there is also a database upgrade for the Cache database as well as updates to the MediSpan drug database.

As was the case for attestation in Stage 1, the first year of Stage 2 is allows for a 90 day compliance period as opposed to 365 days in subsequent years. However, unlike stage 1, which allowed hospitals to choose any 90 day period, Stage 2 requires the period to coincide with a quarter within the Federal Fiscal year. HHC plans to have all software upgrades completed by the fall of 2013, thus permitting hospitals to attest in one of the three remaining quarters of the fiscal year: January – March 2014; April – June 2014; or July – September 2014 (last chance).

METROPLUS HEALTH PLAN, INC.

Arnold Saperstein, MD, Executive Director, MetroPlus Health Plan, Inc. presented to the Committee. Dr. Saperstein informed the Committee that the total plan enrollment as of January 31, 2013 was 443,173. Breakdown of plan enrollment by line of business is as follows:

Medicaid	377,914
Child Health Plus	13,466
Family Health Plus	36,467
MetroPlus Gold	3,287
Partnership in Care (HIV/SNP)	5,679
Medicare	6,354
MLTC	6

From December to January, MetroPlus gained 4,630 members. MetroPlus experienced a positive gain in Medicare, gaining 160 enrollees.

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.

Dr. Saperstein informed the Committee that MetroPlus' membership losses to Health First and Fidelis are holding steady at 1,200 per month. MetroPlus continues to reevaluate their marketing and retention efforts to address these losses. The losses due to the dental plan change have tapered off, and MetroPlus is working with Healthplex to continually improve their dental network's satisfaction.

MetroPlus was informed this month that 160 Water Street will be open and available for occupancy on February 15, 2013. Their move back to 160 Water Street is dependent on air quality safety, as well as full availability of phone and data services. MetroPlus is working on their plan for relocating all areas and anticipate having all operations back at 160 Water Street by mid-March 2013.

This month, MetroPlus completed an analysis of their Medicare disenrollments and found that the majority of their losses were because members voluntarily disenrolled to join another plan. The largest segment of the members surveyed left MetroPlus' Platinum product to join Healthfirst Medicare.

Enrollment for MetroPlus' new Managed Long Term Care product began on January 1, 2013. MetroPlus currently has six members and are expecting 22 new members in February, including 13 new auto assignments.

MetroPlus is in the process of preparing to submit an application for the Fully Integrated Duals Advantage (FIDA) program. FIDA is a three-year demonstration project designed to test new service delivery and capitated payment models for beneficiaries dually eligible for Medicaid and Medicare. These beneficiaries must require more than 120 days of long term support and services. The demonstration project will be effective in January 2014 and will service eight New York counties, including Bronx, Kings, New York, Queens, Nassau, Suffolk, Richmond and Westchester. The total number of beneficiaries eligible for the demonstration is estimated at 123,000. Beneficiaries currently enrolled in the MetroPlus MLTC program will be passively enrolled in the FIDA program, with an option to opt-out. All Medicare Advantage plans will transition to a product line to provide FIDA. Otherwise, plans that do not transition to FIDA will only serve duals that opt-out or dis-enroll from FIDA. The initial application is due to CMS February 15, 2013.

On January 31, 2013 the New York Health Benefit Exchange issued its invitation to health insurers and dental plans to participate in the New York Health Benefit Exchange. The letter of interest is due on February 15, 2013, and the submission of a participation form is required by April 5, 2013. NYS Health Benefit Exchange will go live in October 2013. Qualified Health Plans (QHPs) are classified into 4 types of product levels, Platinum, Gold, Silver, and Bronze; with progressively increased copayments and deductibles. Within each plan there will be an additional pediatric option and within the Silver plan there are three additional levels of coverage based on a member's income as compared to the federal poverty level. Given these requirements, MetroPlus must offer a minimum of 16 products in the NYS Health Benefit Exchange, which will also include a Catastrophic Plan.

Governor Cuomo released his Executive Budget on Tuesday January 22, 2013. The Executive Budget proposes to revise existing Medicaid categories and convert eligibility levels to a Modified Adjusted Gross Income (MAGI) equivalent standard. The Executive's proposal establishes a new adult category for individuals ages 19 to 64 with incomes below 133 percent of the Federal Poverty Level (FPL) and provides that these beneficiaries receive a Benchmark benefit package. There will also be unique eligibility levels for pregnant women, parents, infants and children The Executive Budget also defines the Medicaid eligibility categories that will not be subject to MAGI financial methodologies and adds a new mandatory eligibility category for former foster care children, up to age 26 years old, who were receiving Medicaid when they aged out of foster care. The Executive Budget establishes 12 month continuous eligibility for individuals whose Medicaid eligibility is based on MAGI methodologies, except for individuals whose eligibility changes due to citizenship, residency or failure to provide a valid social security number.

Other changes in the Executive Budget include:

- Medicaid global cap (3.9%) remains in place and the 2% across-the-board payment cut, which was scheduled to expire at the end of this fiscal year, is extended through March of 2015;
- A repeal of "prescriber prevails" authority for atypical antipsychotics in Medicaid managed care and in the entire Medicaid fee-for-service (FFS) pharmacy program;
- Institutes a new $20 million quality incentive program for the Managed Long Term Care program;
- Eliminates statutory impediments to enrolling excluded FFS populations into Medicaid managed care;

- Amends the autism mandate to replace the $45,000 annual benefit cap with 680 hours of treatment per policy or calendar year;
- Enacts numerous provisions that will enable New York to align and conform with the federal Affordable Care Act (ACA) and move forward with the New York Health Exchange including:
    - Beginning a phase out of the Family Health Plus (FHP) and FHP buy-in programs;
    - Eliminating the standardized individual direct pay products, effective October 2013, and establishing a new individual market product outside of the Exchange that must conform to Exchange requirements;
    - Eliminating the Healthy New York program, effective December 31, 2013.

INFORMATION ITEM:

1. Meaningful Use Update – Stage 2

Presenting to the Committee was Louis Capponi, MD, Chief Medical Informatics Officer. Starting in 2014, providers participating in the EHR Incentive Programs who have met Stage 1 for two or three years will need to meet meaningful use Stage 2 criteria. Stage 2 includes new objectives to improve patient care through better clinical decision support, care coordination and patient engagement. With this next stage, EHRs will further save our health care system money, save time for doctors and hospitals, and save lives.

Dr. Capponi reviewed the core objectives and menu objectives comparing the changes from Stage 1 to Stage 2 (see attached table for details). Highlights of the changes are below.

More than 50 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH have their information available online within 36 hours of discharge (Stage 1 was 10%, menu set). More than 5 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH view, download or transmit to a third party their information during the reporting period (new). Clinical summaries provided to patients within 24 hours for more than 50 percent of office visits (Stage 1 was 3 days).

More than 10 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) are provided patient- specific education resources identified by Certified EHR Technology (Stage 1 was menu set). A secure message was sent using the electronic messaging function of Certified EHR Technology by more than 10 percent of unique patients seen during the EHR reporting period (New – Eligible Provider).

The eligible hospital or CAH performs medication reconciliation for more than 65 percent of transitions of care in which the patient is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) (Stage 1 was 50%, menu set). The eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals. The eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care electronically transmits a summary of care record using certified EHR technology to a recipient with no organizational affiliation and using a different Certified EHR Technology vendor than the sender for more than 10 percent of transitions of care and referrals (Stage 1 was one test of transmission).

Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process (added data at rest).

In summary, there are a total of 22 Meaningful Use objectives of which 16 are core items required for Stage 2 and 3 of 6 menu items required for Stage 2. In Stage 2, Stage 1 menu items are now required, seven new objectives added and some related Stage 1 objectives combined. In addition, quality reporting now separate element of meaningful use. Hospitals now must report on 16 measures. Quality measures include the following 29 measures in six domains: Patient and Family Engagement (5); Patient Safety (6); Care Coordination (2); Population and Public Health (0); Efficient Use of Healthcare Resources (2); and Clinical Processes/Effectiveness (14).

There being no further business the meeting adjourned at 11:04 A.M.

Core Objectives

Core Objective	Measure Stage 1	Measure Stage 2
1. CPOE	**30%** medication	Use CPOE for **more than** 60% of medication, **30%** of laboratory, and **30%** of radiology
2. Demographics	**50%** demographics	Record demographics for more than **80%**
3. Vital Signs	**50%** vital signs over age 2	Record vital signs for **more than** 80%, blood pressure over age 3.
4. Smoking Status	**50%** smoking status	Record smoking status for **more than** 80%
5. Interventions	1 clinical support	Implement 5 clinical decision support interventions + drug/drug and drug/allergy
6. Labs	**40%** lab results	Incorporate lab results for **more than** 55%
7. Patient List	Same	Generate patient list by specific condition
8. eMAR	NEW	eMAR is implemented and used for **more than** 10% of medication orders
9 Transitions of Care Record	**50%** patients who request electronic copy are provided within 3 days.	Provided for more than 50% of transitions of care or referrals (does not have to be electronic) More than 10% are transmitted electronically • Care plan, including goals and instructions • List of team members, including PCP
10. Education Resources	Provide education resources. (previously a menu item)	Provide education resources **more than 10%** by certified EHR technology
11. Rx Reconciliation	Same (previously a menu item)	Medication reconciliation **at more than** 50% of transitions of care

Core Objectives

Core Objective	Measure Stage 1	Measure Stage 2
12. Summary of Care Record for Patient	(New)	Updated measure. Patients can View, Download, and transmit to a Third Party a summary of care document within 36 hours, 50% of the time and 5% of patients actually do so.
13. Immunizations	Perform 1 test on EHR to submit data (previously a menu item)	Successful ongoing transmission of immunization data
14. Reportable Labs	Perform 1 test on EHR to submit data (previously a menu item)	Successful ongoing submission of reportable laboratory results
15. Syndromic Surveillance	Perform 1 test on EHR to submit data (previously a menu item)	Successful ongoing submission of electronic syndromic surveillance data
16. Security Analysis	Conduct or review security analysis	Conduct or review security analysis and incorporate in risk management process addressing encryption of data

HHC NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

Menu Objectives (choose 3)

Menu Objective	Measure Stage 1	Measure Stage 2
1. Advanced Directives	**50%** of transactions of care.	Record advanced directives for **more than 50%** of patients 65 years or older
2. Progress Notes	NEW	Enter an electronic progress note for **more than 30%** of unique patients
3. Imaging Results	NEW	**More than 20%** of imaging results are accessible through Certified EHR Technology
4. Family History	NEW	Record family health history for **more than 20%**
5. E-Rx	NEW	**More than 10%** electronic prescribing (eRx) of discharge medication orders
6. Labs	NEW	Provide structured electronic lab results to EPs for **more than 20%**

HHC NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

Bert Robles
Senior Vice President, Information Technology Services
Report to the M&PA/IT Committee to the Board
Thursday, March 14, 2013 – 12:00 Noon

Thank you and good afternoon. I would like to provide the Committee with the following updates:

1. **HHC's Response to the February 21st Cyber-Attacks:**

On Thursday, February 21st, China according to "*The Washington Post*" hacked computers of virtually every institute in Washington. Additionally on the same day, Froedhert Hospital in Milwaukee, Wisconsin announced that it encountered one massive security hack that caused 43,000 patient records to be exposed. It was estimated that this security breach could cost Froedhert hospital close to $8.3m in damages.

Following these developments, the EITS Security Team became extra vigilant in monitoring intrusion attempts on our corporate assets especially from outside HHC. On February 22nd, the EITS Security Team proactively engaged the "*US Computer Emergency Readiness Team"* (US-CERT) and received specific IP addresses and websites that were involved in attacks against US government and private entities. This was non-public information and was received over a secure channel. In addition, the Security Team engaged and alerted its security partners/vendors and sister agencies. Based on historical institutional knowledge and information received from the Department of Homeland Security, the FBI and other

entities contacted, the EITS Security Team elevated HHC's security status which included re-calibrating our perimeter security devices (Intrusion Prevention Systems, Anti-Virus, DNS, Firewalls etc.,) within a matter of 4 hours to cover all known as well as unknown but expected intrusions. In addition, the monitoring which is usually from 8am-6pm was extended to 24 by 7 from Friday, February 22nd through Monday, February 25th.

As a result of these proactive measures and collaboration with internal and external entities, HHC managed to block all malicious attempts. At this point, there is no reported or detected compromise of any HHC asset due to the alleged Chinese cyber-attacks. We continue to operate our security devices at increased sensitivity but have resumed normal security monitoring

2. ICIS Electronic Health Record (EHR) Program Update:

I wanted to update the committee on EITS' activities regarding the Epic implementation. Since my last update to the committee at the January meeting, I am pleased to report that our planning phase for this program is well underway.

Staffing:

As you all know, our first major deadline with the project was to have identified 80% of the project team members by March 1st in order for HHC to begin the first wave of Epic training on March 25th. Depending on their identified roles, EHR staff may need to attend multiple trainings at the Epic campus in order to receive their certification on specific application modules. It was critical for the program team to recruit and identify those

key staff members who would be attending the first trainings scheduled for the week of March 25th. I am happy to report that the team has met this challenge and we will be sending our first wave of trainees to EPIC in late March.

Current Program Activities:

I am also pleased to report that the Infrastructure and Operations team has ordered the necessary hardware for the program and it is being staged for initial review of the EPIC application.

The program team continues to work on and prioritize workflows for standardization across the enterprise. We are in the process of developing a plan for application review sessions which will start in late June of this year and go through August. We anticipate some 200+ sessions for this review by HHC clinical and non-clinical staff over a 6-8 week period. Planning for this large scale event is underway and the team is currently exploring venues where this event could be held.

We are also in the process of finalizing the program plan which includes establishing a governance model, refining baseline timelines and milestones, as well as creating a risk plan. With Epic, we are also in the process of looking at key criteria that will be used in discussions with Senior HHC leadership to identify which facility/network will be the initial site for our implementation strategy.

Going forward, I will continue to provide a monthly update to the committee members on our progress.

This completes my report today. Thank you.

MetroPlus Health Plan, Inc.
Report to the
HHC Medical and Professional Affairs Committee
March 14th, 2013

Total plan enrollment as of February 28th, 2013 was 440,352. Breakdown of plan enrollment by line of business is as follows:

Medicaid	376,316
Child Health Plus	13,090
Family Health Plus	35,650
MetroPlus Gold	3,184
Partnership in Care (HIV/SNP)	5,604
Medicare	6,485
MLTC	23

This month, we had a net loss of 4,339 members. We experienced a positive gain in Medicare, gaining 346 enrollees.

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.

This month, we analyzed disenrollments from our plan. In February, we had 19,978 disenrollments from MetroPlus, and 15,639 new applications. The majority of the losses were due to loss of Medicaid eligibility, likely a catch-up after Superstorm Sandy.

Our membership losses to Health First and Fidelis continue to be a significant part of our monthly losses. In February, we lost 899 members to Healthfirst and we lost 783 members to Fidelis Care. As I have reported in the past, approximately 80% of the members that transfer from MetroPlus to Healthfirst leave the HHC system as well. This trend began this summer, after our dental transition to Healthplex. We have completed further disenrollment surveys beyond the dental transition period and the overwhelming number of members surveyed stated that they wish to see doctors that are not a part of the MetroPlus network.

This month, MetroPlus successfully completed the submission of the initial Centers for Medicaid and Medicare Services (CMS) FIDA application on February 21st, 2013. The FIDA program is a demonstration project between CMS and the State of New York and is focused on long term care. MetroPlus is currently waiting for guidance from the State on any next steps that may be required.

In February, MetroPlus implemented an authorization program for outpatient high tech radiology services (PT, MRI, MRA, CT) and nuclear cardiology services. Due to the volume of requests, and expertise required, MetroPlus will be partnering with MedSolutions to issue the authorizations for these services. All HHC facilities are excluded from this authorization requirement.

The HHC Health Home initiative has entered into its second phase of enrollment. At the end of January, the State sent HHC a new list of members for outreach to join the HHC Health Home. The current outreach strategy includes a target outreach population of 50% of HHC FFS patients and 50% MetroPlus members. A mailing of 1,300 letters was sent this month and the response is favorable. The current enrollment in the HHC Health Home is 640 patients, 348 of which are MetroPlus members. In addition, the NYSDOH notified health plans that the plans must diversify their contracts beyond HHC. MetroPlus has entered into negotiations with other Health Homes that are not considered direct competitors.

This month, the state has announced the Phase II Medicaid Redesign Team rate adjustments for health plans. There will be an overall increase of 0.6% to Medicaid rates and 0.7% to Family Health Plus rates. In the future, there will also be a rate increase for our Managed Long Term product line. The calculation for reimbursement was made on the assumption that 80% of members in the program would be nursing home certifiable. The actual number has proven to be 98% of members that are nursing home certifiable- generating the rate increase.

There will be a .7% shift in dollars due to the transportation carve-out; these dollars will be used to support the primary care rate increase required by the Affordable Care Act. For dates of service starting January 1st, 2013, the statute specifies that higher payment applies to primary care services delivered by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine. The regulation specifies that specialists and subspecialists within those designations as recognized by the American Board of Medical Specialties (ABMS) the American Osteopathic Association (AOA) or the American Board of Physician Specialties (ABPS) also qualify for the enhanced payment. In order to be eligible for higher payment physicians must first self-attest to a covered specialty or subspecialty designation. It was recently announced that the State will collect attestations from providers and will provide plans with an eligibility file to aid in the reimbursement process.

As the New York State Medicaid Redesign Team continues their work to cut costs, the focus is now on the Behavioral Health population. The latest recommendation for NYC will be full benefit integrated SNPs (affiliated with existing plan or freestanding) for high need populations to be called Health and Recovery Plans (HARPs). HARPs eligibility criteria and specialized benefits will be developed by DOH, OASAS, OMH and NYC with stakeholder input. The state has issued a draft BH benefit redesign proposal timeline which shows that applicants will need to be prepared to respond to serve as a HARP in the Summer of 2013 with a 30-day response time to an RFP. HARPs will begin operation in Fall/Winter 2014.

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

February-2013

		Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13
Total Members	Prior Month	436,861	438,861	437,983	437,477	439,074	440,766	444,691
	New Member	19,121	15,925	14,290	19,154	11,239	13,415	15,639
	Voluntary Disenroll	3,471	3,072	2,578	3,264	2,134	2,524	2,920
	Involuntary Disenroll	13,650	13,731	12,218	14,293	7,413	6,966	17,058
	Adjusted	-8	-4	2	124	788	1,522	0
	Net Change	2,000	-878	-506	1,597	1,692	3,925	-4,339
	Current Month	438,861	437,983	437,477	439,074	440,766	444,691	440,352
Medicaid	Prior Month	368,999	371,618	371,454	371,422	373,730	375,165	379,400
	New Member	16,199	13,323	11,858	16,403	9,418	10,878	13,063
	Voluntary Disenroll	2,904	2,599	2,192	2,831	1,824	2,067	2,395
	Involuntary Disenroll	10,676	10,888	9,698	11,264	6,159	4,576	13,752
	Adjusted	-4	1	9	124	804	1,486	0
	Net Change	2,619	-164	-32	2,308	1,435	4,235	-3,084
	Current Month	371,618	371,454	371,422	373,730	375,165	379,400	376,316
Child Health Plus	Prior Month	16,095	15,692	15,370	15,120	14,668	14,479	13,469
	New Member	397	437	467	454	216	334	381
	Voluntary Disenroll	53	33	35	39	21	38	29
	Involuntary Disenroll	747	726	682	867	384	1,306	731
	Adjusted	-1	-1	-2	-2	-4	3	0
	Net Change	-403	-322	-250	-452	-189	-1,010	-379
	Current Month	15,692	15,370	15,120	14,668	14,479	13,469	13,090
Family Health Plus	Prior Month	36,887	36,667	36,302	36,021	35,672	36,108	36,468
	New Member	2,173	1,818	1,603	1,917	1,279	1,491	1,819
	Voluntary Disenroll	366	243	215	260	151	205	238
	Involuntary Disenroll	2,027	1,940	1,669	2,006	692	926	2,399
	Adjusted	0	-2	-3	-3	-6	1	0
	Net Change	-220	-365	-281	-349	436	360	-818
	Current Month	36,667	36,302	36,021	35,672	36,108	36,468	35,650

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

February-2013

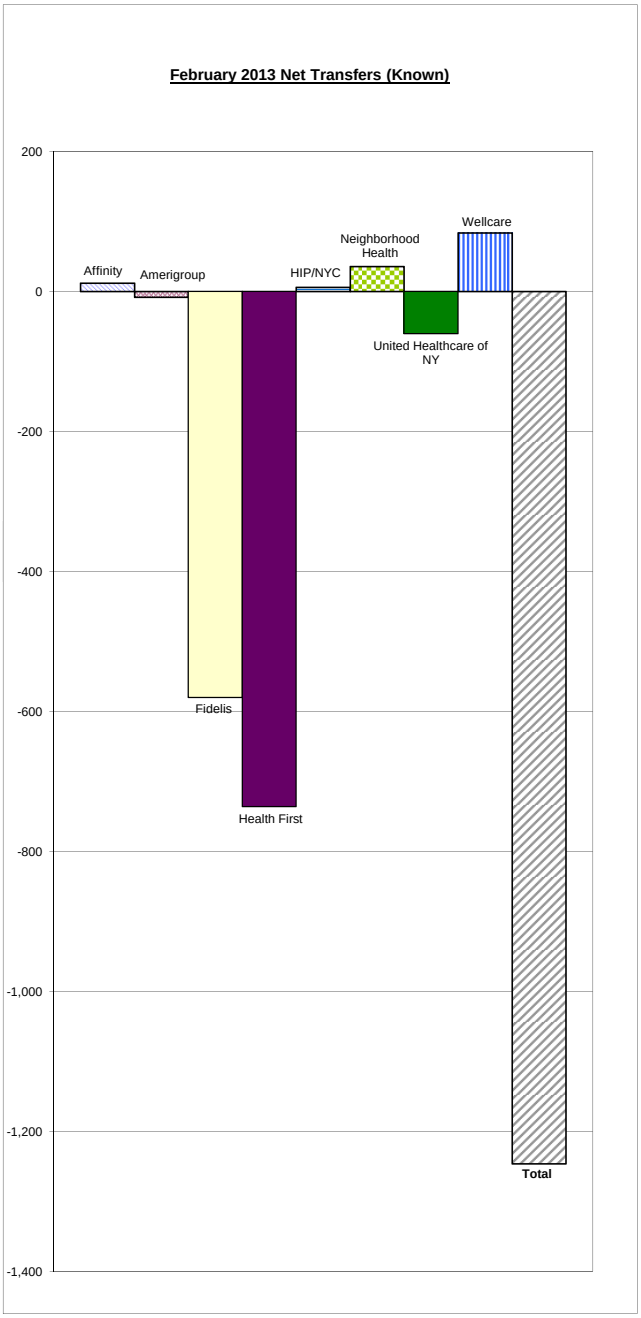
		Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13
HHC	Prior Month	3,187	3,128	3,131	3,135	3,119	3,114	3,318
	New Member	18	26	25	17	20	231	4
	Voluntary Disenroll	0	2	0	0	0	0	113
	Involuntary Disenroll	77	21	21	33	25	27	25
	Adjusted	-5	-4	-3	4	-5	31	0
	Net Change	-59	3	4	-16	-5	204	-134
	Current Month	3,128	3,131	3,135	3,119	3,114	3,318	3,184
SNP	Prior Month	5,801	5,790	5,773	5,754	5,748	5,711	5,677
	New Member	110	107	94	102	74	74	74
	Voluntary Disenroll	42	43	33	33	27	34	44
	Involuntary Disenroll	79	81	80	75	84	74	103
	Adjusted	2	2	2	2	-2	-2	0
	Net Change	-11	-17	-19	-6	-37	-34	-73
	Current Month	5,790	5,773	5,754	5,748	5,711	5,677	5,604
Medicare	Prior Month	5,892	5,966	5,953	6,025	6,137	6,189	6,353
	New Member	224	214	243	261	232	401	281
	Voluntary Disenroll	106	152	103	101	111	180	101
	Involuntary Disenroll	44	75	68	48	69	57	48
	Adjusted	0	0	-1	-1	1	3	0
	Net Change	74	-13	72	112	52	164	132
	Current Month	5,966	5,953	6,025	6,137	6,189	6,353	6,485
Managed Long Term Care	Prior Month	0	0	0	0	0	0	6
	New Member	0	0	0	0	0	6	17
	Voluntary Disenroll	0	0	0	0	0	0	0
	Involuntary Disenroll	0	0	0	0	0	0	0
	Adjusted	0	0	0	0	0	0	0
	Net Change	0	0	0	0	0	6	17
	Current Month	0	0	0	0	0	6	23

Disenrollments TO Other Plans		Feb-13			Mar-12 to Feb-13		
		FHP	MCAD	Total	FHP	MCAD	Total
	INVOL.	0	0	0	1	3	4
	VOL.	24	122	146	149	1,341	1,490
Affinity Health Plan	TOTAL	24	122	146	150	1,344	1,494
	INVOL.	0	2	2	3	21	24
	VOL.	25	207	232	219	2,430	2,649
Amerigroup/Health Plus/CarePlus	TOTAL	25	209	234	222	2,452	2,674
	INVOL.	0	0	0	1	20	21
	VOL.	73	710	783	782	6,686	7,468
Fidelis Care	TOTAL	73	710	783	783	6,706	7,489
	INVOL.	0	0	0	3	35	38
	VOL.	59	839	898	758	8,742	9,500
Health First	TOTAL	59	840	899	761	8,779	9,540
	INVOL.	0	1	1	0	3	3
	VOL.	12	80	92	133	980	1,113
HIP/NYC	TOTAL	12	81	93	133	983	1,116
	INVOL.	0	2	2	1	5	6
	VOL.	17	121	138	147	1,392	1,539
Neighborhood Health	TOTAL	17	123	140	148	1,398	1,546
	INVOL.	0	0	0	0	6	6
	VOL.	12	138	150	149	1,143	1,292
United Healthcare of NY	TOTAL	12	138	150	149	1,149	1,298
	INVOL.	0	0	0	2	11	13
	VOL.	3	38	41	32	335	367
Wellcare of NY	TOTAL	3	38	41	34	346	380
	INVOL.	0	5	5	11	104	115
	VOL.	225	2,255	2,480	2,369	23,049	25,418
Disenrolled Plan Transfers:	TOTAL	225	2,261	2,486	2,380	23,157	25,537
	INVOL.	10	26	36	61	583	644
	VOL.	13	99	112	173	1,019	1,192
Disenrolled Unknown Plan Transfers:	TOTAL	23	125	148	234	1,603	1,837
	INVOL.	1,697	13,027	14,724	12,115	111,590	123,705
	UNK.	0	0	0	33	75	108
	VOL.	0	41	41	87	1,608	1,695
Non-Transfer Disenroll Total:	TOTAL	1,697	13,068	14,765	12,235	113,273	125,508
	INVOL.	1,707	13,058	14,765	12,187	112,277	124,464
	UNK.	0	1	1	33	80	113
	VOL.	238	2,395	2,633	2,629	25,676	28,305
Total MetroPlus Disenrollment:	**TOTAL**	**1,945**	**15,454**	**17,399**	**14,849**	**138,033**	**152,882**

Disenrollments FROM Other Plans	Feb-13			Mar-12 to Feb-13		
	FHP	MCAD	Total	FHP	MCAD	Total
Affinity Health Plan	19	139	158	255	2,433	2,688
Amerigroup/Health Plus/CarePlus	21	205	226	513	4,407	4,920
Fidelis Care	11	192	203	176	2,420	2,596
Health First	11	152	163	197	2,334	2,531
HIP/NYC	5	94	99	77	1,267	1,344
Neighborhood Health	19	157	176	228	2,120	2,348
United Healthcare of NY	9	81	90	103	1,266	1,369
Wellcare of NY	16	109	125	223	1,343	1,566
Total	111	1,129	1,240	1,772	17,590	19,362
Unknown (not in total)	1,732	12,009	13,741	21,961	136,153	158,114

Data Source: RDS Report 1268a&c Updated 02/18/2013

Net Difference	Feb-13			Mar-12 to Feb-13		
	FHP	MCAD	Total	FHP	MCAD	Total
Affinity Health Plan	-5	17	12	105	1,089	1,194
Amerigroup/Health Plus/CarePlus	-4	-4	-8	291	1,955	2,246
Fidelis Care	-62	-518	-580	-607	-4,286	-4,893
Health First	-48	-688	-736	-564	-6,445	-7,009
HIP/NYC	-7	13	6	-56	284	228
Neighborhood Health	2	34	36	80	722	802
United Healthcare of NY	-3	-57	-60	-46	117	71
Wellcare of NY	13	71	84	189	997	1,186
Total	-114	-1,132	-1,246	-608	-5,567	-6,175



MetroPlus Health Plan

New Member Transfer From Other Plans

	2012_03		2012_04		2012_05		2012_06		2012_07		2012_08		2012_09		2012_10		2012_11		2012_12		2013_01		2013_02		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	20	254	30	242	38	296	26	239	21	180	23	199	22	212	15	202	15	190	7	128	19	152	19	139	2,688
Amerigroup/Health Plus/CarePlus	55	555	63	494	77	614	74	549	44	372	47	342	30	333	20	263	36	281	22	188	24	211	21	205	4,920
Fidelis Care	16	207	17	190	27	224	11	199	5	159	22	220	14	215	11	206	24	285	12	159	6	164	11	192	2,596
Health First	17	250	20	213	19	253	25	212	13	212	20	244	22	177	13	165	18	192	5	117	14	147	11	152	2,531
HIP/NYC	10	128	7	117	5	130	7	130	9	95	7	112	8	128	4	96	4	106	5	53	6	78	5	94	1,344
Neighborhood Health Provider PHPS	18	233	22	190	30	250	32	200	15	140	16	184	13	186	13	144	19	195	13	110	18	131	19	157	2,348
United Healthcare of NY	10	125	10	89	11	161	10	144	10	96	6	95	14	92	9	98	5	115	4	90	5	80	9	81	1,369
Unknown PLan	2,066	11,417	1,914	10,656	2,476	14,769	2,180	12,021	1,950	11,514	2,029	13,344	1,692	10,659	1,524	9,375	1,789	13,737	1,201	7,359	1,408	9,293	1,732	12,009	158,114
Wellcare of NY	31	121	23	144	15	185	27	146	19	84	32	137	13	91	16	79	18	86	8	70	5	91	16	109	1,566
TOTAL	2,243	13,290	2,106	12,335	2,698	16,882	2,392	13,840	2,086	12,852	2,202	14,877	1,828	12,093	1,625	10,628	1,928	15,187	1,277	8,274	1,505	10,347	1,843	13,138	177,476

Report ID: MHP1268C
Report Run Date: 2/15/2013

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 02/14/2013

Other Plan Name	Category	2012_03		2012_04		2012_05		2012_06		2012_07		2012_08		2012_09		2012_10		2012_11		2012_12		2013_01		2013_02		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	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	1	0	0	4
	VOLUNTARY	6	71	7	130	14	128	13	115	11	112	15	113	11	133	11	93	21	151	7	88	9	85	24	122	1,490
	TOTAL	6	71	7	130	14	129	13	115	11	113	15	113	11	133	11	93	21	151	8	88	9	86	24	122	1,494
Amerigroup/ Health Plus/CarePlus	INVOLUNTARY	0	2	0	3	0	2	1	4	0	1	0	2	2	1	0	1	0	0	0	2	0	1	0	2	24
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
	VOLUNTARY	14	128	20	197	33	187	22	267	11	242	19	242	11	236	14	182	17	210	11	168	22	164	25	207	2,649
	TOTAL	14	130	20	200	33	189	23	271	11	243	19	244	13	237	14	183	17	210	11	170	22	166	25	209	2,674
Fidelis Care	INVOLUNTARY	0	0	0	1	0	1	0	1	0	4	0	2	0	0	0	2	0	1	0	6	1	2	0	0	21
	VOLUNTARY	17	147	21	264	28	274	27	240	77	564	148	989	98	792	90	652	79	874	40	547	84	633	73	710	7,468
	TOTAL	17	147	21	265	28	275	27	241	77	568	148	991	98	792	90	654	79	875	40	553	85	635	73	710	7,489
Health First	INVOLUNTARY	1	0	1	3	0	3	0	3	0	5	0	4	0	0	0	5	0	0	1	4	0	8	0	0	38
	UNKNOWN	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2
	VOLUNTARY	29	300	54	478	61	635	45	603	76	780	115	997	69	911	60	833	73	934	62	664	55	768	59	839	9,500
	TOTAL	30	300	55	481	61	638	45	606	76	786	115	1,001	69	911	60	838	73	934	63	668	55	776	59	840	9,540
HIP/NYC	INVOLUNTARY	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	3
	VOLUNTARY	9	54	14	113	13	99	17	83	11	83	7	84	10	91	12	52	17	90	6	69	5	82	12	80	1,113
	TOTAL	9	54	14	114	13	99	17	83	11	83	7	84	10	92	12	52	17	90	6	69	5	82	12	81	1,116
Neighborhood Health Provider PHPS	INVOLUNTARY	0	0	0	1	0	0	0	0	0	0	0	1	1	0	0	0	0	1	0	0	0	0	0	2	6
	UNKNOWN	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	VOLUNTARY	8	75	15	94	13	139	17	106	8	119	23	140	13	133	10	122	14	169	5	61	4	113	17	121	1,539

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 02/14/2013

		2012_03		2012_04		2012_05		2012_06		2012_07		2012_08		2012_09		2012_10		2012_11		2012_12		2013_01		2013_02		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	TOTAL	8	76	15	95	13	139	17	106	8	119	23	141	14	133	10	122	14	170	5	61	4	113	17	123	1,546
United Healthcare of NY	INVOLUNTARY	0	1	0	1	0	0	0	0	0	1	0	2	0	0	0	0	0	0	0	1	0	0	0	0	6
	VOLUNTARY	7	49	8	68	12	102	11	69	13	110	18	129	11	92	7	84	21	144	12	74	17	84	12	138	1,292
	TOTAL	7	50	8	69	12	102	11	69	13	111	18	131	11	92	7	84	21	144	12	75	17	84	12	138	1,298
Wellcare of NY	INVOLUNTARY	0	0	0	1	2	5	0	0	0	2	0	1	0	0	0	1	0	1	0	0	0	0	0	0	13
	VOLUNTARY	2	13	1	17	3	27	1	30	4	15	2	38	3	30	3	31	3	45	2	24	5	27	3	38	367
	TOTAL	2	13	1	18	5	32	1	30	4	17	2	39	3	30	3	32	3	46	2	24	5	27	3	38	380
Disenrolled Plan Transfers	INVOLUNTARY	1	3	1	11	2	12	1	8	0	14	0	12	3	2	0	9	0	3	2	13	1	12	0	5	115
	UNKNOWN	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	4
	VOLUNTARY	92	837	140	1,361	177	1,591	153	1,513	211	2,025	347	2,732	226	2,418	207	2,049	245	2,617	145	1,695	201	1,956	225	2,255	25,418
	TOTAL	93	841	141	1,372	179	1,603	154	1,521	211	2,040	347	2,744	229	2,420	207	2,058	245	2,620	147	1,708	202	1,969	225	2,261	25,537
Disenrolled Unknown Plan Transfers	INVOLUNTARY	6	31	7	84	8	59	3	33	11	34	2	33	4	20	1	93	5	32	0	83	4	55	10	26	644
	UNKNOWN	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	VOLUNTARY	18	68	26	75	7	40	31	102	9	72	19	103	17	100	8	86	15	132	6	79	4	63	13	99	1,192
	TOTAL	24	100	33	159	15	99	34	135	20	106	21	136	21	120	9	179	20	164	6	162	8	118	23	125	1,837
Non-Transfer Disenroll Total	INVOLUNTARY	1,252	10,186	1,062	9,786	1,077	9,304	1,270	10,972	971	9,738	1,191	9,733	1,194	10,142	889	8,874	1,226	10,547	155	5,494	131	3,787	1,697	13,027	123,705
	UNKNOWN	2	13	2	15	3	9	5	5	8	6	5	2	2	4	4	15	2	1	0	3	0	2	0	0	108
	VOLUNTARY	78	781	2	98	7	133	0	92	0	76	0	69	0	81	0	57	0	82	0	50	0	48	0	41	1,695
	TOTAL	1,332	10,980	1,066	9,899	1,087	9,446	1,275	11,069	979	9,820	1,196	9,804	1,196	10,227	893	8,946	1,228	10,630	155	5,547	131	3,837	1,697	13,068	125,508
Total MetroPl	INVOLUNTARY	1,259	10,220	1,070	9,881	1,087	9,375	1,274	11,013	982	9,786	1,193	9,778	1,201	10,164	890	8,976	1,231	10,582	157	5,590	136	3,854	1,707	13,058	124,464

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 02/14/2013

		2012_03		2012_04		2012_05		2012_06		2012_07		2012_08		2012_09		2012_10		2012_11		2012_12		2013_01		2013_02		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	**UNKNOWN**	2	15	2	15	3	9	5	5	8	7	5	2	2	4	4	15	2	1	0	3	0	3	0	1	113
	VOLUNTARY	188	1,686	168	1,534	191	1,764	184	1,707	220	2,173	366	2,904	243	2,599	215	2,192	260	2,831	151	1,824	205	2,067	238	2,395	28,305
	TOTAL	1,449	11,921	1,240	11,430	1,281	11,148	1,463	12,725	1,210	11,966	1,564	12,684	1,446	12,767	1,109	11,183	1,493	13,414	308	7,417	341	5,924	1,945	15,454	152,882

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate a contract with CyraCom International, Inc., Language Line Services, and Pacific Interpreters, Inc. to provide over-the-phone-medical interpreting (OPI) services to the Corporation to meet the patient care needs of its limited English proficient patient population and comply with external review agency requirements for a term of three years with two-one year options to renew, solely exercisable by the Corporation, for an amount not to exceed $30,853, 396.

WHEREAS, the Corporation is committed to providing equitable, safe, timely, efficient patient centered care in the languages spoken by its patient populations; and

WHEREAS, in fiscal year 2012 over twenty-five percent of the Corporation's patient population was deemed limited English proficient; and

WHEREAS, in fiscal year 2012, over 190 languages and dialects were spoken by the patients receiving care by the Corporation; and

WHEREAS, the Corporation requires the assistance of firms specializing in over-the-phone medical interpreting services to support the provision of patient care services in the languages spoken by the populations served by the Corporation's acute care hospitals, long term care facilities, diagnostic and treatment centers, certified home health agency and, community based clinics.

WHEREAS, CyraCom International, Inc., Language Line Services, and Pacific Interpreters, Inc. are recognized leaders in the provision of over-the-phone medical interpreting services; and

WHEREAS, the Corporation will benefit from the provision of over-the-phone medical interpreting services to its patients requiring such services; and

WHEREAS, the provision of over-the-phone medical interpreting services will enable compliance with external review agency regulations, standards and law; and

WHEREAS, the responsibility for monitoring these contracts shall reside with the Senior Vice President for Safety and Human Development.

NOW, Therefore, BE IT

RESOLVED, THAT THE President of the New York City Health and Hospitals Corporation (the "Corporation") be and hereby is authorized to negotiate a contract with CyraCom International, Inc.,

Language Line Services, and Pacific Interpreters, Inc. to provide over-the-phone-medical interpreting (OPI) services to the Corporation to meet the patient care needs of its limited English proficient patient population and comply with external review agency requirements for a term of three years with two-one year options to renew, solely exercisable by the Corporation, for an amount not to exceed $30,853,396.

EXECUTIVE SUMMARY

The accompanying resolution requests authorization to negotiate a three year contract with two-one year options to renew with CyraCom International, Inc., Language Line Services, and Pacific Interpreters, Inc. for the provision of over-the-phone medical interpreting services for the HHC acute care hospitals, long term care facilities, community based clinics and certified home health agency.

Contracts with these Vendors are required to enable HHC to provide culturally competent care, meet the patient care needs of its diverse limited English proficient patient population, and comply with federal law, and external review agency requirements/standards. To assure patient care quality and safety, under these contracts, CyraCom, Language Line, and Pacific will provide medically qualified interpreters for 100% of interpretation calls requested by any HHC facility or program. Each Vendor will provide the equipment to enable over-the-phone interpretations. Each Vendor will also provide on-demand and monthly reports detailing duration of each interpreting assignment, language requested, hospital unit, provider name, medical record number, or any other information the specific facility requests be collected for reporting purposes. Reports of all languages requested by an HHC facility that was unavailable at the time of the request and the action(s) taken, including response time to provide the language will be standard.

CyraCom, Language Line, and Pacific have been providing OPI services at the HHC facilities since 2002, 2006 and 2009, respectively. The existing agreements with the three (3) Vendors were entered into in 2009. The contracts with the three Vendors expire on March 31, 2013, May 6, 2013, and May 9, 2013.

Consistent with Operating Procedure 100-5, a competitive request for proposals process was initiated in October 2012. Subsequent to a robust evaluation process, CyraCom International, Inc., Language Line Services, and Pacific Interpreters, Inc. were selected to provide medical interpreting services because they each met the requirements as set forth in the RFP, offered a competitive rate of $0.75 per minute of medical interpreting services, and, had positive references. HHC currently pays $0.90 per minute of medical interpreting services. The proposed contracts are for a term of three years with two-one year options to renew, solely exercisable by the Corporation, for an amount not to exceed $30,853,396.

CONTRACT FACT SHEET

New York City Health and Hospitals Corporation

Contract Title: Over-the-Phone Medical Interpreting Services

Project Title & Number: Over-the-Phone Medical Interpreting Services DCN#: 2014

Project Location: HHC Acute Hospitals, Community-based Clinics, LTC Facilities, Certified Home Health Agency

Successful Respondents:

CyraCom International, Inc., Pacific Interpreters, Inc., and Language Line Services

Contract Amount: $ 30,853,396.00

Contract Term: 3 years with 2 additional one year options to renew solely exercisable by the Corporation

Requesting Dept.: Division of Safety and Human Development, Office of CLAS/LEP

Number of Respondents: (If sole source, explain in Background section) Ten

Range of Proposals: $ 0.67/minute to $ 0.99/minute

Minority Business Enterprise Invited: X Yes If no, please explain: _____

Funding Source: X General Care Capital
Grant: explain _____
Other: explain _____

Method of Payment: X Lump Sum Per Diem XX Time and Rate
Other: explain Payable upon invoice based on utilization

EEO Analysis: Complete

Compliance with HHC's McBride Principles? X Yes No

Vendex Clearance Yes No N/A **PENDING**

(required for contracts In the amount of $50,000 or more awarded pursuant to an RFP or as a sole source, or $100,000 or more if awarded pursuant to an RFB.)

CONTRACT FACT SHEET(continued)

Background *(include description and history of problem; previous attempts, if any, to solve it; and how this contract will solve it):*

The Division of Safety and Human Development is seeking authorization to contract with three vendors to provide over-the-phone medical interpreting services (OPI) to enable HHC to meet the patient care needs of its diverse patient population and comply with external review agency requirements. The selected Vendors are CyraCom International, Inc., Language Line Services, and Pacific Interpreters, Inc.

The provision of effective, timely and medically accurate interpreter services is a patient's right that is essential to the provision of patient-centered care, and foundational to assuring patient safety. Regulatory and accreditation agencies (Centers for Medicare and Medicaid Services, New York State Department of Health, The Joint Commission), federal law (Title VI of the Civil Rights Act), and national standards (National Standards for Culturally and Linguistically Appropriate Services) mandate the provision of healthcare services in a manner understood by patients. This includes providing an interpreter for those patients who are not proficient in English. The Joint Commission explicitly requires the following: "The hospital respects the patient's right to and need for effective communication"; "The hospital provides information in a manner tailored to the patient's age, language, and ability to understand"; and "The hospital provides language interpretation and translation services."

Historically, HHC has contracted with external vendors to provide OPI services. Given the volume of services required, it is necessary for HHC to contract with multiple vendors. In FY 12, over 25% of HHC's patient population was deemed limited English proficient. In FY 12, OPI services were utilized enterprise-wide for over 680,000 interpretation requests in over 190 different languages and dialects for a total of more than 7 million minutes of interpreting services at a cost of $6,665,000 to the HHC acute hospitals, long term care facilities, diagnostic and treatment centers, community health clinics, and certified home health agency. The need for OPI services will not diminish.

OPI services are currently being provided to HHC by three (3) vendors: Pacific Interpreters, Inc., Language Line Services, and CyraCom International, Inc. HHC entered into the existing agreements with the three (3) vendors in 2009 and the contracts expire on March 31, 2013, May 6, 2013, and May 9, 2013, respectively. The agreement with Language Line and CyraCom were extensions to a prior contract. The agreement with Pacific was new in 2009. The current negotiated rate per minute of medical interpreting is $0 .90. Each vendor invoices the HHC facilities that utilize their service; payments are remitted to the vendor by each facility.

Consistent with HHC Operating Procedure 100-5, a request for proposals for OPI services was issued on October 12, 2012. Ten (10) proposals were received of which three (3) vendors were selected. The selected vendor(s) have the capacity to meet HHC's current and potential increasing demand for OPI services. The proposed term of the new contracts with each of the three vendors will be for a period of three years, with two additional one-year options to renew, solely exercisable by the Corporation. The anticipated total cost of the contract over 5 years is $30,853,396.00 which includes a 10% contingency of $2,804,854.00.

CONTRACT FACT SHEET (continued)

Contract Review Committee

Was the proposed contract presented at the Contract Review Committee (CRC)? (include date):

Yes. October 3, 2012

Has the proposed contract's scope of work, timetable, budget, contract deliverables or accountable person changed since presentation to the CRC? If so, please indicate how the proposed contract differs since presentation to the CRC:

No

CONTRACT FACT SHEET (continued)

Selection Process *(attach list of selection committee members, list of firms responding to RFP, list of firms considered, describe here the process used to select the proposed contractor, the selection criteria, and the justification for the selection):*

List of Selection Committee Members

Chairperson: Aleksandra Sas, Associate Director, CLAS
Patricia Banks, Assistant Director, Language Coordinator, Coney Island Hospital
Melanie Colon, Assistant Director, Bellevue Hospital Center
Joanne Grimes, Director of Patient Relations, Jacobi Medical Center
Lucila Jimenez, Associate Director, Language Assistance Program, Lincoln Medical and Mental Health Center
Fernando Lee, Assistant Director, Volunteer Public Department, Elmhurst Hospital Center
Irene Quinones, Associate Director, Metropolitan Hospital Center
Frederick Covino, Assistant Vice President, Corporate Budget
Mark Walter, Senior Counsel, Legal Affairs

List of Firms Responding to RFP

Certified Languages International
CyraCom International, Inc.
Language Line Services
Language Select
Linguistica International, Inc.
Optimal Phone Interpreters
Pacific Interpreters, Inc.
Telelanguage, Inc.
Translation Plus, Inc.
Transperfect Remote Interpreting

Process used to Select the Proposed Contractors

Proposals were received from ten (10) Vendors. Each proposal received by close of business November 13, 2012 was reviewed to determine if it met the minimum qualifications as specified in the RFP: Vendor must have a minimum of 10 years of experience working with hospitals and healthcare organizations to provide over-the-phone medical interpreting; Vendor must adopt the National Standards of Practice for Interpreting in Healthcare and the National Code of Ethics for Interpreters in Healthcare; Vendor must be capable of providing exclusively medically qualified interpreters; and, Minimum of three non-HHC healthcare facility or healthcare system client references, for services provided within the past three years. None of the proposals were eliminated and all 10 were considered for evaluation by the Selection Committee.

The proposals were sent to the members of the Selection Committee for review along with the evaluation criteria. The Selection Criteria included points for:

A. Technical Qualifications (40%)
- Evaluation of the Vendor Qualification Requirements delineated in the Scope of Services
- Evaluation of the Medical Interpreter Qualification Requirements delineated in the Scope of Services
- Clear description of emergency back-up process for providing medically qualified interpreters
- Capacity to provide services compatible with standard/vendor/brand neutral phone equipment
- Adequacy of currently provided capacity/volume of OPI medical interpreting, in minutes
- Documented proof of languages provided (including lesser diffusion languages)

B. Previous Client References (10%)
- Minimum of three non-HHC healthcare facility or healthcare system client references for services provided within the last 3 years.
- List of current/recent clients for similar scope of work as delineated in this RFP (volume, languages, etc.)

C. Company Organization and Qualification (15%)

- 10 years of experience working with hospitals and healthcare organizations in OPI medical interpreting
- Evidence that the Vendor has adopted the National Standards of Practice for Interpreting in Healthcare and the National Code of Ethics for Interpreters in Healthcare
- Description of Company and its organizational structure

D. Cost of Proposal ((25%)

- Reasonable flat fee cost per minute for the three year contract term and for each one year renewable option

E. Other (10%)

- Capacity and willingness to meet the performance requirements as indicated in the RFP: Response time to provide qualification data on each interpreter when requested within 24 hours; and, Evidence of connection time within an average of 40 seconds

Selection Committee Members reviewed and scored each vendor proposal and submitted their completed evaluation forms to the Associate Director CLAS/LEP. Total score per bidder ranged from 40.34 to 69.61. Price per minute per vendor ranged from $0.67 to $0.99 per minute of interpretation. The Associate Director CLAS/LEP aggregated the scores.

Selection Committee members met to discuss and agree on the potential finalists. Subsequent to the meeting, a Selection Committee member re-tabulated the scores given to each proposal to validate the accuracy of the initial aggregated scores.

The three vendors with the highest evaluation scores were selected as finalists pending reference checks.

Three references were contacted for each of the 3 proposed finalists.

After review of references, Committee Members re-confirmed the selection of the 3 vendors. A "best and final offer" was requested from each of the three vendors.

On December 26, 2012 correspondence was sent to CyraCom International, Inc, Language Line Services, and Pacific Interpreters, Inc. via e-mail and postal service notifying each that they had been selected as a potential vendor pending approval by the HHC Board of Directors.

Correspondence was sent to the remaining 7 vendors via e-mail that they had not been selected.

All original materials submitted in response to this solicitation are maintained in the Office of CLAS/LEP.

Justification for the Selection

Of the 10 proposals received, the Selection Committee determined that CyraCom International, Inc., Pacific Interpreters, and Language Line Services met the RFP requirements, received the highest evaluation scores, received positive references, and offered a competitive rate of $0.75/minute of medical interpretation. Based on a review of the proposals, the 3 vendors combined can meet the current and future OPI volume requirements of the Corporation.

Scope of work and timetable:

The selected vendor(s) have demonstrated expertise and extensive experience in over-the-phone medical interpreting for healthcare agencies and are capable of meeting HHC's volume and language requirements. Each vendor will provide medically qualified interpreters for 100% of interpretation calls requested by any HHC facility or program, within an average of 40 seconds. Each Vendor will provide monthly reports detailing duration of each interpreting assignment, language requested, hospital unit, provider name, medical record number or other information the specific facility ask to be collected for reporting purposes. Each Vendor will also provide monthly reports of all languages requested by an HHC facility that was unavailable at the time of the request and the action(s) taken, including response time to provide the language. The contracts will be effective April 1, 2013 pending Board approval.

CONTRACT FACT SHEET (continued)

Costs/Benefits:

Given the extensive range of languages and dialects spoken by HHC's patient population, particularly lesser diffusion languages, it would be impossible and cost-prohibitive for HHC to internally staff the provision of medically qualified interpreter services, across 21 facilities plus home health services, 24/7/365. Qualified medical interpreters have extensive training to accurately interpret complex medical terminology and convey this information between members of the healthcare team and the patient and his/her family. Qualified medical interpreters allay the concerns of both patients and providers by effectively communicating with the patient and minimizing opportunity for error. OPI is a high quality, cost effective vehicle for providing critically essential, high-volume patient care services.

Why can't the work be performed by Corporation staff:

The Corporation does not have staff at each facility on all tours who speak over 190 languages and dialects and who are expert in providing highly specialized medical interpreter services. Given HHC's diverse limited English proficient population, it would be prohibitively expensive, inefficient and a risk to patient care quality and safety to in-source this work.

Will the contract produce artistic/creative/intellectual property? Who will own It? Will a copyright be obtained? Will it be marketable? Did the presence of such property and ownership thereof enter into contract price negotiations?

No

Contract monitoring (include which Senior Vice President is responsible):

Aleksandra Sas, Associate Director, HHC's Office of CLAS/LEP will have daily responsibility for contract monitoring with oversight by Caroline M. Jacobs, Senior Vice President for Safety and Human Development.

CONTRACT FACT SHEET (continued)

Equal Employment Opportunity Analysis *(include outreach efforts to MBE/WBE's, selection process, comparison of vendor/contractor EEO profile to EEO criteria. Indicate areas of under-representation and plan/timetable to address problem areas):*

Received By E.E.O. _____
Date

*Analysis Completed By E.E.O.*_____ _____
Date *Name*

Waiver of NYS Executive Law Article 15-A M/WBE Goals received on September 18, 2013. (See Attached)

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
nyc.gov/hhc
346 Broadway • Room 500B • New York, NY 10013 • Tel: 212-788-3380 • Fax: 212-788-3689

Manasses C. Williams
Assistant Vice President
Affirmative Action/EEO
manasses.williams@nychhc.org

TO: Aleksandra Sas
Associate Director,
Center for Culturally and Linguistically Appropriate Services (CLAS)

FROM: Manasses C. Williams

DATE: Febuary 20, 2013

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor **CyraCom LLC** has submitted to the Affirmative Action Office a completed Contract Compliance Questionnaire and the appropriate EEO documents.

This company is a:
[ ] Minority Business Enterprise [ ] Woman Business Enterprise [X] Non-M/WBE

Project Location(s): Central Office

Contract Number: _____ Project: Interpretation/Translation services

Submitted by: Center for Culturally and Linguistically Appropriate Services (CLAS)
EEO STATUS:

1. [X] Approved

2. [ ] Conditionally approved with follow-up review and monitoring-No EEO Committee Review

3. [ ] Not approved

4. [ ] Conditionally approved subject to EEO Committee Review

COMMENTS:

MCW:gsp

HHC NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
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346 Broadway • Room 500B • New York, NY 10013 • Tel: 212-788-3380 • Fax: 212-788-3689

Manasses C. Williams
Assistant Vice President
Affirmative Action/EEO
manasses.williams@nychhc.org

TO: Aleksandra Sas
Associate Director
Central Office – CLAS

FROM: **Manasses C. Williams**

DATE: **February 25, 2013**

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor/consultant, Language Line Services Inc., has submitted to the Affirmative Action Office a completed Contract Compliance Questionnaire and the appropriate EEO documents.
This company is a:
[ ] Minority Business Enterprise [ ] Woman Business Enterprise [X] Non-M/WBE

Project Location(s): HHC – Corporate Wide

Contract Number: _____ Project Number:_____

Submitted by: Central Office – CLAS

EEO STATUS:

1. [x] Approved

2. [ ] Conditionally approved with follow-up review and monitoring-No EEO Committee Review

3. [ ] Not approved

4. [ ] Conditionally approved subject to EEO Committee Review

COMMENTS:

c:

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
nyc.gov/hhc

125 Worth Street, Suite 401, New York, NY 10013 Tel: 212-788-3380 Fax: 212-788-3689

Manasses C. Williams
Assistant Vice President
Affirmative Action/EEO
manasses.williams@nychhc.org

TO: Aleksandra Sas, M.A.
Associate Director
Center for Culturally and Linguistically Appropriate Services

FROM: Manasses Williams

DATE: February 12, 2013

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor/consultant, **Pacific Interpreters, Inc.** has submitted to the Affirmative Action Office a completed Contract Compliance Questionnaire and the appropriate EEO documents.

This company is a:

[ ] Minority Business Enterprise [ ] Woman Business Enterprise [X] Non-M/WBE

Project Location(s): HHC's Corporate Wide

Contract Number: _____ Project: Language Interpreting Services

Submitted by: Center for Culturally and Linguistically Appropriate Services

EEO STATUS:

1. [X] Approved

2. [ ] Conditionally approved with follow-up review and monitoring-No EEO Committee Review

3. [ ] Not approved

4. [ ] Conditionally approved subject to EEO Committee Review

COMMENTS:

c: pt

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nyc.gov/hhc

Manasses C. Williams
Assistant Vice President
Affirmative Action/EEO
manasses.williams@nychhc.org

TO: Caroline M. Jacobs
Senior Vice President
Office of Patient Safety, Accreditation & Regulatory Services

FROM: Manasses C. Williams

DATE: September 18, 2012

SUBJECT: Waiver of NYS Executive Law Article 15-A M/WBE Goals

---

The New York City Health & Hospitals Corporation is in receipt of your email request dated 9/18/2012 for goals for the **RFP** for **Over-the-Phone Medical Interpreting Services (OPI) for the New York City Health and Hospitals Corporation.**

A review of the submitted data indicated that a **waiver** of the (M and/or WBE) goals for this **RFP**, is appropriate. A review of the scope of work required for this contract indicates that no Article 15A goals are required. The scope of work and method of negotiating the contract did not meet the requirements of Article 15A for establishing M/WBE goals. The Office of Affirmative Action/Equal Employment Opportunity will grant a waiver for the (MBE / WBE) goals on this contract.

Thank you for your cooperation. If you have any further questions, you may contact Martin Everette. He can be reached at (212) 788-3374.

MCW:moe

c: Martin O. Everette

Waiver Approval

RECEIVED ON
SEP 19 2012
PATIENT SAFETY

Over-the-Phone (OPI) Medical Interpreting Services

CyraCom International, Inc.
Language Line Services
Pacific Interpreters, Inc.

Caroline M. Jacobs
Chief Patient Safety Officer
Senior Vice President
Safety and Human Development

What are Over-the-Phone Interpreting Services (OPI)?

- A technique that uses telephones to connect professional human interpreters to individuals who need to speak to each other but who do not share a common language
- Connect remotely via telephone to professionals who are proficient in the languages of both the speaker and receiver and who may also have some knowledge or familiarity with both cultures
- In the healthcare environment, medical OPI services facilitate and support
  - Patient's ability to converse with their health care providers
  - Health care providers ability to converse with patients and their family

Why are Medical OPI Services Necessary?

- 25% of HHC's patient population is limited English proficient
- Critical to patient safety and the provision of culturally competent, patient-centered care
  - Clearly and concisely transfers complex, sensitive medical information in a manner understood by patients
  - Increases patient satisfaction
  - May reduce length of stay and, potentially, readmissions
- Enables compliance with external review agency requirements and federal laws and mandates for the provision of healthcare in a manner understood by patients (e.g., the Centers for Medicare and Medicaid Services, The Joint Commission, NYS Department of Health, Title VI of the Federal Civil Rights Act, local executive directives)

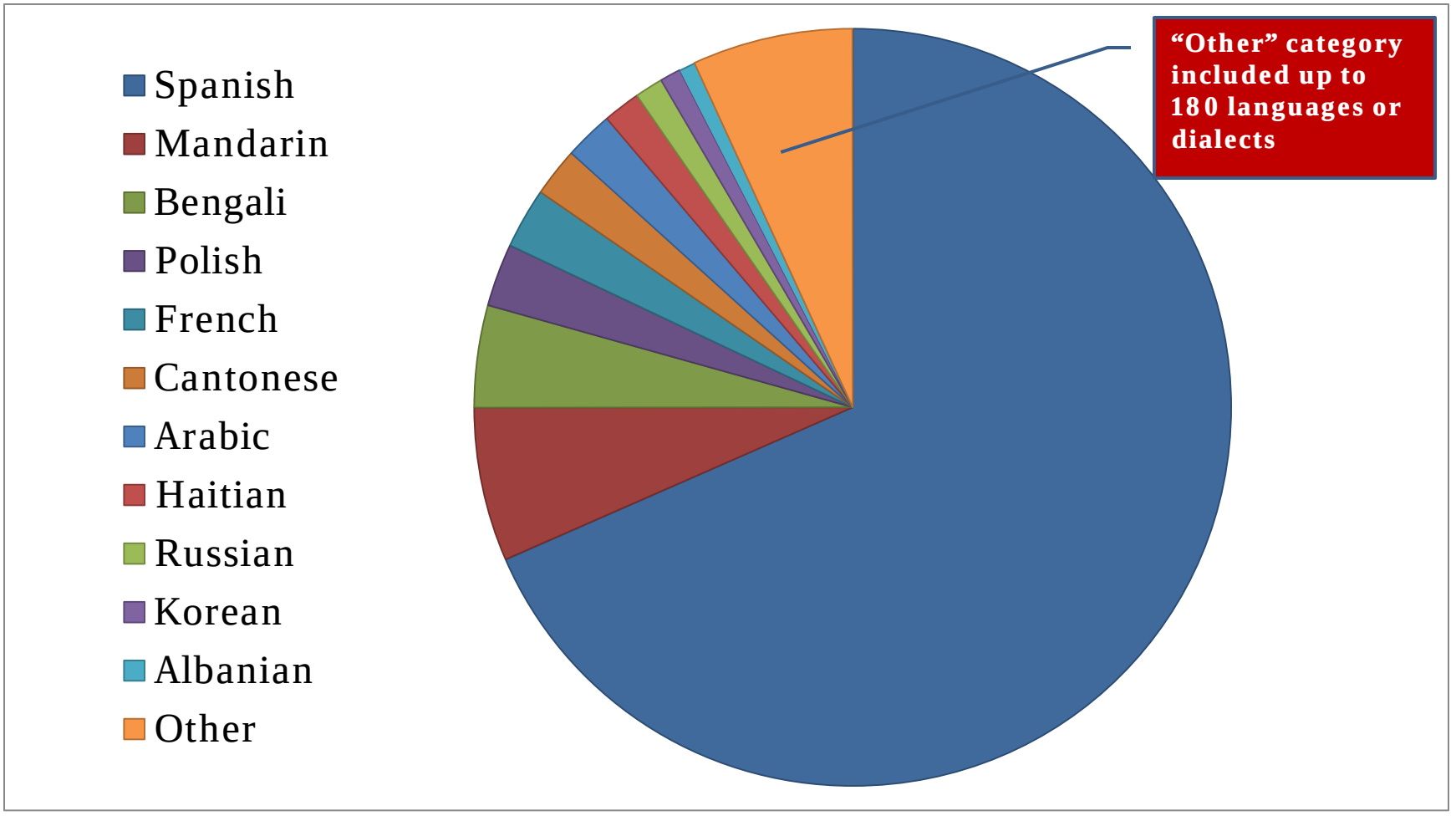
Over-the-Phone Medical Interpreting Service Usage at HHC (FY 12)

- OPI services used for approximately **700,000** interpreter requests in over **190** languages and dialects ranging from 0over 450,000 requests for Spanish to 1 request for Kanjobal (Mayan dialect)

- Over **7,000,000** minutes of medical OPI services requested and provided enterprise-wide at a total cost of **$6,670,000**

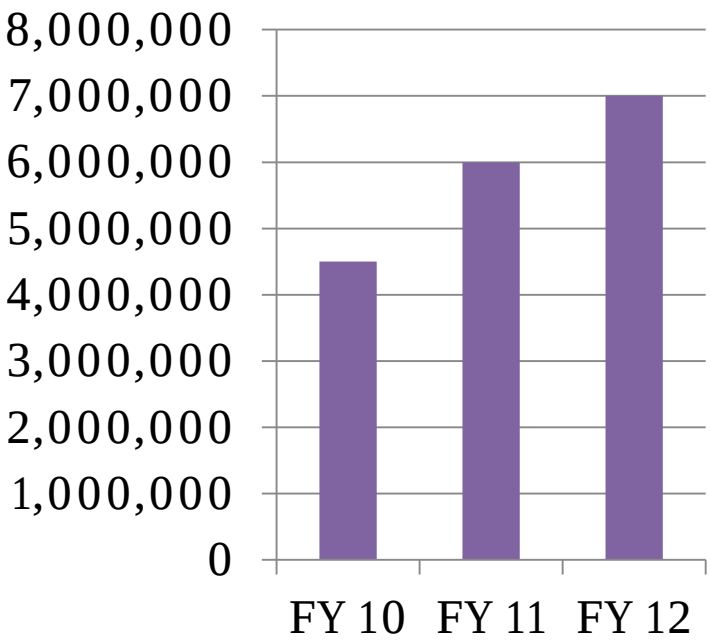
HHC Language Interpretation Statistics

Requested Interpretations by Language FY 12

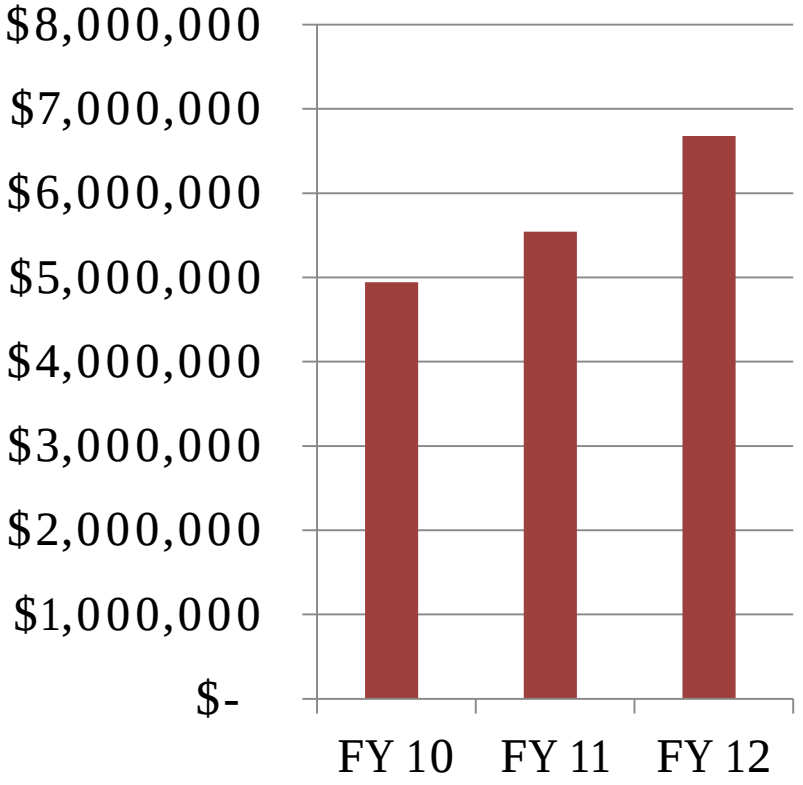


Current State – Growing Volume; Growing Expenditure FY 10 - FY 12

Interpretations in Minutes of Service



Expenditure



Current State

- Current contracts initiated with CyraCom International, Inc. (2002), Language Line Services (2006), and Pacific Interpreters, Inc. (2009). Each contract expires Spring 2013.
- Current flat fee rate is $0.90 per minute of medical interpreting services.
- Determined that we needed to scan the medical OPI market to assure the Corporation was receiving the best value and quality for the expenditure

Selection Process

- RFP issued October 12, 2012
- Non-mandatory bidders conference October 31, 2012 – 13 vendors participated
- Proposal due date – November 13, 2012
  - Proposals received from ten (10) Vendors
- Selection Committee deliberations and clarifications from Vendors
  - November - December
- Vendor notification, December 26, 2012
  - CyraCom International, Inc.
    Language Line Services
    Pacific Interpreters, Inc.

Key Contract Deliverables

- Provision of services by exclusively qualified medical interpreters for 100% of requests
- A 24/7 live operator to respond to HHC interpretation requests and connect each call within an average of 40 seconds, including lesser diffusion languages
- A 24/7 live operator to address HHC customer service concerns and an efficient complaint resolution process
- Monthly and on-demand reports of vendor performance
- Equipment (e.g., corded dual handset and cordless phones)

Contract

- Three years with 2-one year options to renew solely exercisable by the Corporation at a flat fee of $0.75 per minute of interpretation, irrespective of language, day of week, or time of day at an amount not to exceed $ 30, 853,396 for the 5 years

- New rate is a $0.15 per minute decrease over the current rate of $0.90 per minute of interpretation

- Facilities will determine the vendor they wish to receive services from; facilities may choose to receive services from more than one vendor

Contract Monitoring

- Responsibility rests with the Senior Vice President for Safety and Human Development through the HHC Office of Cultural and Linguistically Appropriate Services/Limited English Proficiency (CLAS/LEP)

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

nyc.gov/hhc

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate and execute a contract and related agreements with North Shore-Long Island Jewish Health Systems, Inc. ("NSLIJ") (i) to establish a jointly controlled not-for–profit hospital cooperative ("CoOpLab") that will provide laboratory services at cost to NSLIJ's and the Corporation's respective health systems in a new cooperative laboratory facility to be located within the City of New York for this purpose; (ii) for the period prior to CoOpLab obtaining the requisite licenses to provide such laboratory services, to have NSLIJ's existing not-for-profit corporation, which operates its core laboratory perform the Corporation's reference laboratory work that is now sent to commercial vendors at cost and have the Corporation join such not-for-profit corporation as a member; and (iii) to provide for NSLIJ to indemnify the Corporation for any cost, damage or liability arising out of its laboratory activities prior to the launch of the cooperative venture and out of any ongoing laboratory activities unrelated to the cooperative venture and for CoOpLab to purchase liability insurance to cover any claims that may arise in the conduct of CoOpLab's cooperative business.

AND

Authorizing the President of the Corporation to effectuate the establishment of CoOpLab and take such other actions as he/she deems appropriate to establish the cooperative laboratory structure described below consistent with these Resolutions.

WHEREAS, the Corporation's internal studies as augmented by independent consultants lead to the determination that the best way to assure high quality laboratory services and achieve savings is to collaborate with another large health system to establish a shared core laboratory to process clinical lab work for the Corporation's health system; and

WHEREAS, not-for-profit NSLIJ, the biggest integrated healthcare network in the New York metropolitan area, currently operates an efficient, high quality consolidated core laboratory to serve the needs of its member hospitals, and wishes to establish a new, larger consolidated core laboratory in collaboration with the Corporation to achieve even greater efficiencies; and

WHEREAS, a core laboratory shared by HHC and NSLIJ is expected to benefit the Corporation by achieving economies of scale, improved quality of services, lower prices and savings, and data sharing of best practices; and

WHEREAS, NSLIJ will be solely responsible to finance the purchase or lease of the selected site for the new laboratory facility, its improvements and outfitting; and

WHEREAS, the amount charged to CoOpLab by NSLIJ shall be capped at an amount based on a maximum agreed upon capital project cost; and

WHEREAS, both NSLIJ and the Corporation will appoint members of the board of directors of CoOpLab under an agreement providing that the following actions of CoOpLab will require the consent of the Corporation in its capacity as a founding member: (i) any sale, relocation or dissolution of the laboratory or of CoOpLab and any action that terminates the Corporation's membership status; (ii) any capital call; and (iii) the establishment of the level of reserves to be maintained by CoOpLab; and

WHEREAS, the governing documents of CoOpLab shall clearly establish that the Board of

CoOpLab shall act in the interest of all of its members and that any action that is proposed to be taken that will benefit NSLIJ and will impose any significant risks or costs on HHC will require the consent of HHC; and

WHEREAS, the Corporation will be indemnified by CoOpLab for any costs, damages or liability that arise from NSLIJ's activities conducted within the cooperative structure or prior to its establishment and CoOpLab will purchase liability insurance to cover any claims that may arise in the conduct of CoOpLab's cooperative business; and

WHEREAS, a CoOpLab joint standards committee with representatives of NSLIJ and the Corporation will develop the laboratory quality assurance standards and other methods and metrics for the laboratory operations of CoOpLab; and

WHEREAS, current employees of NSLIJ and the Corporation will be provided to CoOpLab to provide the needed laboratory services with all associated costs paid by CoOpLab; and

WHEREAS, through the cooperative structure, the Corporation will benefit from volume discounts on its purchases of laboratory equipment, blood products, systems and supplies;

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation") be, and hereby is, authorized to negotiate and execute a contract and related agreements with North Shore-Long Island Jewish Health Systems, Inc. ("NSLIJ") (i) to establish a jointly controlled not-for–profit hospital cooperative ("CoOpLab") that will provide laboratory services at cost to NSLIJ's and the Corporation's respective health systems in a new cooperative laboratory facility to be located within the City of New York for this purpose; (ii) for the period prior to CoOpLab obtaining the requisite licenses to provide such laboratory services, to have NSLIJ's existing not-for-profit corporation, which operates its core laboratory perform the Corporation's reference laboratory work that is now sent to commercial vendors at cost and have the Corporation join such not-for-profit corporation as a member; and (iii) to provide for NSLIJ to indemnify the Corporation for any cost, damage or liability arising out of its laboratory activities prior to the launch of the cooperative venture and out of any ongoing laboratory activities unrelated to the cooperative venture and for CoOpLab to purchase liability insurance to cover any claims that may arise in the conduct of CoOpLab's cooperative business; and

BE IT FURTHER RESOLVED, that the President of the Corporation be, and hereby is, authorized to effectuate the establishment of CoOpLab and take such other actions as he/she deems appropriate to establish the cooperative laboratory structure described consistent with these Resolutions.

HHC Laboratory Restructuring Project

March 12, 2013
Finance Committee

Agenda

- Overview
- Vision of the Cooperative
- Structure of the Cooperative
- Governance
- Business Model
- Staffing Changes
- Five Year Cost Savings Projections
- Implementation

Overview

- Current HHC lab operations
  - 4 Core Labs serving entire system
  - 12 Rapid Response Laboratories at each of the hospitals
- Restructuring project:
  - Efforts and savings to date
  - Review of options for restructuring
  - Identification of opportunity to achieve greater efficiencies through a shared core lab with another large health system
- Process to identify potential partners
- Cooperative with North Shore Long Island Jewish (NSLIJ)

Vision of the Cooperative

- Standard test menus for local hospital clinical tests
- Hospital labs provide:
  - Clinical lab results needed in less than four hours on behalf of Emergency Departments and Inpatient Units
  - Surgical and Anatomical Pathology
  - Blood Bank
- NSLIJ and HHC will cooperate to create one Shared Core Laboratory to process:
  - Clinical lab work on behalf of nursing homes, diagnostic and treatment centers and hospital clinics
  - Micro and Molecular Biology tests
  - Tests on behalf of community physicians and/or other outside business
- Through collaboration will achieve economies of scale, better pricing, savings for both entities, improved quality and data sharing of best practices

Structure of the Cooperative

- **“CoOpLab”**
  - Not for profit corporation
  - NSLIJ and HHC will have joint membership and operate shared core lab
  - Board of Directors from NSLIJ and HHC
  - CEO and management
  - Maintain NSLIJ outreach business and support HHC commercial insurance collection
- **NSLIJ and HHC**
  - Collaborate on lab methods but independently operate hospital rapid response labs
  - Share information technology
  - Same test menus
  - Group purchasing of equipment, reagents, and Blood products

Governance

- NSLIJ will have majority seats on the Board of Directors of “CoOpLab”
  - 15 years building the Core Lab
  - NSLIJ will be providing all of the initial capital
  - Given the phase in of HHC over 4 years and NSLIJ test growth rate it is almost certain that NSLIJ will always have the plurality of test volume
- HHC receives founding member status, which guarantees that if new members join, HHC’s rights and benefits shall not be diminished
- Critical decisions will require HHC’s consent as a founding member

Governance

- Decisions requiring HHC's consent as a founding member include:
  - Sale, closing, or relocation of core lab
  - Requirement that HHC contribute capital
  - The addition of any new member with the same rights as HHC
  - Termination of HHC's membership
  - Increases to the level of reserves of CoOpLab requiring increases to the cost per test
  - Any action taken to benefit NSLIJ at the expense of HHC

Governance

“CoOpLab”
Board of Directors
HHC/NSLIJ

CEO and Management Team

Shared Core Lab

Shared Suppliers
- Vendors (Best Pricing)
  - Reference Test and Blood products
  - Equipment
  - Reagents
  - Information Technology

Joint Standards Committees
HHC/NSLIJ
- System Interoperability
- Equipment and reagents
- Policy and Procedures
- Test Menu
- Research

Rapid Response Laboratories

HHC Hospitals

NSLIJ Hospitals

Business Model

HHC

- Staff and operate hospital labs
- Provide staff to “CoOpLab”
- Pay “CoOpLab” per test

“CoOpLab”

- Sell tests to HHC and NSLIJ at actual cost
- Pay HHC and NSLIJ for staff
- Pay NSLIJ rent
- Bill Commercial Insurers
- Group purchasing
- Methods best practice sharing

NSLIJ

- Staff and operate hospital labs
- Provide staff to “CoOpLab”
- Pay “CoOpLab” per test

Staffing Changes

Staff at HHC facilities	Base	FY2014	FY2015	FY2016	FY2017	FY2018
Clinical*	636	591	545	487	455	446
Microbiology**	162	162	132	71	0	0
Pathology and Blood Bank	607	607	607	607	607	607
HHC staff at HHC	1405	1360	1285	1165	1062	1053
HHC staff at the Core**	0	0	30	91	162	162
Total	**1405**	**1360**	**1315**	**1256**	**1224**	**1215**

*Clinical staff will not be replaced as they leave and will be redeployed across HHC

**Microbiology staff move to the core as we transition our hospitals

Five Year Cost Projections– Current State ($s in millions)

Current State	Base	FY2014	FY2015	FY2016	FY2017	FY2018
Testing						
Personal Services	$ 130.4	$ 132.4	$134.4	$136.6	$138.9	$ 141.3
Other Than Personal Services	$ 59.5	$ 63.0	$ 70.0	$ 69.9	$ 72.2	$ 74.5
Capital	$ 3.0	$ 6.5	$ 6.6	$ 6.7	$ 6.8	$ 6.9
Indirect	$ 23.4	$ 23.4	$ 23.4	$ 23.4	$ 23.4	$ 23.4
Subtotal	$ 216.2	$ 225.3	$234.4	$236.6	$241.3	$ 246.1
Blood Bank	$ 17.1	$ 17.6	$ 18.1	$ 18.6	$ 19.2	$ 19.8
Total	**$ 233.3**	**$ 242.9**	**$252.5**	**$255.3**	**$260.5**	**$ 265.9**

Five Year Cost "CoOpLab" model Projections ($s in millions)

"CoOpLab"	Base	FY2014	FY2015	FY2016	FY2017	FY2018
Testing						
Personal Services	$ 130.4	$ 128.5	$124.0	$115.9	$107.9	$ 108.9
Other Than Personal Services	$ 59.5	$ 44.6	$ 48.5	$ 40.6	$ 35.6	$ 33.0
Capital	$ 3.0	$ 3.9	$ 3.7	$ 3.2	$ 2.8	$ 2.5
Indirect	$ 23.4	$ 23.4	$ 23.4	$ 23.4	$ 23.4	$ 23.4
Subtotal	$ 216.2	200.3	199.6	183.1	169.5	167.8
Blood Bank	$ 17.1	$ 16.2	$ 16.4	$ 16.7	$ 17.0	$ 17.4
"CoOpLab"	$ -	$ 15.3	$ 22.8	$ 41.1	$ 59.3	$ 62.2
Total	**$ 233.3**	**$ 231.8**	**$238.7**	**$240.9**	**$245.9**	**$ 247.4**

Five Year Cost Savings Projections ($s in millions)

Change	Base	FY2014	FY2015	FY2016	FY2017	FY2018
Total Cost Current State	$ 233.3	$ 242.9	$252.5	$255.3	$260.5	$ 265.9
Total Cost Future State	$ 233.3	$ 231.8	$238.7	$240.9	$245.9	$ 247.4
Savings		**$ 11.1**	**$ 13.9**	**$ 14.4**	**$ 14.6**	**$ 18.5**
Additional Revenue			**$ 0.3**	**$ 1.9**	**$ 2.6**	**$ 4.6**
Total Benefit		**$ 11.1**	**$ 14.1**	**$ 16.3**	**$ 17.1**	**$ 23.1**

Implementation

- NSLIJ may immediately offer membership to HHC in its existing 501 C-3 which will allow HHC to send reference tests to the lab at cost for a savings of $1.7 million.
- NSLIJ would enter into a real estate lease and pay build out costs and pass actual rental and debt service costs down to the Core lab
- NSLIJ and HHC must agree to the allowable costs for the build out
- HHC and NSLIJ shall seek 501 C-3 status. If it is not awarded within nine months we will ask the IRS for 501 E status.

Implementation

- CoOpLab will need:
  - Liability and Insurance
    - Shared Core Lab must obtain
      - Commercial insurance
      - Malpractice insurance
    - NSLIJ must indemnify the new entity against prior claims
    - Each party must assume responsibility for claims arising out of non-member business
  - Regulatory/Certifications
    - Shared Core Lab must maintain all requirements
  - Disaster Plan
    - Shared Core Lab must have a plan to maintain business operations in the event of a disaster

North Shore LIJ Laboratories
North Shore-Long Island Jewish Health System

North Shore LIJ Health System Laboratories Presentation to HHC Medical and Professional Affairs Committee

James Crawford, MD, PhD – SVP, Chairman of Pathology and Laboratory Medicine
Bob Stallone - Vice President North Shore LIJ Health System Laboratories

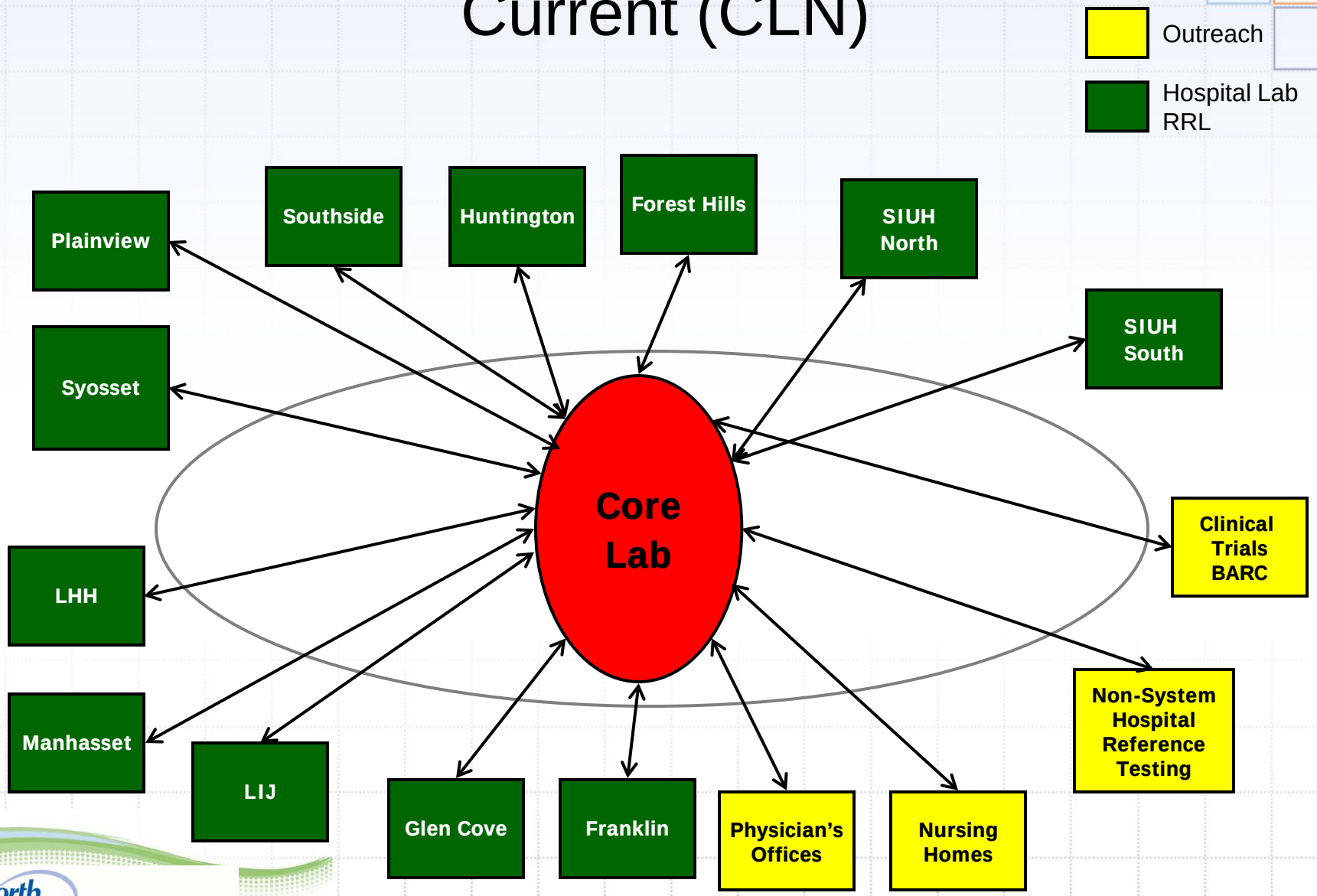
North Shore LIJ

Overview

- Strategically Located Core Laboratory
  - 15 years of continuous integration and growth
  - Current space limitations
- 11 Rapid Response Laboratories
  - Unified Management
  - Standardized Information Systems and Equipment
  - All testing capabilities available on site for patient management
  - Highly developed logistics service and infrastructure
- Goals:
  - Strategically partner with another non-for-profit organization who shares similar public/community/ teaching mission
  - Increase volume to reduce cost and improve quality and depth of service
  - Develop additional value opportunities through the relationship

North Shore LIJ

NSLIJ Centralized Laboratory Network Current (CLN)



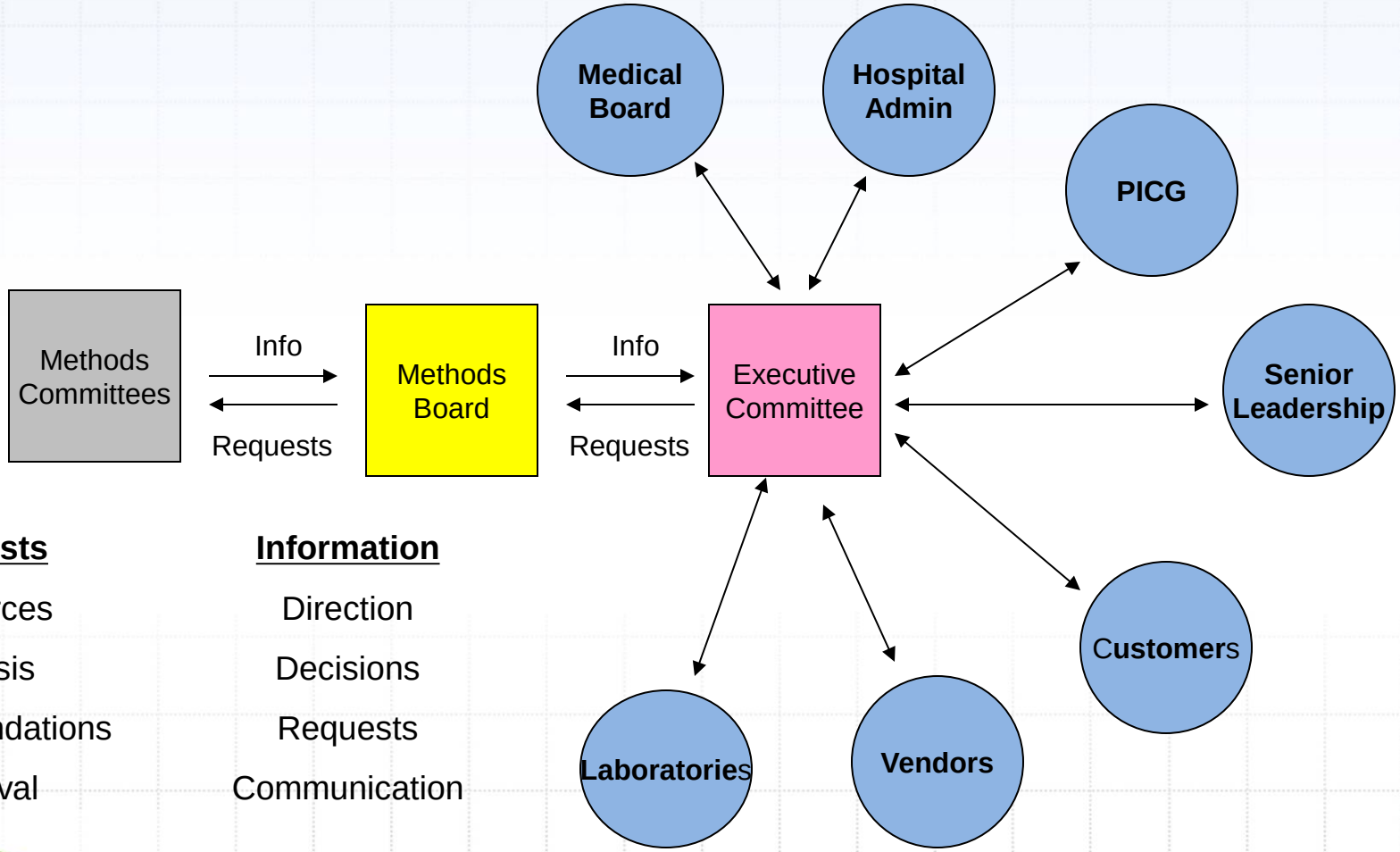
North Shore LIJ Laboratories
North Shore-Long Island Jewish Health System

Performance Metrics

Core Lab Key Indicators

Metric	Performance Area	Goal	Current
Stat Turn Around Time (call to call)	Service Excellence	240 min	186 min
Routine Turn Around Time	Service Excellence	95%- less than 4 hours	99.6%
Laboratory Error Rates	Operational Performance	275 DPMO (.03%)	229 DPMO (.02%)
“Likelihood to Recommend” (patient)	Customer Service	95%	99.7%
“Likelihood to Recommend” (physician)	Customer Service	95.8%	97.5%
Abandoned Call Rates	Customer Service	4.4%	3.4%
Live Voice in 20 Sec.	Customer Service	70%	71%
Critical Value Notification	Patient Safety	98% in 15 min	98%

Joint Standards Committee Process



Requests	**Information**
Resources	Direction
Analysis	Decisions
Recommendations	Requests
Approval	Communication

Improving Hypertension Control at HHC

March 14, 2013

David Stevens, MD

Office of Healthcare Improvement

Medical & Professional Affairs

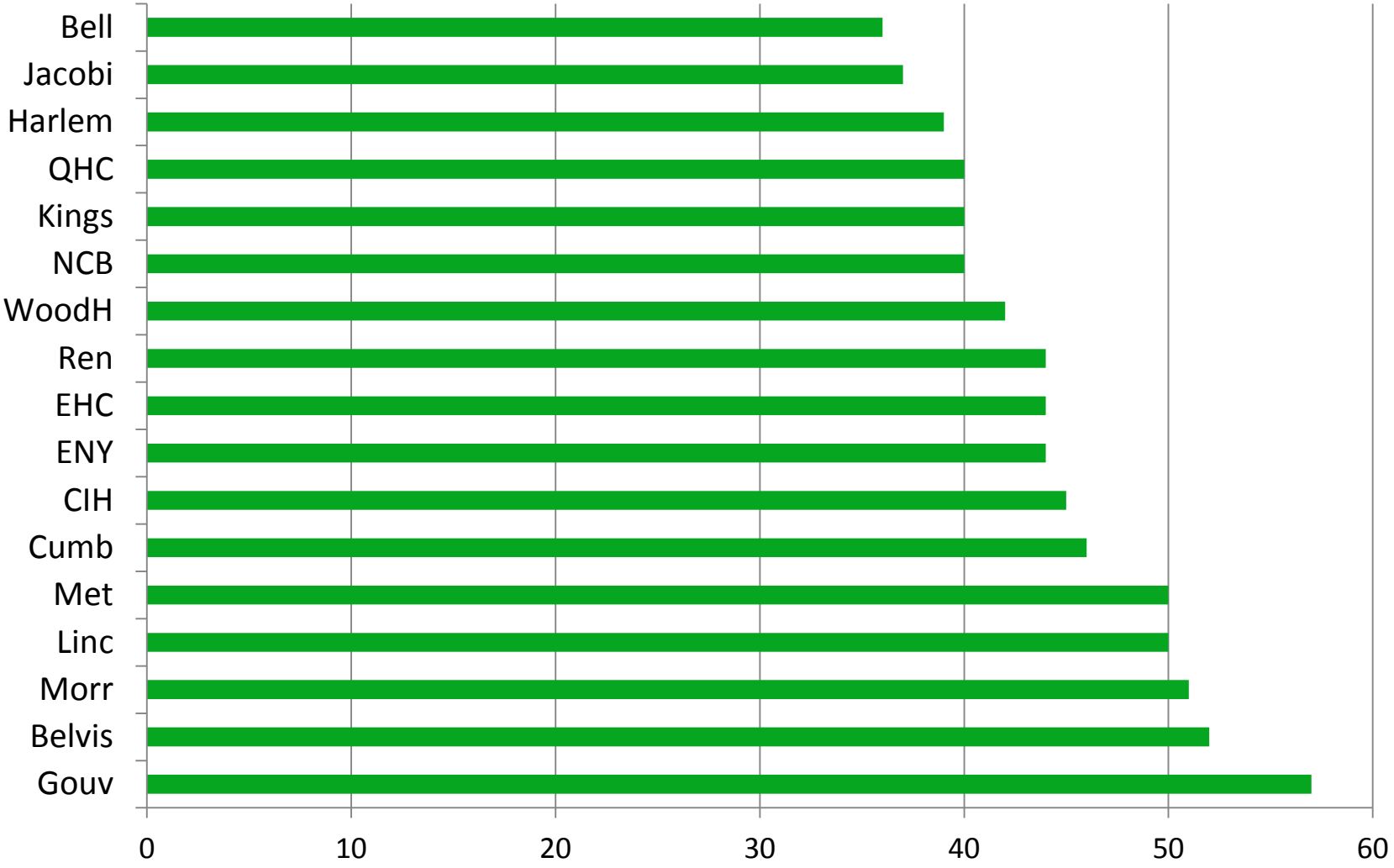
Hypertension at HHC

- #**2 Threat** to Population Health in US
  - 120,000 in Primary Care at HHC
    - **43**% are controlled (<140/90) (*46% nationally)*

- **HHC Quality Gap**: *Target is 75% Controlled*
  - *Meeting this target would mean 38,400 additional patients controlled, resulting in:*
    - *1920 fewer Heart Attacks every year*
    - *768 fewer Strokes every year*

*Each **1**% improvement across HHC prevents **60** MIs and **24** strokes*

Percentage of Primary Care patients with BP controlled at <140/90 – January 2013



BP Control at HHC

January 2010: 44%

January 2011: 43%

January 2012: 43%

January 2013: 43%

… No Improvement

Factors Contributing to Uncontrolled Hypertension

Physician Barriers

- Accepting 'close enough' ('therapeutic inertia')
- Ineffective counseling
- Unaware of own performance (compared w/ others)

Patient Barriers

- Insufficient engagement (awareness, commitment)
- Time and Cost involved in appointments

System Barriers

- Access to primary care appointments

Strategies for Hypertension Improvement at HHC

- Feedback to PCPs on Performance
- Identify Uncontrolled Patients in Registry
- Engage Patients as Partners in their Care:
  - Home BP monitors
  - Collaborative goal setting
  - Close relationship with RN care manager:
    - Uncover patients' barriers
    - Support patients' motivation for better BP control

Treat-to-Target: Essential Elements

1. **PCP**:
   - Determines & negotiates goal with patient
   - Directs RN in BP target and medication adjustments

2. **RN**:
   - Evaluates pt frequently: *Reaching target? Adhering?*
   - Counsels and adjusts treatment plan as needed
   - Consults with PCP as needed, documents (PCP cosigns)

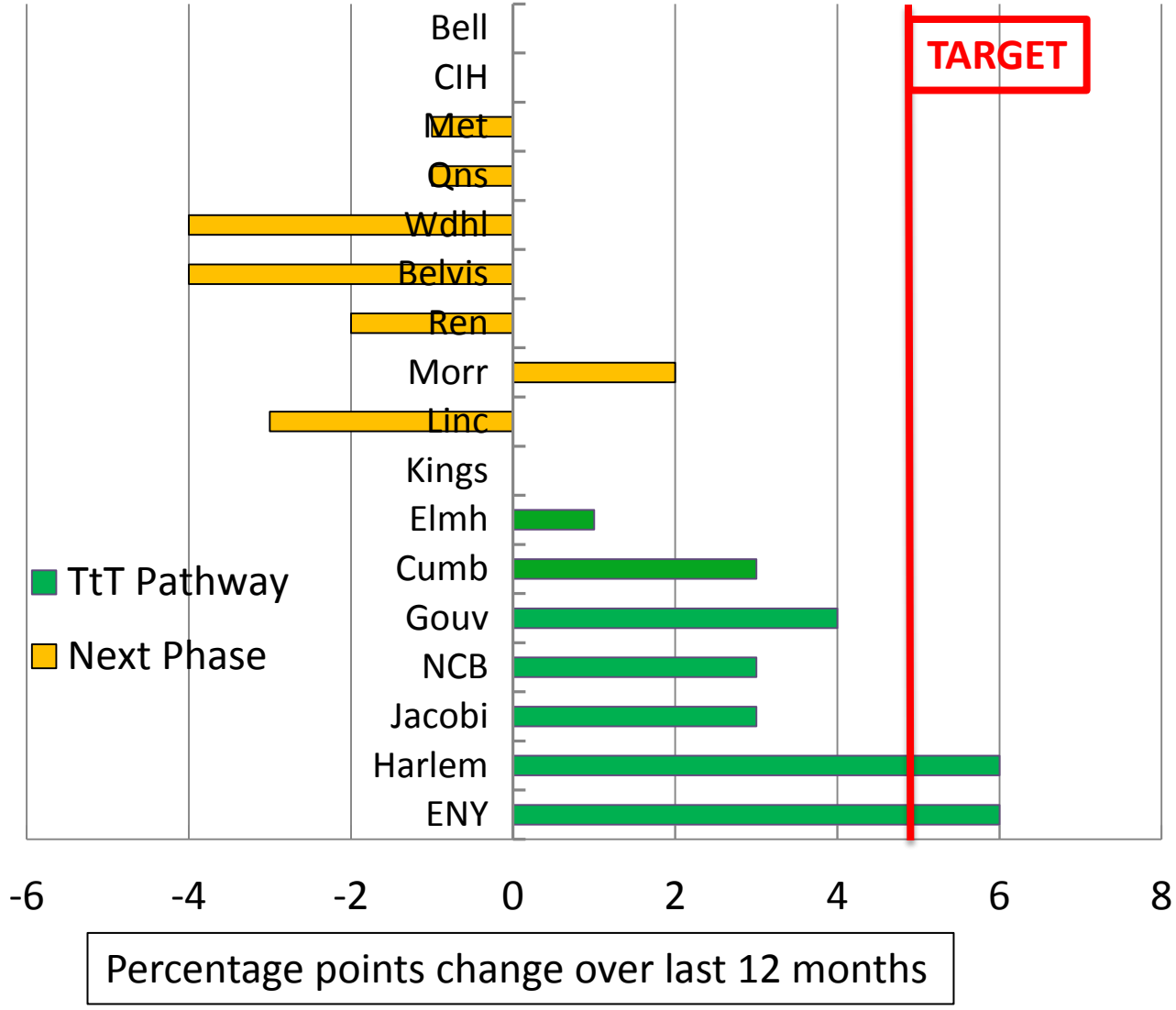
3. **Oversight of Progress**
   - Review program performance, provide feedback

Key Strategy:
RN-Led Treat-to-Target Pathway

Implemented in 6 facilities beginning May '13

- ***Focused***
  - Patients seen frequently by RN until BP is at target
  - "They get the message– this is about controlling BP"
- ***Supportive***
  - Relationship building with RN
  - Patients talk about their concerns about treatments
  - "Patients feel they have a team caring for them"
- ***Convenient***
  - "In and out" – patients appreciate minimal wait time

Percentage Change in BP Control: 12 months*



*Bellevue and CIH data is Jan 12 vs Oct 12

Next Steps

- **Spread** T-t-T Model to all facilities
- **Integrate** new conditions:
  - Phase 2:
    - Hyperlipidemia
    - Depression in hypertensive patients
  - Phase 3:
    - Diabetes
- **Innovations** to promote engagement
  - Community-based self-management groups
  - Pedometers and other devices
  - Digital social networks
- **Payment Models** that align with better outcomes
- **Registry** that integrates all population health concerns