AGENDA

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE

Meeting Date: April 16th, 2015
Time: 9:00 AM
Location: 125 Worth Street, Room 532

BOARD OF DIRECTORS

CALL TO ORDER — **DR. CALAMIA**

ADOPTION OF MINUTES
March 12th, 2015

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

METROPLUS HEALTH PLAN — **DR. SAPERSTEIN**

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

ACTION ITEMS:

I. **Authorizing the President of the New York City Health and Hospitals Corporation to execute a sole source contract for software licenses, maintenance and support services agreement with 3M Health Information Systems (3M) for the Coding and Reimbursement Information System installed at HHC's acute care hospitals, long-term care facilities and MetroPlus. The contract is for three years with two options to renew, each for one-year. The not too exceed amount for the full term of the agreement is $13,510,101 which includes a contingency of $643,338.** — **MR. GUIDO/MS. KATZ**

II. **Authorizing the New York City Health and Hospitals Corporation ("the Corporation") to purchase storage hardware, software, and associated maintenance from various vendors via Third Party Contract(s) in an amount not to exceed $13,220,000 for a one year period.** — **MR. GUIDO/MR. WILLIAMS**

INFORMATION ITEMS:

III. **Access to Ambulatory Care** — **DR. WILSON/DR. JENKINS**

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: March 12, 2015

ATTENDEES

COMMITTEE MEMBERS

Vincent Calamia, MD, Committee Chair
Josephine Bolus, RN
Antonio D. Martin (representing Dr. Ram Raju in a voting capacity)
Hillary Kunins, MD, (representing Dr. Gary Belkin in a voting capacity)

HHC CENTRAL OFFICE STAFF:

Machelle Allen, MD, Deputy Chief Medical Officer, Office of Health Care Improvement
Maricar Barrameda, Assistant Vice President of EITS
Janette Baxter, Senior Director, Risk Management
Nicholas V. Cagliuso, Assistant Vice President, Office of Emergency Management
Deborah Cates, Chief of Staff, Board Affairs
Tammy Carlisle, Associate Executive Director, Corporate Planning
Michael Coppa, Legal Intern, Legal Affairs
Paul Contino, Chief Technology Officer, EITS
Juliet Gaengan, Senior Director, Quality & Innovation
Kenra Ford, Assistant Vice President Clinical Lab Operations/M&PA
Sal Guido, Acting Chief Information Officer, EITS
Caroline Jacobs, Senior Vice President, Safety and Human Development
Christina Jenkins, MD Senior Assistant Vice President, Quality & Performance Innovation
John Jurenko, Senior Assistant Vice President, Intergovernmental Relations
Lauren Johnston, Senior Assistant Vice President/Chief Nursing Officer, Patient Centered Care
Susan Kansagra, Assistant Vice President, Population Health
Patricia Lockhart, Secretary to the Corporation
Katarina Madej, Director Communication and Marketing
Glenn Manjorin, Director, Enterprise It Service
Ana Marengo, Senior Vice President, Communications & Marketing
Randall Mark, Chief of Staff, President Office
Ian Michaels, Media Director, Communication and Marketing
Deirdre Newton, Senior Counsel, Legal Affairs
Eileen O'Donnell, Assistant Vice President, EITS
Salvatore Russo, Senior Vice President & General Counsel, Legal Affairs
Lynnette Sainbert, Assistant Director, Board Affairs
Marisa Salamone-Greason, Assistant Vice President, EITS
Jared Sender, Senior Director, Population Health EITS
David Shi, Senior Director, Medical and Professional Affairs
Pat Slesarchik, Assistant Vice President, Labor Relation
Diane E. Toppin, Senior Director, M&PA Divisional Administrator
Joyce Wale, Senior Assistant Vice President, Office of Behavioral Health
Ross Wilson, MD, Senior Vice President/Corporate Chief Medical Officer, Medical and Professional Affairs

FACILITY STAFF:

Gregory Almond, MD, Chief Medical Officer (Acting), Metropolitan Hospital Center
Ernest J. Baptiste, Executive Director, Kings County Hospital Center
Lillian Diaz, Chief Nurse Executive, Metropolitan Hospital Center
Marie Eliver, Senior Associate Executive Director, Queens Hospital Center

Rachel Jacobs, Associate Director of Nursing, Queens Hospital Center
John Maese, MD, Medical Director, Coney Island Hospital
Andreea Mera, Special Assistant to the President, MetroPlus Health Plan, Inc.
Anthony Rajkumar, Acting Executive Director, Metropolitan Hospital Center
Arnold Saperstein, Executive Director, MetroPlus Health Plan, Inc.
Denise Soares, Executive Director, Harlem Hospital Center
Reba Williams, Medical Director, Renaissance Diagnostic & Treatment Center

OTHERS PRESENT

James Cassidy, Analyst, Office of Management & Budget (OMB)
Moira Dolan, Senior Assistant Director, DC37
Scott Hill, Account Executive, Quadramed
David N. Hoffman, Chief Compliance Officer, PAGNY
Richard McIntyre, Siemens
Kristyn Raffaele, Analyst, OMB
Dhruneanne Woodrooffe, Analyst OMB

MEDICAL AND PROFESSIONAL AFFAIRS/
INFORMATION TECHNOLOGY COMMITTEE
Thursday, March 12, 2015

Dr. Vincent Calamia, Chair of the Committee, called the meeting to order at 9:00 AM. The minutes of the February 12, 2015 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.

ACO Updates

The HHC ACO Board of Directors recently endorsed a finalized distribution plan for shared savings generated by the ACO's strong 2013 Year 1 performance. For this first distribution, the portion of savings allotted to our ACO's primary care physicians will be spread evenly based on FTE. Going forward, the ACO will continue to refine the incentive model as part of a broader savings reinvestment plan to advance the population health goals of HHC and the HHC ACO. As part of a strategic planning process conducted by the ACO in the Fall of 2014, eight domains of strategic priority were identified: Population Management, Network Development, Financial Sustainability, Rewarding Excellence, Advanced Leveraging of Data & Technology, HHC-Affiliate-Physician Alignment, National Policy & Thought Leadership, and Strong Governance. The ACO is now developing work plans for each domain, with a focus on Network Development and growth potential. ACO Quality Reporting for 2014 performance is nearly completed, involving HHC-wide mobilization of electronic and manual performance data in partnership with facility Quality Management teams, IT, and ACO leadership.

Office of Population Health

In coordination with CNO's office, nurse educators from every facility were trained on PCMH, in order to strengthen the role of the RN in this team based care model. HHC is renewing an MOU with the NYC Dept of Health which would continue supporting some public health activities at HHC, including the point-of-care Nicotine Replacement Therapy distribution program and Treat-to-Target blood pressure program. HHC will be launching HHCYouthHealth.org at the end of this month, a website to promote the adolescent health services offered by HHC. To coincide with the launch of the website, there will be a community kick-off event, social media and press outreach, and promotion thru community-based organizations. Next month, HHC will be hosting a conference to explore on integration models for behavioral health services into primary care, for adolescents.

Care Management

As a culmination of NYS Hospital-Medical Home Demonstration Program reporting, each of our hospitals—in collaboration with their D&TCs—submitted a final report to the State in February that summarized and analyzed their participation in the two-year program. Our facilities described success in transforming care through the support of the Program, especially in improving the patient-centered medical home, expanding and enhancing residency training opportunities, improving access to ambulatory care, integrating depression management in primary care, and improving quality and safety in select inpatient initiatives. On March 3rd, 2015, the NYS Office of Mental Health conducted a site visit to Bellevue Hospital Center to examine our Care Plan Management System (CPMS). CPMS successfully met the registry requirements for our facilities which have been approved for participation in the NYS Medicaid Collaborative Care for Depression Program. Dr. Dave Chokshi, AVP for Care Management in M&PA, served as an investigator in a recently-published study entitled, "Convenient Care: Retail Clinics and Urgent Care Centers in New York State." The study examined proliferation of convenient care nationally, the distribution of these providers in New York State, and their potential impact on two special populations—the medically underserved and children. The study was sponsored by the United Hospital Fund and is available at: https://www.uhfnyc.org/publications/881033.

LABORATORY SERVICES

General

System-wide effort continues as the HHC laboratories work together to plan for the implementation of a standardized Cerner laboratory computer system for HHC laboratories. Focus has been to verify the appropriateness of the future HHC Rapid lab test menu. Efforts are now underway to standardize the Anatomic Pathology and Microbiology test menus, equipment and related processes.

NSLIJ Reference Testing

Management oversight continues both by NSLIJ and HHC laboratory leadership to ensure that expected levels of service and financial performance are met. Results are reviewed monthly at a corporate and facility level. Planning is underway to coordinate the review of quality metrics during the HHC Chief of Pathology/Laboratory Directors Council meeting.

Equipment

Critical laboratory equipment replacement is in progress. Chemistry, hematology and POC middleware software is undergoing user evaluation which include assessments by the vendors as well as site visits by HHC staff. Included in the process is participation by all HHC laboratories to ensure we are working towards equipment standardization during the replacement process. Project planning is underway for implementation of 4th generation (increased sensitivity and specificity) HIV testing at four (4) HHC laboratories. A 90 day implementation plan is currently in development for the four facilities. There will be a possible joint presentation at another MPAIT meeting with Lab and IT.

Office of Patient Center Care

Some of the presentations scheduled in the next few weeks:
April 7 - presenting regarding Lessons learned during Hurricane Sandy at the Healthcare Organizations Emergency Preparedness Seminar in Virginia. April 8 - presenting on the HHC Ebola experience at the MedAssets National Client Conference in Las Vegas, NV. May 4 - presenting at the GHX national conference regarding Nursing and Procurement partnering during Ebola

Office of Emergency Management

NYC HHC continues to collaborate with FDNY on EVD preparedness. To that end, we've conducted facility familiarization walkthroughs at our 11 acute care facilities during which FDNY EMS and Hazardous Materials leadership meet with Central Office and facility leadership to prepare for the unlikely event of a patient with a fever and travel history to one of the affected West African countries who is in extremis and requires transportation to a 911-receiving facility. From there the groups are conducting tabletop exercises to discuss the clinical and operational elements of such s response. It is important to note that to see, there have been so such critically ill fever and travel history patients transported by FDNY EMS and that every effort would be made to transport such patients to a designated treatment facility such as Bellevue.

The HHC Emergency Management Council continues to bring external partners to each month's meeting. In January, NYPD's Counterrorism Bureau offered an overview off the current international, national and local threats. In February, NYC DOHMH Emergency Preparedness leadership provided the group with their current priorities and in March, NYC Emergency Management will give us their insights into their Health and Medical Group. Future invitees include NYSDOH, FEMA Region 2, UCLA Emergency Management and Denver Health Authority's Health and Safety group.

IMSAL

On March 10, 2015, in the Critical Care and Trauma Unit (CCT) of the King's County Hospital Center (KCHC) Emergency Department (ED) the first "In-situ simulation", a team-based training technique conducted in patient care

units, commenced. This research is collaboration between HHC's Simulation program, the Institute for Medical Simulation and Advanced learning (IMSAL), and KCHC ED. In-situ simulation is a novel training tool with potential to improve teamwork and clinical outcomes.
In preparation for this initiative, all members of the healthcare team including Ward Clerks in the unit have undergone simulation training in the simulation center environment and structured training in teamwork and communication using TeamSTEPPS-based training.

The objectives of the study are to assess the effect of the proposed intervention, an additional program of regular in situ simulations and debriefings, on:

a) Teamwork and communication skills occurring in the unit.
b) Staff satisfaction in the unit.
c) Selected indicators of clinical care (stroke and sepsis) occurring in the unit.

The target population for the intervention is teams of emergency medicine physicians (attending and resident), nurses, patient care associates, patient care technicians and clerical staff.

The project intervention will include implementation of regular, brief simulations, occurring at least twice per week, conducted over a 6 month intervention period. Each simulation will be followed by a 10 minute debriefing session. Debriefings will be conducted by a simulation faculty member, trained in debriefing using the techniques of 'debriefing with good judgment' and 'advocacy and inquiry' to explore frames pertaining to teamwork, communication, and clinical performance. Cases will be designed to require teamwork and communication and will include cases of sepsis and stroke.

Several trained observers have observed 30 actual patient presentations pre-intervention and will observe 30 more post intervention. Group teamwork and communication skills were assessed using a Emergency room team performance tool. The tool has been previously validated and the same tool will be used for the post intervention. Items evaluated include; team structure, leadership, situation monitoring, mutual support and communication. The tool uses a Likert scale (1-5) for rating of each component. Overall scores will be calculated as a mean of individual item scores. Staff satisfaction will be measured using a staff satisfaction questionnaire which has been administered to unit staff during pre-intervention time and will be administered following the intervention.

DSRIP Update

The HHC-led Performing Provider System (PPS; now known as OneCity Health) continues its preparation for implementation of Delivery System Reform Incentive Payment (DSRIP) Program projects and programs.

Because our DSRIP success depends significantly on partners who share our patients, we continue in our collaborations with partners and other PPSs in order to develop simple, unified protocols for each of our projects. We have launched project implementation planning to develop a standardized approach across our four PPS hubs, and are using the input of HHC and partner clinical and operational experts to help define clinical guidelines and workflows. In April, we expect to begin local planning, which will include HHC facilities and local partners who will work together to design the projects in a way that is patient-centered and feasible.

For DSRIP Program valuation, we expect to learn our potential 5-year award in late March, and while no firm date is yet known, the NYS DOH estimates the first payment will be distributed in mid-April. It is important to remember that to earn the full potential award amount, our PPS must satisfy reporting and performance requirements as set forth by NYS DOH.

Additional to DSRIP funds, NYS made $1.2B available statewide for PPSs to implement capital projects intended to enable and help sustain DSRIP transformation. On February 20, OneCity Health (the HHC-led PPS) submitted capital applications totaling $760M, representing asks from HHC and all partners. HHC's portion of that total request was

approximately $435M, divided nearly equally between facility-based projects intended to further our access, care coordination, and primary care and behavioral health integration efforts; and IT-focused projects intended to provide connectivity and a population-health focused platform for HHC and its partners. We will be able to do modifications to the State capital application submission. State requirements can't make modification.

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 February 1, 2015 was 466,261. Breakdown of plan enrollment by line of business is as follows:

Medicaid	409,748
Child Health Plus	12,078
Family Health Plus	7
MetroPlus Gold	3,420
Partnership in Care (HIV/SNP)	4,836
Medicare	8,599
MLTC	824
QHP	26,001
SHOP	736
FIDA	12

Despite open enrollment being almost two months shorter, with much less publicity for this period, Metro Plus marketing staff submitted approximately the same number of applications for health insurance this year when compared to last, approximately 32,000. Two thirds of these applicants were for Medicaid and one third qualify for QHP. Further while most of these are MetroPlus applications, our staff is required to submit applications for those who choose other plans.

I would like to inform this committee of a few new regulations from the New York State of Health.

First, the Open Enrollment period was extended to February 28th, 2015, for the persons who were unable to complete the enrollment process before the February 15th deadline. Plan facilitated enrollers are allowed to complete the applications via telephone. Effective date for the individuals enrolling during this extended period will be April 1, 2015.

Second, New York State of Health announced a Special Enrollment period (SEP) for individuals and families who had to pay a federal penalty for2014 and had not been aware of or understood that they would have to pay a penalty for not having health insurance coverage. The SEP will start on March 1st and end on April 30th, 2015. Consumers who do not enroll during this period and do not meet the criteria for other SEPs will not be able to purchase coverage for the remainder of 2015 and may be subject to a federal tax penalty when they file their 2015 federal income taxes.

The State also proposed to include in the NYSOH application language emphasizing the importance of selecting a PCP for Medicaid Managed Care (MMC) and Child Health Plus (CHP) with a hyperlink to the plan's provider network page. PCP selection would not be possible at the time of application, but would be prompted once the member is enrolled and becomes active.

In addition, the Affordable Care Act calls for a new product called the Basic Health Plan (BHP). This new line of business is applicable only to the Aliessa population starting in April 2015 (the Aliessa decision made the full range of New York's Medicaid program available to all lawfully present legal immigrants) and it provides a new option for states to offer health coverage for individuals with family incomes between 133 and 200 percent of the federal poverty level (FPL) and for individuals from zero to 200 percent FPL who are lawfully present in the United States but do not qualify for Medicaid due to their immigration status. This coverage is in lieu of Marketplace coverage. States operating a BHP enter

into contracts to provide standard health plan coverage to eligible individuals. Eligible individuals in such a state could enroll in BHP coverage and would not have access to coverage through the Health Insurance Marketplace. The amount of the monthly premium and cost sharing charged to eligible individuals enrolled in a BHP may not exceed the amount of the monthly premium and cost sharing that an eligible individual would have paid if he/she were to receive coverage from a QHP through the marketplace. A state that operates a BHP will receive federal funding equal to 95% of the premium tax credit (PTC) and the cost-sharing reductions (CSR) that would have been provided to (or on behalf of) eligible individuals.

Enrollment in BHP will be open all year. Applications for BHP coverage in 2016 will be processed starting October 1, 2015. Federal regulations require that BHP enrollees have a choice of insurance plan in each county of the state. Applicants will have the ability to choose to participate in the commercial QHP Individual market, Small Business Marker, or the BHP, or any combination. The Aliessa population will have additional benefits for non-emergency transportation, non-prescription drugs, orthotic devices, orthopedic footwear, and vision care. Adult benefits will be available to BHP as follows: immigrants at or below 138% who previously qualified for Medicaid will receive additional dental benefits through BHP, and all other enrollees will be able to purchase stand-alone dental plans.

Starting July 1, 2015, plans will be expected to contract for urgent and routine primary care with School Based Health Center (SBHC) sponsoring entities. SBHC sponsors will have to contract with the Plan's oral health and behavioral health vendors in addition to the Plan. Reproductive Health Services would remain carved out of the SBHC. Providers will bill fee-for-service if the primary visit is for reproductive health.

Regarding transgender related benefits and care, the Department of Health is proposing the following new services: cross-sex hormone therapy and surgical gender reassignment, including post-transition care. These benefits apply to the Medicaid population, while approval for the CHP population is pending.

INFORMATION ITEMS:

Eileen O'Donnell, Assistant Vice President Enterprise of Enterprise Information Technology, presented to the committee the Epic Implementation to the committee.

The objectives are to demonstrate to clinical workgroup members, through a series of scenarios, major workflows that span multiple clinical settings. To provide clinical workgroup members with a final opportunity, and provide comments on system design after build completion and before moving on to testing.

Only Subject Matter Experts (SMEs) who have been involved with clinical workgroups are invited to attend. Sessions are tentatively scheduled for May-June, 2015. Sessions will take place at the acute care hospital of each network and Health & Home Care Manhattan office to accommodate and minimize the disruption of SMEs' schedules. Representatives from each application team will be stationed outside of the sessions to document comments from the attendees about the demonstrated workflows. Comments will be categorized: Patient Safety, Regulatory Requirements, Workflow-Critical, Future State, Nice-To-Have and triaged accordingly. A sample Scenario was given and the preliminary schedule was provided.

Next Steps will be to finalize locations, dates and times by late March. Send out invitations to workgroup members by early April. Finalize presentations and workflows by mid-April. Conduct dress rehearsals by late April. Testing to start late summer, tool has to support team - nurses must be involved, this should not be restricted to subject matter experts only and there should be pre-presentation.

There being no further business, the meeting was adjourned at 09:50 AM.

MetroPlus Health Plan, Inc.
Report to the
HHC Medical and Professional Affairs Committee
April 16, 2015

Total plan enrollment as of March 1, 2015 was 469,750. Breakdown of plan enrollment by line of business is as follows:

Medicaid	411,536
Child Health Plus	12,287
MetroPlus Gold	3,441
Partnership in Care (HIV/SNP)	4,802
Medicare	8,587
MLTC	883
QHP	27,557
SHOP	641
FIDA	16

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.

One of our main goals is to have significant membership growth, up to one million members by the year 2020. We have developed a solid strategic plan and started undertaking many initiatives to help us reach this membership goal. One of the next steps in our growth plan is holding a special session with the MetroPlus Board of Directors whereby additional strategies can be discussed and approved.

It is important to point out that despite the 165,710 disenrollments from our Medicaid product in the last twelve months (out of which 91% were involuntary), our Medicaid membership grew by 15% (approximately 53,000 lives). A small portion of the growth is attributed to some of the FHP members rolling into our Medicaid line, while the majority of it is a result of aggressive marketing and retention efforts.

The QHP membership experienced a net growth of 30% in the last twelve months. It peaked at approximately 49,000 in May 2014, then slowly decreased mainly due to member termination for non-payment. Following the 2015 Open Enrollment Period, to date, we continue to see a familiar trend in members choosing our non-standard Exchange product. On average, 80% of the commercial population chose the non-standard package, which includes dental and vision. This is an indicator of our members making informed decisions about their coverage. Compared to 2014, however, the age distribution of the QHP population is different. We now see that only 34% of the members are under the age of 35 (as opposed to 42% in 2014), and 37% are over the age of 50 (as opposed to 32% in 2014). We expect this will balance the cost-sharing, risk corridor amount due in 2016.

As of the date of this report, the FIDA product line has 16 opt-in members. We are expecting another 70 passive members for the month of April 2015. The biggest challenge for FIDA care

management is that providers do not have sufficient time to take part in the Interdisciplinary Team (IDT) meetings. Another great challenge is that it takes the Care Manager between 60 and 90 minutes to train each individual that will serve in the IDT meeting for each member.

We have well-defined strategic marketing plans to help us maximize enrollment into our Exchange line throughout the Special Election Period (SEP). In addition, we are closely monitoring the development of a number of immigration executive actions which can help us increase the number of members we serve.

MetroPlus' delegation of all Behavioral Health (BH) and Substance Use Disorder services to Beacon Health Strategies began on January 1st when Beacon began managing the FIDA line of business. Beacon and MetroPlus held HHC specific Clinical Orientation Sessions in all four boroughs for all Psychiatric Directors, Assistant Directors, BH Central Office Staff and other staff delegated by the Psych Directors. Beacon also held ongoing web based trainings for the entire MetroPlus network. By all accounts this has been a very smooth transition for MetroPlus members and providers.

It is important to bring to this Committee's attention that the Affordable Care Act requires every health plan participating in the Exchange to be accredited by an HHS-approved accrediting body by 2016. HHS has approved URAC (Utilization Review Accreditation Commission), NCQA (national Committee for Quality Assurance, and AAAHC (Accreditation Association for Ambulatory Health Care) as accrediting bodies for health plans participating in the Exchange.

We have decided to pursue URAC accreditation. There are 44 health plans that have either been accredited by URAC or are in the process of being accredited. URAC provides cutting-edge quality measures and data analytics capabilities that minimize the burden and cost of data reporting while providing a level of analysis not available in other accreditation programs. Its flexible design allows incorporation of state-specific standards and measures while its collaborative educational approach helps guide health plans in achieving accreditation.

Lastly, the previously announced discontinuance of the online renewal option though ACCESS NYC has been delayed. The option currently remains available to non-disabled, aged, and blind consumers with cases active in WMS, who do not have to supply any documentation at renewal. The Human Resources Administration anticipates that the renewal option will be disabled sometime in mid-April (initially scheduled for March 9, 2015).

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 03/14/2015

Other Plan Name	Category	2014_04		2014_05		2014_06		2014_07		2014_08		2014_09		2014_10		2014_11		2014_12		2015_01		2015_02		2015	TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	MCAD	
AETNA	INVOLUNTARY	0	3	1	3	1	1	1	6	0	7	0	8	1	4	0	5	0	8	0	4	0	9	6	68
	VOLUNTARY	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	TOTAL	0	3	1	3	1	2	1	6	0	7	0	8	1	4	0	5	0	8	0	4	0	9	6	69
Affinity Health Plan	INVOLUNTARY	1	16	11	90	0	19	5	91	3	20	1	23	3	24	0	35	2	23	0	43	2	32	31	475
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	3
	VOLUNTARY	11	104	0	1	4	78	0	0	7	52	6	93	6	53	3	62	0	43	1	45	0	34	50	653
	TOTAL	12	120	11	91	4	97	5	91	10	72	7	116	9	77	3	97	2	66	4	88	2	66	81	1,131
Amerigroup/ Health Plus/CarePlus	INVOLUNTARY	0	25	12	165	1	43	6	129	0	45	0	55	1	53	5	55	4	54	3	90	0	55	58	859
	UNKNOWN	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	2
	VOLUNTARY	6	182	0	0	10	148	0	1	5	80	2	114	0	67	1	98	3	93	2	67	0	79	74	1,032
	TOTAL	6	207	12	165	11	191	6	131	5	125	2	169	1	120	6	153	7	147	5	158	0	134	132	1,893
BC/BS OF MNE	INVOLUNTARY	0	9	1	6	1	13	2	9	1	12	0	21	1	8	3	19	3	13	1	18	0	20	69	230
	VOLUNTARY	1	1	0	0	1	2	0	0	0	0	0	0	0	0	0	1	0	2	0	4	0	0	1	13
	TOTAL	1	10	1	6	2	15	2	9	1	12	0	21	1	8	3	20	3	15	1	22	0	20	70	243
CIGNA	INVOLUNTARY	0	3	0	5	0	1	0	1	1	5	0	0	0	0	0	5	0	0	0	0	0	7	7	35
	TOTAL	0	3	0	5	0	1	0	1	1	5	0	0	0	0	0	5	0	0	0	0	0	7	7	35
Fidelis Care	INVOLUNTARY	2	52	48	429	1	104	20	393	5	134	3	149	4	160	1	172	1	122	7	252	0	136	157	2,352
	UNKNOWN	0	0	0	0	1	0	0	0	0	0	0	0	0	0	2	0	1	0	1	0	0	0	1	6
	VOLUNTARY	35	454	0	0	42	416	0	0	10	314	22	405	16	298	11	335	7	340	9	280	0	199	256	3,449
	TOTAL	37	506	48	429	44	520	20	393	15	448	25	554	20	458	14	507	9	462	17	532	0	335	414	5,807

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 03/14/2015

		2014_04		2014_05		2014_06		2014_07		2014_08		2014_09		2014_10		2014_11		2014_12		2015_01		2015_02		2015	TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	MCAD	
GROUP HEALTH INC.	INVOLUNTARY	0	4	1	4	0	3	0	7	0	3	1	4	0	4	0	6	0	6	0	5	0	7	4	59
	VOLUNTARY	1	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	1	2	6
	TOTAL	1	4	1	4	0	3	0	7	0	3	1	6	0	4	0	6	0	6	0	5	0	8	6	65
Health First	INVOLUNTARY	2	90	40	696	9	185	25	657	1	178	5	195	6	241	5	271	7	202	4	409	1	297	281	3,807
	UNKNOWN	0	0	0	0	1	0	0	0	1	0	0	1	2	1	2	1	1	0	0	0	0	0	0	10
	VOLUNTARY	48	758	0	2	39	750	0	0	25	522	18	733	18	523	12	560	10	648	4	514	0	361	554	6,099
	TOTAL	50	848	40	698	49	935	25	657	27	700	23	929	26	765	19	832	18	850	8	923	1	658	835	9,916
HEALTH INS PLAN OF GREATER NY	INVOLUNTARY	0	2	0	1	0	0	0	2	0	3	0	1	0	4	1	7	0	2	0	3	0	2	9	37
	VOLUNTARY	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	2
	TOTAL	0	2	0	1	0	0	0	2	0	3	0	2	0	5	1	7	0	2	0	3	0	2	9	39
HIP/NYC	INVOLUNTARY	0	15	4	57	0	21	1	71	0	18	0	20	0	28	0	24	0	24	0	41	0	21	19	364
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	2
	VOLUNTARY	5	80	0	1	2	59	0	0	1	33	2	37	2	38	1	33	1	27	1	35	0	24	33	415
	TOTAL	5	95	4	58	2	80	1	71	1	51	3	57	2	66	1	57	1	51	1	77	0	45	52	781
OXFORD INSURANCE CO.	INVOLUNTARY	1	1	1	2	0	0	1	1	1	2	0	6	0	3	1	5	0	2	0	2	0	3	8	40
	VOLUNTARY	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	3
	TOTAL	1	2	1	2	0	0	1	1	1	2	0	6	0	3	1	5	0	2	0	3	0	4	8	43
UNION LOC. 1199	INVOLUNTARY	2	5	4	13	1	4	1	8	0	4	1	1	0	2	2	4	0	2	0	3	0	6	6	69
	VOLUNTARY	5	15	0	0	1	10	0	0	1	14	8	23	5	7	1	9	0	5	0	16	0	3	1	124
	TOTAL	7	20	4	13	2	14	1	8	1	18	9	24	5	9	3	13	0	7	0	19	0	9	7	193

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 03/14/2015

		2014_04		2014_05		2014_06		2014_07		2014_08		2014_09		2014_10		2014_11		2014_12		2015_01		2015_02		2015	TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	MCAD	
United Healthcare of NY	INVOLUNTARY	1	24	2	86	1	33	6	71	0	40	1	47	0	62	4	47	2	54	5	89	0	50	57	682
	UNKNOWN	0	0	0	0	1	0	0	0	1	0	0	0	1	0	1	0	3	0	0	0	0	0	0	7
	VOLUNTARY	8	81	0	1	7	66	0	0	2	39	1	63	3	38	0	32	0	60	0	48	0	27	41	517
	TOTAL	9	105	2	87	9	99	6	71	3	79	2	110	4	100	5	79	5	114	5	137	0	77	98	1,206
Wellcare of NY	INVOLUNTARY	0	16	1	25	2	19	9	42	1	10	0	28	1	36	0	55	2	31	2	49	0	26	29	384
	UNKNOWN	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	3
	VOLUNTARY	1	20	0	0	0	12	0	0	0	26	3	21	5	14	1	13	0	14	0	13	0	14	19	176
	TOTAL	1	36	1	25	2	31	11	42	1	36	3	49	6	50	1	68	2	45	3	62	0	40	48	563
Disenrolled Plan Transfers	INVOLUNTARY	9	265	126	1,582	17	446	77	1,488	13	481	12	558	17	629	22	710	21	543	22	1,008	3	671	741	9,461
	UNKNOWN	0	0	0	0	3	0	2	1	2	0	1	1	3	1	5	1	5	0	5	2	0	0	1	33
	VOLUNTARY	121	1,696	0	5	106	1,542	0	1	51	1,080	62	1,492	55	1,039	30	1,143	21	1,232	17	1,023	0	743	1,031	12,490
	TOTAL	130	1,961	126	1,587	126	1,988	79	1,490	66	1,561	75	2,051	75	1,669	57	1,854	47	1,775	44	2,033	3	1,414	1,773	21,984
Disenrolled Unknown Plan Transfers	INVOLUNTARY	8	30	4	72	4	54	5	136	1	35	1	62	4	41	6	68	3	40	3	48	0	55	62	742
	UNKNOWN	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	2
	VOLUNTARY	0	32	0	10	0	52	0	19	1	42	0	51	2	78	0	67	0	48	0	41	0	40	57	540
	TOTAL	8	62	4	82	4	107	5	155	2	77	1	113	6	119	6	135	4	88	3	89	0	95	119	1,284
Non-Transfer Disenroll Total	INVOLUNTARY	1,012	11,448	950	11,433	860	10,577	850	10,494	799	10,900	778	9,864	1,061	10,869	1,286	10,303	366	8,140	653	11,054	14	12,901	13,930	140,542
	UNKNOWN	13	13	14	12	22	15	29	22	34	45	10	47	1	55	19	42	7	39	0	28	0	31	8	506
	VOLUNTARY	2	88	0	47	2	83	0	107	1	90	3	78	1	81	4	73	4	124	0	46	0	524	36	1,394
	TOTAL	1,027	11,549	964	11,492	884	10,675	879	10,623	834	11,035	791	9,989	1,063	11,005	1,309	10,418	377	8,303	653	11,128	14	13,456	13,974	142,442

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 03/14/2015

		2014_04		2014_05		2014_06		2014_07		2014_08		2014_09		2014_10		2014_11		2014_12		2015_01		2015_02		2015	TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	MCAD	
Total MetroPlus Disenrollment	**INVOLUNTARY**	1,029	11,743	1,080	13,087	881	11,077	932	12,118	813	11,416	791	10,484	1,082	11,539	1,314	11,081	390	8,723	678	12,110	17	13,627	14,733	150,745
	UNKNOWN	13	13	14	12	25	16	31	23	36	45	11	48	4	56	24	43	13	39	5	30	0	31	9	541
	VOLUNTARY	123	1,816	0	62	108	1,677	0	127	53	1,212	65	1,621	58	1,198	34	1,283	25	1,404	17	1,110	0	1,307	1,124	14,424
	TOTAL	1,165	13,572	1,094	13,161	1,014	12,770	963	12,268	902	12,673	867	12,153	1,144	12,793	1,372	12,407	428	10,166	700	13,250	17	14,965	15,866	165,710

MetroPlus Health Plan

New Member Transfer From Other Plans

	2014_04		2014_05		2014_06		2014_07		2014_08		2014_09		2014_10		2014_11		2014_12		2015	2015	2015	TOTAL
	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	MCAD	MCAD	MCAD	
AETNA	1	6	0	3	1	4	0	3	0	8	0	6	0	7	1	9	0	8	7	1	1	66
Affinity Health Plan	10	119	8	113	7	112	1	88	3	95	5	101	2	87	1	87	2	118	63	68	76	1,166
Amerigroup/Health Plus/CarePlus	16	173	8	141	7	186	5	119	3	115	5	135	3	96	0	93	0	142	92	147	89	1,575
BC/BS OF MNE	5	14	0	6	0	11	0	7	0	19	0	30	0	25	0	49	0	44	28	18	12	268
CIGNA	2	7	0	3	0	5	0	6	0	0	0	1	0	4	0	1	0	1	1	0	1	32
Fidelis Care	10	188	5	163	10	144	9	146	6	115	6	137	2	116	0	97	0	113	113	123	90	1,593
GROUP HEALTH INC.	0	13	0	10	0	11	0	2	0	5	0	13	0	9	0	4	0	8	8	3	5	91
Health First	14	166	7	126	8	159	7	146	4	133	2	182	1	128	3	131	0	196	118	134	104	1,769
HEALTH INS PLAN OF GREATER N	0	9	0	2	0	5	0	3	0	8	0	8	1	3	0	10	0	15	10	2	6	82
HIP/NYC	2	74	2	64	1	72	2	43	0	36	0	53	0	55	0	50	0	52	36	46	30	618
OXFORD INSURANCE CO.	0	6	0	3	0	2	0	5	1	2	0	7	0	0	0	4	0	5	2	3	1	41
UNION LOC. 1199	8	27	4	19	1	21	3	8	2	12	1	18	0	17	2	3	0	6	14	2	0	168
United Healthcare of NY	4	91	3	56	4	66	0	54	0	43	0	56	0	55	0	64	0	54	44	56	58	708
Unknown Plan	946	7,267	161	4,756	72	6,032	14	4,724	9	4,365	5	5,222	14	4,810	4	5,170	8	5,908	6,006	3,516	2,940	61,949
Wellcare of NY	9	122	6	103	6	82	1	52	3	52	2	57	1	48	0	37	1	53	64	63	46	808
TOTAL	1,027	8,282	204	5,568	117	6,912	42	5,406	31	5,008	26	6,026	24	5,460	11	5,809	11	6,723	6,606	4,182	3,459	70,934

Report ID: MHP1268C
Report Run Date: 3/15/2015

Management Indicator Report # 1

For Enrollment Month 201503

Indicator #1A for Enrollment Month: March 2015

Disenrollments To Other Plans

		Enrollment Mont			Twelve Months Period		
		FHP	MCAD	Total	FHP	MCAD	Total
	INVOLUNTARY		31	31	28	447	475
	VOLUNTARY		50	50	38	615	653
Affinity Health Plan	**TOTAL**		**81**	**81**	**66**	**1062**	**1128**
	INVOLUNTARY		58	58	32	827	859
	VOLUNTARY		74	74	29	1003	1032
Amerigroup/Health Plus/CarePlus	**TOTAL**		**132**	**132**	**61**	**1830**	**1891**
	INVOLUNTARY		157	157	92	2260	2352
	UNKNOWN		1	1	5	1	6
	VOLUNTARY		256	256	152	3297	3449
Fidelis Care	**TOTAL**		**414**	**414**	**249**	**5558**	**5807**
	INVOLUNTARY		281	281	105	3702	3807
	VOLUNTARY		554	554	174	5925	6099
Health First	**TOTAL**		**835**	**835**	**279**	**9627**	**9906**
	INVOLUNTARY		19	19	5	359	364
	VOLUNTARY		33	33	15	400	415
HIP/NYC	**TOTAL**		**52**	**52**	**20**	**759**	**779**
	INVOLUNTARY		57	57	22	660	682
	VOLUNTARY		41	41	21	496	517
United Healthcare of NY	**TOTAL**		**98**	**98**	**43**	**1156**	**1199**
	INVOLUNTARY		29	29	18	366	384
	VOLUNTARY		19	19	10	166	176
Wellcare of NY	**TOTAL**		**48**	**48**	**28**	**532**	**560**
	INVOLUNTARY		741	741	339	9122	9461
	UNKNOWN		1	1	26	7	33
	VOLUNTARY		1031	1031	463	12027	12490
Disenrolled Plan Transfers	**TOTAL**		**1773**	**1773**	**828**	**21156**	**21984**
	INVOLUNTARY		62	62	39	703	742
	VOLUNTARY		57	57	3	537	540
Disenrolled Unknown Plan Transfers:	**TOTAL**		**119**	**119**	**42**	**1240**	**1282**
	INVOLUNTARY		13930	13930	8629	131913	140542
	UNKNOWN		8	8	149	357	506
	VOLUNTARY		36	36	17	1377	1394
Non-Transfer Disenroll Total:	**TOTAL**		**13974**	**13974**	**8795**	**133647**	**142442**
	INVOLUNTARY		14733	14733	9007	141738	150745
	UNKNOWN		9	9	176	365	541
	VOLUNTARY		1124	1124	483	13941	14424
Total MetroPlus Disenrollment:	**TOTAL**		**15866**	**15866**	**9666**	**156044**	**165710**

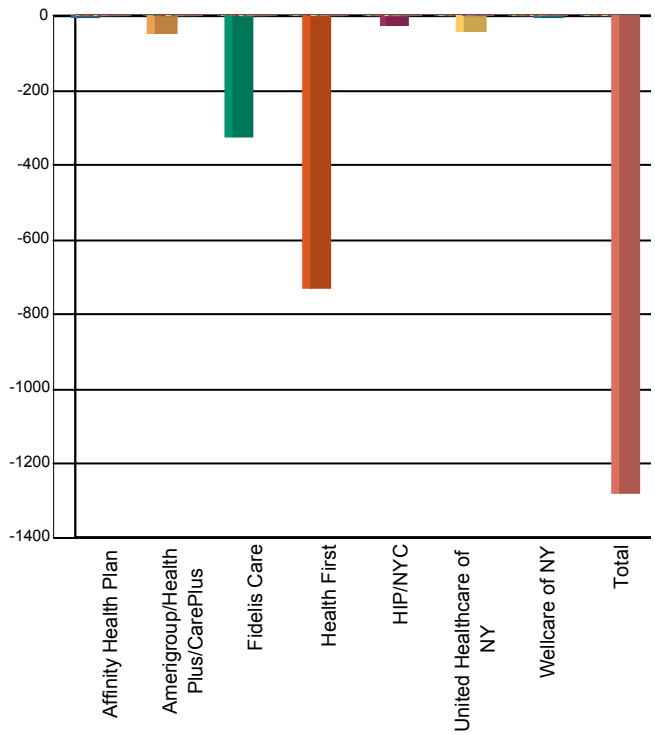
New MetroPlus Members Disenrolled From Other Plans

	FHP	MCAD	Total	Y FHP	Y MCAD	Y Total
Affinity Health Plan		76	76	39	1,127	1,166
Amerigroup/Health Plus/CarePlus		89	89	47	1,528	1,575
Fidelis Care		90	90	48	1,545	1,593
Health First		104	104	46	1,723	1,769
HIP/NYC		30	30	7	611	618
United Healthcare of NY		58	58	11	697	708
Wellcare of NY		46	46	29	779	808
Total		493	493	227	8,010	8,237
Unknown/Other (not in total)		2,940	2,940	1,233	60,716	61,949

Net Difference

	Enrollment Month			Twelve Months Period		
	FHP	MCAD	Total	FHP	MCAD	Total
Affinity Health Plan		-5	-5	-27	65	38
Amerigroup/Health Plus/CarePlus		-43	-43	-14	-302	-316
Fidelis Care		-324	-324	-201	-4,013	-4,214
Health First		-731	-731	-233	-7,904	-8,137
HIP/NYC		-22	-22	-13	-148	-161
United Healthcare of NY		-40	-40	-32	-459	-491
Wellcare of NY		-2	-2	1	247	248
Total		-1,280	-1,280	-601	-13,146	-13,747

Enroll Month Net Transfers (Known)



MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

March-2015

		Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Total Members	Prior Month	464,281	466,840	466,852	467,962	471,398	465,710	465,345
	New Member	20,512	19,056	19,909	19,654	27,221	16,659	22,088
	Voluntary Disenroll	1,973	1,495	1,639	1,691	1,995	1,863	1,582
	Involuntary Disenroll	15,980	17,549	17,160	14,527	30,914	15,161	16,101
	Adjusted	-1	-29	5	-521	252	822	0
	Net Change	2,559	12	1,110	3,436	-5,688	-365	4,405
	Current Month	466,840	466,852	467,962	471,398	465,710	465,345	469,750
Medicaid	Prior Month	381,274	387,250	391,190	396,425	403,951	411,940	410,510
	New Member	18,150	16,745	17,651	17,705	21,244	13,552	16,895
	Voluntary Disenroll	1,622	1,198	1,283	1,405	1,110	1,307	1,124
	Involuntary Disenroll	10,552	11,607	11,133	8,774	12,145	13,675	14,745
	Adjusted	11	-24	16	-495	265	774	0
	Net Change	5,976	3,940	5,235	7,526	7,989	-1,430	1,026
	Current Month	387,250	391,190	396,425	403,951	411,940	410,510	411,536
Child Health Plus	Prior Month	11,672	11,819	12,043	12,199	12,300	12,151	12,121
	New Member	683	826	696	707	840	530	817
	Voluntary Disenroll	68	49	98	99	527	153	253
	Involuntary Disenroll	468	553	442	507	462	407	398
	Adjusted	-3	-2	-3	-3	11	43	0
	Net Change	147	224	156	101	-149	-30	166
	Current Month	11,819	12,043	12,199	12,300	12,151	12,121	12,287
Family Health Plus	Prior Month	14,964	12,411	9,426	5,893	3,535	82	5
	New Member	23	23	14	12	1	0	0
	Voluntary Disenroll	65	58	34	25	17	0	0
	Involuntary Disenroll	2,511	2,950	3,513	2,345	3,437	77	5
	Adjusted	0	1	2	2	-2	-2	0
	Net Change	-2,553	-2,985	-3,533	-2,358	-3,453	-77	-5
	Current Month	12,411	9,426	5,893	3,535	82	5	0

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

March-2015

		Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
HHC	Prior Month	3,509	3,538	3,440	3,450	3,463	3,619	3,439
	New Member	56	67	30	59	192	13	15
	Voluntary Disenroll	0	0	0	0	0	170	0
	Involuntary Disenroll	27	165	20	46	36	23	13
	Adjusted	-10	-4	-5	-6	2	20	0
	Net Change	29	-98	10	13	156	-180	2
	Current Month	3,538	3,440	3,450	3,463	3,619	3,439	3,441
SNP	Prior Month	5,198	5,095	5,013	4,958	4,937	4,904	4,841
	New Member	58	49	61	61	43	58	36
	Voluntary Disenroll	78	36	54	29	29	46	22
	Involuntary Disenroll	83	95	62	53	47	75	53
	Adjusted	0	-1	-1	-8	-2	6	0
	Net Change	-103	-82	-55	-21	-33	-63	-39
	Current Month	5,095	5,013	4,958	4,937	4,904	4,841	4,802
Medicare	Prior Month	8,245	8,340	8,388	8,468	8,539	8,564	8,595
	New Member	336	306	359	291	443	296	263
	Voluntary Disenroll	138	154	169	133	312	187	183
	Involuntary Disenroll	103	104	110	87	106	78	88
	Adjusted	2	2	1	0	1	-1	0
	Net Change	95	48	80	71	25	31	-8
	Current Month	8,340	8,388	8,468	8,539	8,564	8,595	8,587
Managed Long Term Care	Prior Month	627	673	723	774	805	814	825
	New Member	58	66	84	55	37	42	81
	Voluntary Disenroll	0	0	1	0	0	0	0
	Involuntary Disenroll	12	16	32	24	28	31	23
	Adjusted	0	0	0	-3	0	1	0
	Net Change	46	50	51	31	9	11	58
	Current Month	673	723	774	805	814	825	883

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

March-2015

		Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
QHP	Prior Month	38,109	36,998	35,899	35,052	33,098	22,926	24,350
	New Member	1,097	934	986	717	4,387	2,140	3,957
	Voluntary Disenroll	2	0	0	0	0	0	0
	Involuntary Disenroll	2,206	2,033	1,833	2,671	14,559	716	750
	Adjusted	-1	-1	-5	-8	-17	-12	0
	Net Change	-1,111	-1,099	-847	-1,954	-10,172	1,424	3,207
	Current Month	36,998	35,899	35,052	33,098	22,926	24,350	27,557
SHOP	Prior Month	683	716	730	743	770	707	647
	New Member	51	40	28	47	31	19	19
	Voluntary Disenroll	0	0	0	0	0	0	0
	Involuntary Disenroll	18	26	15	20	94	79	25
	Adjusted	0	0	0	0	-6	-7	0
	Net Change	33	14	13	27	-63	-60	-6
	Current Month	716	730	743	770	707	647	641
FIDA	Prior Month	0	0	0	0	0	3	12
	New Member	0	0	0	0	3	9	5
	Voluntary Disenroll	0	0	0	0	0	0	0
	Involuntary Disenroll	0	0	0	0	0	0	1
	Adjusted	0	0	0	0	0	0	0
	Net Change	0	0	0	0	3	9	4
	Current Month	0	0	0	0	3	12	16

Sal Guido, Acting Senior Vice President/Corporate CIO
Enterprise Information Technology Services
Report to the M&PA/IT Committee to the Board

Thursday, April 16, 2015 9:00 AM

Thank you and good morning. I'd like to update the Committee on several key initiatives that are underway: Epic Electronic Medical Records (EMR) New Wave Program Management Approach, the updated Epic Program Governance Structure and the status of Meaningful Use.

1. New Wave Program Management for the Epic EMR Implementation:

The EMR leadership team is in the process of restructuring the Electronic Medical Record (EMR) program in order to better manage and facilitate the completion of key program milestones over the next twelve (12) months. Our EMR Program Management Office (PMO) was tasked with a "new wave of thoughts and ideas" on how to bring the Epic program from present day to implementation go-live. The EMR PMO has completed a program charter, defined scope of work and an outline of the overall program structure.

The program plan is now broken out into four (4) workstreams (Management, Clinical & Business, Vendor and Infrastructure) and four (4) phases (Prepare, Enable, Get-Set and Go). The methodology being used to manage the EMR program is called Agile and has been used widely throughout many industries including IT. The agile methodology is designed to provide the EMR project team with a high degree of visibility within each area of the program, enable quick decision making as well as facilitate tracking and managing changes seamlessly without affecting critical aspects of the Epic program.

This methodology is a time-tested approach within program management designed to engage the application teams and workgroups as EITS manages the very complex and diverse needs in the Epic EMR program. The major benefit of using this new wave program management is that the team focuses on producing small chunks of results in a very short time timeframe rather than driving the team to deliver all results at once after a long period of time.

Since the adoption of the Agile methodology by the EMR program members in late February, there has been a better understanding by the stakeholders in what is needed to meet the immediate challenges ahead. The methodology was presented at our March IT Executive Committee and endorsed by the committee members. Other divisions within HHC have been introduced to this methodology for adoption as well and have agreed to use it to manage their major initiatives.

In addition to the introduction of the New Wave Program Management for the EMR program, additional governance has been put in place to address outstanding risks, issues and decisions associated with moving the Epic program to go-live.

2. Epic Program Management Governance:

EITS has developed a layer of senior leadership run steering committees to address and resolve issues identified by the EMR application teams and workgroups and prevent unnecessary escalation to HHC Executive leadership. Three (3) executive steering committees have been

created which will address all clinical, financial and data concerns. Dr. Ross Wilson, HHC's Chief Medical Officer will chair the Clinical Steering Committee; Marlene Zurack, CFO, will head the Finance Steering Committee and JoAnn Liburd, Assistant Vice President for Accreditation and Regulatory Affairs will lead the Data Governance Steering Committee. Success for each of these committees will be measured by their ability to resolve EMR program concerns prior to reaching the IT Executive Committee.

EITS has also put a process in place to connect the already existing project level councils, workgroups and committees to Senior EITS leadership. This process will allow for issues identified by these groups dealing with scope, workflow and/or policy to be channeled to one of the three (3) executive steering committees for resolution. If these governance bodies perform correctly, there should be very few unresolved discussion items reaching the IT Executive Committee.

EITS along with HHC Senior Leadership has contracted with an Epic integration partner "Clinovations" to serve as a strategic partner to NYCHHC as the organization seeks to achieve HHC's first Epic go-live date of March 31, 2016 for Queens and Elmhurst hospitals. Clinovations will provide NYCHHC with the services of Interim Executives for 15 months. Towards this end, Clinovations and the Interim Executives will provide services which will support the Epic program and promote clinical enfranchisement, improved quality of care and drive staff engagement and alignment as well as provide as well as to provide strategic support and leadership to NYCHHC for all of its EPIC-related IT services.

3. Meaningful Use (MU) Update:

Currently, HHC is involved with three (3) phases of Meaningful Use (MU).

For **MU Eligible Hospital Stage 2 Year 1**, HHC will receive a total of $16.5M in Eligible Hospital incentive payments from Medicare and Medicaid.

For **MU Eligible Hospital Stage 2 Year 2**, the QCPR team is working toward meeting the attestation thresholds for a full Federal Fiscal year, which ends September 30, 2015. CMS will be releasing a proposed rule change in the spring that could change the attestation period to ninety (90) days. There will be a third year of Stage 2 extending through September 2016 and Stage 3 will begin in 2017. The challenge remains with maintaining and sustaining the performance threshold to meet the patient portal objective, which is fifty (50%) percent of patients discharged having their visit summaries available within 36 hours. Weekly reports are shared with all involved to encourage transparency. Additionally, a compliance monitoring tool was made available to providers and leadership.

For **MU Eligible Professional (EP) Stage 1 Year**, this initiative will be introduced to outpatient providers for the first time this year. The immediate goals were to identify these eligible professionals and submit an **Adopt, Implement, Upgrade** attestation by March 31st in order to receive the first payment of Electronic Health Record (EHR) MU incentive dollars this year. A provider is eligible if he/she) is fully enrolled in Medicaid; b) had thirty (30) percent Medicaid patient volume in one year and, c) spent over ten (10) percent of the time in the ambulatory care settings. Of the 1700 providers identified, close to 500 providers attested by the March 31st deadline. Because of this effort, HHC is in the process with Legal Counsel to request an Attestation Deadline Extension (ADE) from the State Department of Health (SDOH) to continue the effort of having the remaining providers attest. We have thirty (30)

days from the deadline until the end of April to request this. EITS will continue to work very closely with Finance, PAGNY and the SDOH on the very complicated process of identifying and registering all of the Eligible Professionals. HHC anticipates receiving its first payment of $21,250 for every eligible professional who met the deadline this year.

The team is also working on an additional 800+ providers identified as eligible providers in 2016. Overall, HHC has identified about 2500 providers who met the eligibility criteria set forth by the Centers for Medicare and Medicaid Services to participate in the MU Eligible Professionals EHR incentive programs. Incentive dollars for meeting these criteria will be substantial. HHC anticipates the amount to be over $150 million which would be distributed over five (5) years up to the year 2020.

Additionally, the QCPR team is working very closely with our vendor Quadramed on the EHR enhancements necessary for EP functionality. Harlem Hospital is the beta site and is currently doing regression testing. New functionality will be available to all facilities by July, 2015.

The team is also deeply focused on managing the complexity associated with EP engagement and demonstration of the EHR MU by meeting the thresholds for 18 objectives by each provider across the enterprise. The Ambulatory Care and Population Health leaderships will assist in the decision making related to the implementation of new workflow and monitoring of compliance. Providing clinical summaries to patients as well as access to the patient portal are expected to be challenging for this MU initiative year.

As you are all aware, all of these activities associated with MU Eligible Professional support our efforts currently underway with HHC's Accountable Care Organization (ACO), Patient Centered Medical Homes (PCMH) and the Delivery System Reform Incentive Payment (DSRIP) programs.

This completes my report today. Thank you.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation to execute a sole source contract for software licenses, maintenance and support services agreement with 3M Health Information Systems (3M) for the Coding and Reimbursement Information System installed at HHC's acute care hospitals, long-term care facilities and MetroPlus. The contract is for three years with two options to renew, each for one-year. The not to exceed amount for the full term of the agreement is $13,510,101 which includes a contingency of $643,338.

WHEREAS, the Corporation requires a new contract to continue its software license, maintenance and support services agreement in order to protect its investment in the 3M Coding and Reimbursement Information System; and

WHEREAS, 3M is the owner of the proprietary software and maintenance software and interfaces for which this agreement is required and, as such is the only source able to maintain the software in a timely, reliable, and efficient manner; and

WHEREAS, the Corporation continues to use 3M's Coding and Reimbursement System in daily patient record management and has invested in interfaces between 3M and the Corporation's two financial information systems in operation in 2015; and

WHEREAS, the Corporation invested significantly in Health Information Management employee training and education and upgrading 3M's Coding and Reimbursement System to prepare for ICD-10 implementation.

NOW THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation to execute a sole source contract for software licenses, maintenance and support services agreement with 3M Health Information Systems (3M) for the Coding and Reimbursement Information System installed at HHC's acute care hospitals, long-term care facilities and MetroPlus. The contract is for three years with two options to renew, each for one-year. The not to exceed amount for the full term of the agreement is $13,510,101 which includes a contingency of $643,338.

EXECUTIVE SUMMARY
3M Software Licenses and Maintenance: Coding and Reimbursement Services

3M's Health Information Systems will provide HHC with a suite of software for abstracting International Classification of Diseases (ICD), Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes at acute and long-term care facilities. The 3M suite of products aids selection of codes, maintains a database of patient information, groups codes for validation and provides these codes to financial systems. The contract is for three years with two options to renew, each for one-year. The not to exceed amount for the full term of the agreement is $13,510,101 which includes a contingency of $643,338.

Public solicitation through a Request for Proposal is not in the best interest of the Corporation. The support of proceeding with a sole source procurement from 3M Health Information Systems is based on:

1) 3M is the only provider of New York State groupers that the Corporation must use;
2) HHC's 3M coding software system is integrated with Soarian Financials, HHC's new revenue cycle system. Changing coding software at mid-deployment will endanger the roll-out of Soarian in 2015;
3) Changing coding providers creates unacceptable risk to HHC's readiness for ICD-10 implementation on October 1, 2015 ; and
4) Reconfiguring hardware to another provider is cost prohibitive.

The majority of inpatient claims processed by HHC are for payers that must use the 3M owned grouper; the APR-DRG grouper (Medicaid and Medicaid managed care). NYS mandates use of the 3M APR-DRG for all Medicaid, Workers Compensation and No-Fault discharges. Moreover, as the State has rolled out its healthcare reforms it has relied exclusively on 3M software. HHC must purchase the APR-DRG grouper from 3M.

The Corporation has invested over $230,000 in interfaces between 3M and the Corporation's two financial information systems in operation in 2015. Interfaces are already built between 3M and Unity and Soarian. Claims are routed to the correct system depending on the system originating the input to 3M. Building a new set of interfaces with this capability will delay the Soarian deployment.

The Corporation continues to devote significant resources to Health Information Management employee training using 3M. Coders use the 3M system as they practice coding cases in the ICD-10 code set. 3M was upgraded in 2014 to prepare for ICD-10 implementation. On October 1, 2015 Centers for Medicare and Medicaid is mandating the nation switch from the ICD-9 to the ICD-10 code set. ICD-10 implementation is a substantial change to coding operations. HHC's 3M system is ICD-10 ready and has tested successfully with Unity and Soarian to produce compliant bills.

HHC has invested significantly in 3M hardware for the deployment of an enterprise wide version of 3M. Installing a new system will necessitate creating a duplicative system for an extended period.

Since the advent of DRG (Diagnosis Related Groups) based reimbursement, almost all acute hospital and long-term care billing operations use software to support abstracting. HHC has held an agreement with the 3M Health Information Systems to provide these services since 1984. For HHC's coders, 3M supports the process of selecting the correct codes, assigning them to patients, storing data for audits, medical reporting and transmission to financial systems. 3M is the owner of the owner of the proprietary software and maintenance contractor for the software and interfaces for which this agreement is required. It is the only source able to provide and maintain the software in a timely, reliable, and efficient manner.

CONTRACT FACT SHEET

New York City Health and Hospitals Corporation

Contract Title: 3M Coding and Reimbursement Services

Project Title & Number: Provides software licenses, maintenance and support for 3M's Coding and Reimbursement suite of products including interfaces with financial systems.

Project Location: 55 Water St., New York, NY 10041

Requesting Dept.: EITS

Successful Respondent: 3M Health Information Systems

Contract Amount: $13,510,101 with all renewal options exercised

Contract Term: Three years (FY 2016 to FY 2018) with two one-year renewal options. There is a contingency of $643,338

Number of Respondents:
(If sole source, explain in background) One (1) section)

Range of Proposals: **$** N/A **to $**

Minority Business Enterprise Invited: ☐Yes If no, please explain: This is a sole source agreement.

Funding Source: [X] General Care ☐Capital
☐ Grant: explain
☐ Other: explain

Method of Payment: ☐Lump Sum ☐Per Diem ☐Time and Rate
[X] Other: explain: Licensing software based on HHC patient volume. Paid monthly

EEO Analysis: Pending

Compliance with HHC's:
McBride Principles? Submitted. Pending approval.

Vendex Clearance? Submitted. Pending approval.

(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.)

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

3M's Health Information Systems will provide HHC with a suite of software for abstracting ICD, Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes at acute and long-term care facilities. The 3M suite of products aids selection of codes, maintains a database of patient information, groups codes for validation and provides codes to financial systems. The work includes software licenses, support, maintenance and administrator training on all products.

The Corporation needs to continue its software license, maintenance and support services agreement in order to protect its investment in the 3M Coding and Reimbursement Information System. 3M is the owner of the proprietary software and maintenance contractor for the software and interfaces for which this agreement is required. 3M is the only source able to provide maintain the software in a timely, reliable, and efficient manner. The Corporation uses the Coding and Reimbursement System in daily patient record management and has invested in interfaces between 3M and the Corporation's two financial information systems in operation in 2015. In addition, the Corporation continues to devote significant resources to Health Information Management employee training using 3M. Coders use the 3M system as they practice coding cases in the ICD-10 code set. 3M was upgraded in 2014 to prepare for ICD-10 implementation.

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

The proposed contract was presented to the CRC on March 18, 2015.
Approval was provided.

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 CRCs:

Yes. The scope of work and budget changed since the presentation on March 18th. The CRC presentation included 3M providing components for Epic. These elements were removed. 3M could not provide proposed language acceptable to HHC. This reduced the budget by $3,470,405.

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

Public solicitation through a Request for Proposal is not in the best interest of the Corporation. The support of proceeding with a sole source procurement from 3M Health Information Systems is based on:

1) 3M is the only provider of New York State groupers that the Corporation must use;
2) HHC's 3M coding software system is integrated with Soarian Financials, HHC's new revenue cycle system. Changing coding software at mid-deployment will endanger the roll-out of Soarian in 2015;
3) Changing coding providers creates unacceptable risk to HHC's readiness for ICD-10 implementation on October 1, 2015 ; and
4) Reconfiguring hardware to another provider is cost prohibitive.

The majority of inpatient claims processed by HHC are for payers that must use the 3M owned grouper; the APR-DRG grouper (Medicaid and Medicaid managed care). NYS mandates use of the 3M APR-DRG for all Medicaid, Workers Compensation and No-Fault discharges. Moreover, as the State has rolled out its healthcare reforms it has relied exclusively on 3M software.

HHC is deploying new revenue management software in 2015. Interfaces are already built between 3M and both the legacy Unity and the new Soarian systems. Claims are routed to the correct system depending on the system originating the input to 3M. Building a new set of interfaces with this capability will delay the Soarian deployment.

On October 1, 2015 Centers for Medicare and Medicaid is mandating the nation switch from the ICD-9 to ICD-10 code set. The deadline was delayed twice, as the change is significant for both HIM and information systems. ICD-10 is a significant modification of the existing code set. HHC's 3M system is ICD-10 ready. It has successfully tested with Unity and Soarian to produce compliant bills.

HHC has invested significantly in 3M hardware for the deployment of an enterprise wide version of 3M. Installing a new system will necessitate creating a duplicative system for an extended period.

Since the advent of DRG (Diagnosis Related Groups) based reimbursement, almost all acute hospital and long-term care billing operations use software to support abstracting. HHC has held an agreement with the 3M Health Information Systems to provide these services since 1984. For HHC's coders, 3M supports the process of selecting the correct codes, assigning

them to patients, storing data for audits, medical reporting and transmission to financial systems.

Contract Negotiation Members included:

- Maxine Katz, Senior Assistant Vice President, Finance/Revenue Management
- Laura Free, Assistant Vice President, Finance/ Managed Care
- Brenda Schultz, Assistant Vice President, EITS
- Robert Melican, Senior Director, Finance/ Managed Care
- Elaine Chapnik, Senior Counsel, Legal Affairs

Scope of work and timetable:

The 3M software has four basic components; a database, coding software, DRG groupers and interfaces to fiscal systems. The four components are a unified system. 3M's Health Record Management database stores all coded patient records. The database supports discharged not final billed management, physician research, data management for New York State and others on care practices. 3M's Coding and Reimbursement Plus software aids selection of ICD-9, ICD-10, HCPCS and CPT codes. 3M will provide a suite of DRG grouping services to HHC for Medicaid and Medicare patients. Grouping software will be integrated and work seamlessly with coding services and the Health Record Management Software. The interfaces move data from 3M to the appropriate financial system, either Unity or Soarian depending on the originating system.
Services will continue with no interruptions. The contract begins July 1, 2015

This is a three year contract, with two one-year renewal options.

Cost/Benefit:

HHC requires 3M software to produce ICD, HCPCS and CPT codes required for reimbursement. Deriving these required codes without support of 3M is not possible, it will place all HHC patient revenue in jeopardy.

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

HHC does not have the capability of producing its own coding and reimbursement software.

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?

This contract will not produce artistic/creative/intellectual property.

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

Sal Guido, Interim, Chief Information Officer is responsible for the contract.

The project managers are Janet Karageozian, Interim AVP for Business Applications, EITS and Robert Melican, Senior Director, Finance/ Managed Care.

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):*

EEO process is pending.

Received By E.E.O. _____
Date

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

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

nyc.gov/hhc

Medical and Professional Affairs / IT Committee:

Sole Source Contract with 3M Health Information Systems

Elements of 3M Contract

- Coding & Reimbursement components:
  - Encoder – software that guides coders through a series of questions to provide a pathway to an appropriate ICD code
  - Database – stores all coded case information for reporting
  - Groupers – assembles individual ICD codes into the correct Diagnostic Related Group (DRG)
  - Interfaces – custom connections to Unity and Soarian financial systems
- Function as a unified system for Health Information Management (HIM)

Why 3M?

- 3M developed the Medicaid groupers with NYS in 2009 and is the only provider of the product
  - All software providers in NYS have to purchase these groupers from 3M
- 3M can operate simultaneously with Unity & Soarian financial systems
  - In next 12 months all facilities are moving to Soarian
  - Managing this transition and a change of coding creates unacceptable level of risk
- Migrating to Enterprise version of 3M in next 4 months

3M History with HHC

- First contract in 1984 – 6 renewals
- Terms for 7th renewal are 3 year contract with two one-year renewal options

5 Year	FY '04	FY '05	FY '06	FY '07	FY '08		
Coding & Reimbursement Services	1,131,074	1,217,994	1,234,707	1,258,630	1,308,975		
7 Year	**FY '09**	**FY '10**	**FY '11**	**FY '12**	**FY '13**	**FY '14**	**FY '15**
Coding & Reibursement Services	2,022,671	2,042,806	2,104,233	2,167,504	2,232,676	2,299,804	2,368,947
Proposal							
5 Year	**FY '16**	**FY '17**	**FY '18**	**FY '19**	**FY '20**		
Coding & Reimbursement Services	2,423,514	2,496,219	2,571,106	2,648,239	2,727,686		
Includes Negotiated Annual Increases of 3%				**Total Contract**	**12,866,763**		
				Contingency of 5%	643,338		
				Total Amount	**13,510,101**		

RESOLUTION

Authorizing the New York City Health and Hospitals Corporation ("the Corporation") to purchase storage hardware, software, and associated maintenance from various vendors via Third Party Contract(s) in an amount not to exceed $13,220,000 for a one year period.

WHEREAS, the current EPIC installation upgrade to version 2015 requires the predicted additional storage capacity to support the virtual desktop environment for EPIC and to support several EPIC related application installations; and

WHEREAS, contractors able to provide the needed goods and services are available to the Corporation through the New York State Office of General Services and Federal General Services Administration ("Third Party Contracts"); and

WHEREAS, the Corporation is soliciting proposals from manufacturers and authorized resellers via Third Party Contract(s); and

WHEREAS, Third Party Contracts offer discounted pricing compared to the market price for such equipment; and

WHEREAS, the overall responsibility for managing and monitoring the agreement shall be under the Interim Corporate Chief Information Officer.

NOW, THEREFORE, be it:

RESOLVED, THAT THE President of New York City Health and Hospitals Corporation
be and hereby is authorized to purchase storage hardware, software, and associated maintenance from various vendors via Third Party Contract(s) in an amount not to exceed $13,220,000 over a one year period.

Executive Summary –
Purchases for Epic Storage Hardware, Software, and Maintenance via Third Party Contracts

The accompanying resolution requests approval to purchase storage hardware, software and associated maintenance from various vendors via Third Party Contract(s) in an amount not to exceed $13.22 million for the EPIC Electronic Medical Record (EMR) program. This purchase is included in the EPIC EMR clinical budget.

A Storage Area Network ("SAN") is a dedicated network that provides access to consolidated, block level data storage. SANs are primarily used to make storage devices, such as disk arrays, tape libraries, and optical jukeboxes, accessible to servers so that the devices appear as locally attached devices to the end user.

HHC previously purchased storage for the EPIC project under a single vendor architecture. All of this storage equipment has been installed at both data centers and is active in the development and testing environments.

Predicted and budgeted storage requirements are now needed to complete the Epic production installation including specifications required for the Epic software upgrades, virtual desktops to meet future growth.

The announcement by EPIC of a 2015 version upgrade contained specifications requiring the predicted increase in the size and capacity of the storage systems needed to support the implementation and deployment. Further increase in the EMR storage requirements derives from the need to support the new virtual desktop environment for EPIC. Lastly, predicted storage is now required to support multiple EPIC related applications such as the Enterprise Content Management system.

These purchases will allow the Corporation to add the necessary storage to meet its EMR related demands.

Due to changes in technology and pricing, the Corporation's storage needs can be satisfied through multiple vendors. By using multiple vendors, the Corporation can achieve significant savings. Purchasing from multiple vendors will also protect the Corporation from being reliant upon one vendor's storage prices in the future.

Under this request, solicitations are being conducted from vendors available through Federal General Services Administration and the New York State Office of General Services ("Third Party Contracts") to procure storage equipment for the Corporation's EPIC SAN's. Enterprise Information Technology Services will solicit manufacturers and authorized resellers via Third Party Contracts. These contracts allow the Corporation to receive discounts beyond what is available on the open market. For example, a recent purchase of EMC storage equipment realized a 50% discount off of the list price. A minimum of three resellers will be solicited for each purchase. A purchase order will be issued to the lowest responsive bidder for each purchase.

CONTRACT FACT SHEET

New York City Health and Hospitals Corporation

Contract Title: Storage Hardware, Software, and Maintenance for Epic

Project Title & Number: Electronic Medical Record

Project Location: Enterprise-Wide

Requesting Dept.: Enterprise IT Services

Successful Respondent: Multiple Vendors via Third Party Contracts

Contract Amount: $13,220,000

Contract Term: 12 months

Number of Respondents: Multiple Vendors
(If Sole Source, explain in Background section)

Range of Proposals: $ Not Applicable to $

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

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

Method of Payment: **X** Lump Sum Per Diem Time and Rate
X Other: explain Upon acceptance

EEO Analysis:

Compliance with HHC's McBride Principles? Yes No **X** N/A

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

(Required for contracts in the amount of $100,000 or more awarded pursuant to an RFP, NA or as a Sole Source, or $100,000 or more if awarded pursuant to an RFB.)

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

EITS needs to purchase storage hardware, software and associated maintenance necessary for the EPIC Electronic Medical Records ("EMR") implementation and deployment.

A Storage Area Network ("SAN") is a dedicated network that provides access to consolidated, block level data storage. SANs are primarily used to make storage devices, such as disk arrays, tape libraries, and optical jukeboxes, accessible to servers so that the devices appear as locally attached devices to the end user.

HHC previously purchased storage for the EPIC project under a single vendor architecture. All of this storage equipment has been installed at both data centers and is active in the development and testing environments.

Predicted and budgeted storage requirements are now needed to complete the EPIC production installation including specifications required for the EPIC software upgrades, virtual desktops to meet future growth.

The announcement by EPIC of a 2015 version upgrade contained specifications requiring a dramatic increase in the size and capacity of the storage systems needed to support the implementation and deployment. Further increase in the EMR storage requirements derives from the need to support the new virtual desktop environment for EPIC. Lastly, additional storage is required to support multiple EPIC related applications such as the Enterprise Content Management system.

These purchases will allow the Corporation to add the 3 Petabytes (equivalent to about 3 times the data volume of Facebook's Photo Storage) necessary to meet its EMR related storage demands.

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

CRC approved this submission on April 1, 2015.

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:

N/A

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

Process used to select the proposed contractor –

Under this request, solicitations are being conducted from vendors available through Third Party Contracts. Conducting solicitations via Third Party contracts will ensure that HHC is promoting competition as well as receiving the best price for the required equipment. Third party contracts offer discounted pricing compared to the market price for such equipment.

The selection criteria –

Enterprise IT Services will solicit manufacturers and authorized resellers via Third Party contracts. A minimum of three resellers will be solicited for each purchase. A purchase order will be issued to the lowest responsive and responsible bidder for each purchase.

The justification for the selection –

A purchase order will be issued to the lowest responsive and responsible bidder for each purchase.

Scope of work and timetable:

Vendors will provide Storage Equipment for the Corporation's Epic storage projects. The anticipated project duration for these purchases is one year.

Provide a brief costs/benefits analysis of the services to be purchased.

No services will be included in these purchases. Software, hardware, and maintenance will be purchased off of Third Party Contracts, which offer discounted pricing compared to the market price for such equipment. For example, an EMC storage system was recently purchased for a price of $46,300 via NYS OGS contract. This represents a 50% savings off of the list price of $92,600. By soliciting vendors via Third Party Contracts, the Corporation can obtain potential savings of approximately 50% off list pricing for storage hardware and software purchases.

Provide a brief summary of historical expenditure(s) for this service, if applicable.

FY15: **$2.3 million to date**

Provide a brief summary as to why the work or services cannot be performed by the Corporation's staff.

Not applicable. These purchases are for Storage Hardware, Software and Maintenance.

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):

Sal Guido, Assistant Vice President/ Interim Corporate CIO.

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. _____ ***Not Applicable***
Date

Analysis Completed By E.E.O._____
Date

_____
Name

Purchases for EMR Storage Hardware, Software and Maintenance

Medical and Professional Affairs/IT Committee Meeting

April 16, 2015

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

nyc.gov/hhc

EMR Storage Hardware, Software & Maintenance Purchases – Background

Enterprise IT Services (EITS) is seeking $13.22 million in spending authority to purchase storage hardware, software and maintenance for the EPIC EMR program.

Previously purchased storage for the EPIC program has been installed at both data centers and is active in the development and testing environments.

The predicted and budgeted cost of storage equipment that will be purchased is needed to complete the production installation and includes:

- **Requirements for EPIC software upgrades**
- **Support for virtual desktops**
- **Capacity for future growth**
- **Epic related application installations and projects**

EMR Storage Hardware, Software & Maintenance Purchases – Procurement Process

Purchases will be made via Third Party Contracts to procure storage equipment.

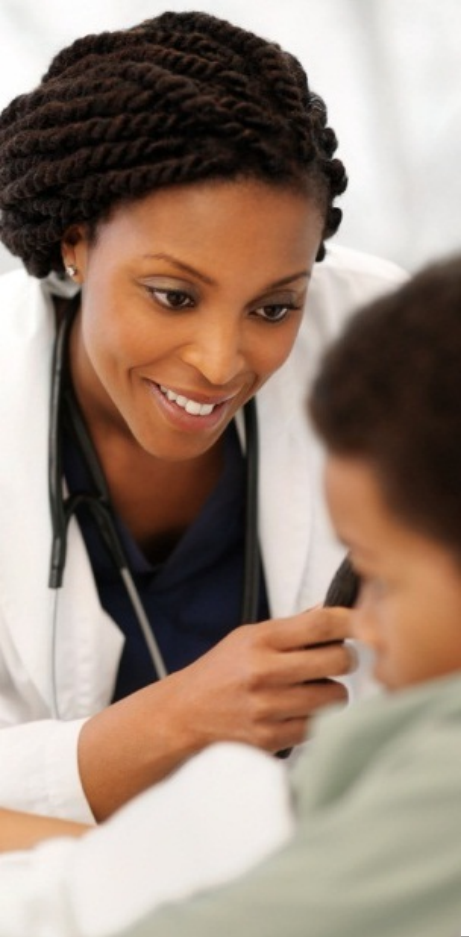
EITS is soliciting manufacturers and authorized resellers using Third Party Contracts. A minimum of three resellers are being solicited for each purchase.

A purchase order will be issued to the lowest responsive and responsible bidder for each purchase.

Third Party Contracts offer discounted pricing. The Corporation can obtain a potential savings of approximately 50% off list pricing for storage hardware and software purchases.

Questions

Questions?



Access to Primary Care

HHC Board of Directors
Medical & Professional Affairs/IT Committee
April 16, 2015

HHC NEW YORK CITY HEALTH AND HOSPITAL CORPORATION

access
The First Step In Meeting Our Patients' Needs

Executive summary

Primary Care

- is the centerpiece of our population health strategy
- Is essential for success in a managed care and ACO environment
- Hence HHC strategy to move to PCMH model and then improve access

Since 2013, HHC has made sustained access improvements :

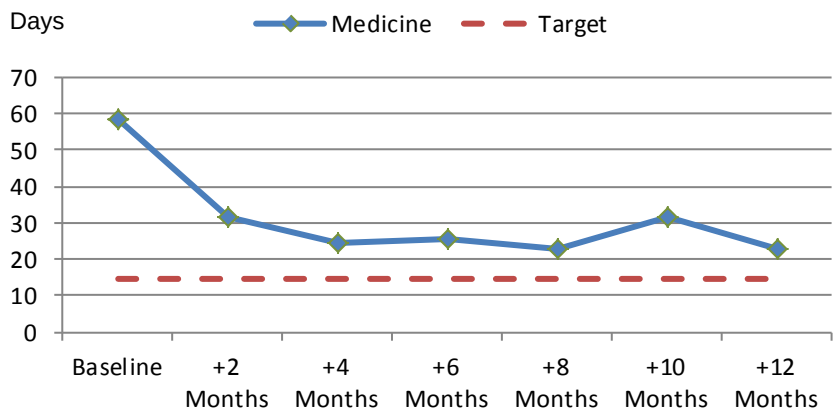
- Access improvement strategies have been implemented at all adult medicine and pediatrics practices at our 17 major ambulatory facilities, and at 175 practices in total
- In adult medicine, HHC-average appointment wait for new patients dropped from ~55 days to under 30 days, with ~40% of our sites currently under our 14-day target [1]
- In pediatrics, average appointment wait for new patients has dropped from ~14 days to ~8 days, with ~65% of our sites currently under our 5-day target [1]

[1] Appointment wait measured as Days to Third Next Available Appointment (TNAA). Current data is from February 2015. Baseline data is from the first month of data collection for each facility, which occurred between mid 2013 – mid 2014.

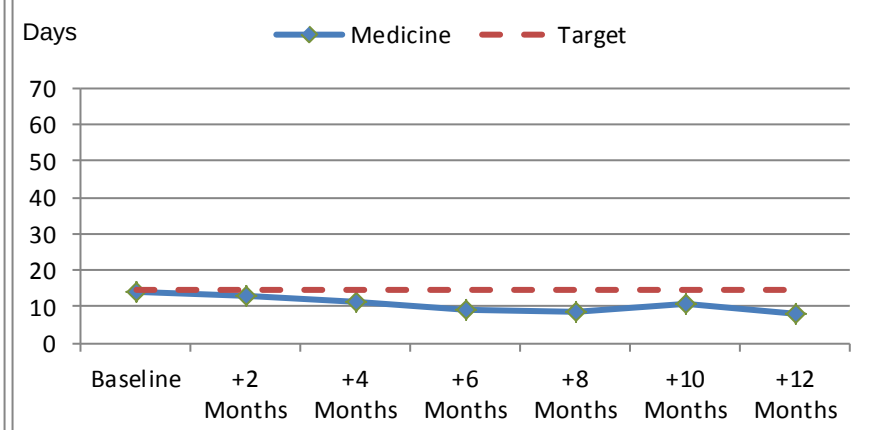
HHC-wide Access performance:
Days to Third Next Available Appointment

Adult Medicine – *Aggregated across sites submitting data for at least 12 months*

New patient appointment wait (TNAA-New)

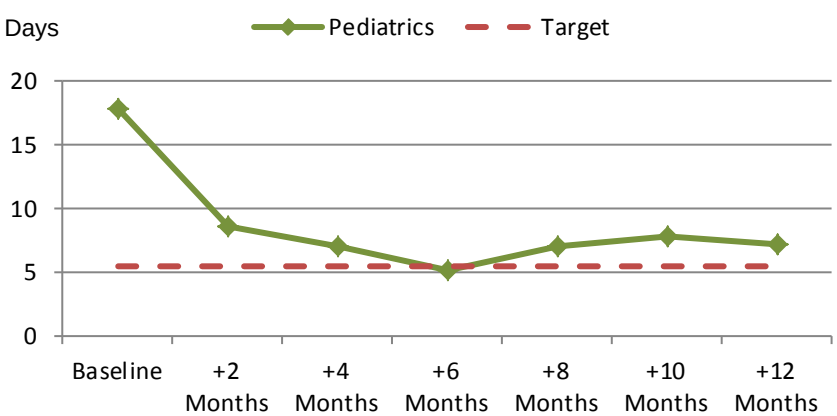


Revisit appointment wait (TNAA-Revisit)

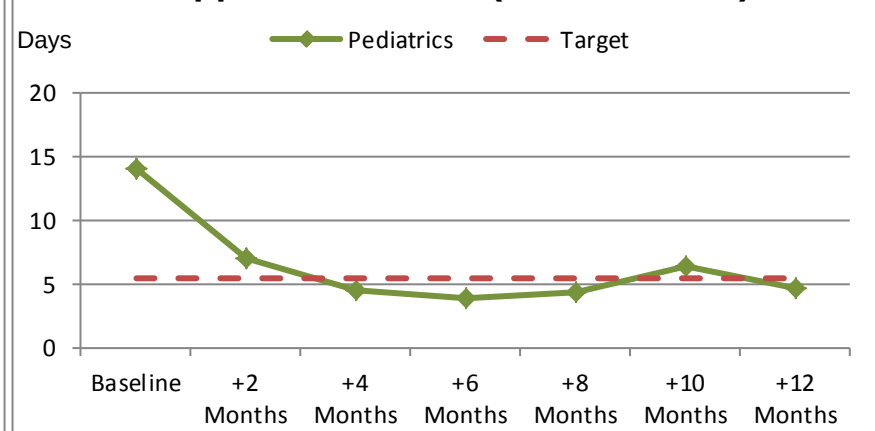


Pediatrics – *Aggregated across sites submitting data for at least 12 months*

New patient appointment wait (TNAA-New)



Revisit Appointment wait (TNAA-Revisit)

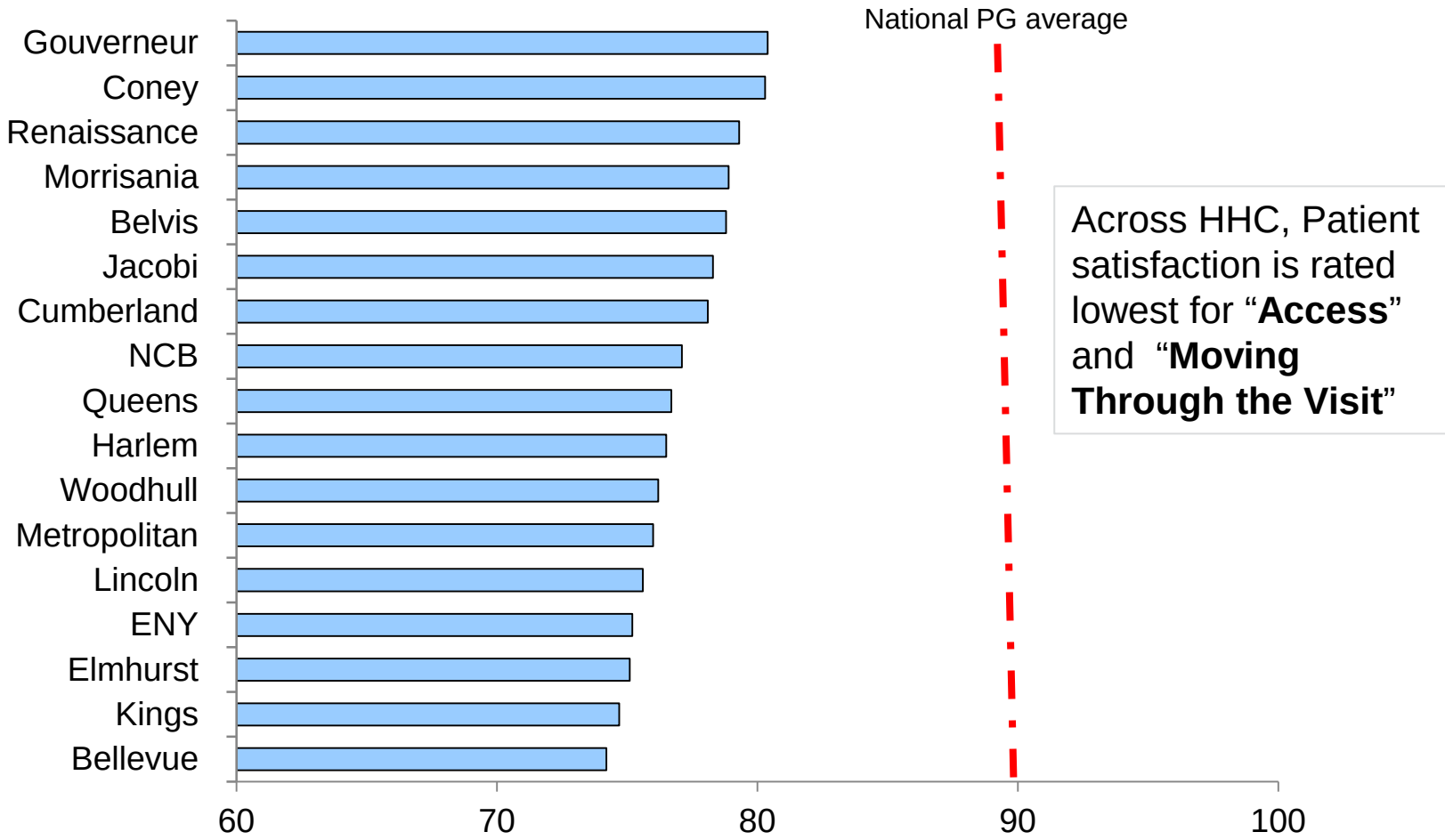


NOTES: 1) 12 facilities include (BE,CU,EY,GV,HA,JA,KC,LI,ME,NO,QU,WO)
2) Baselines are 2-week avgs from baseline collection and do not have same start date
3) Other time ranges represent a 3-week average X months after baseline (X=2, 4, 6, 8, 10, 12)

Patient satisfaction

Adult Medicine Primary Care

Overall Patient satisfaction [1]

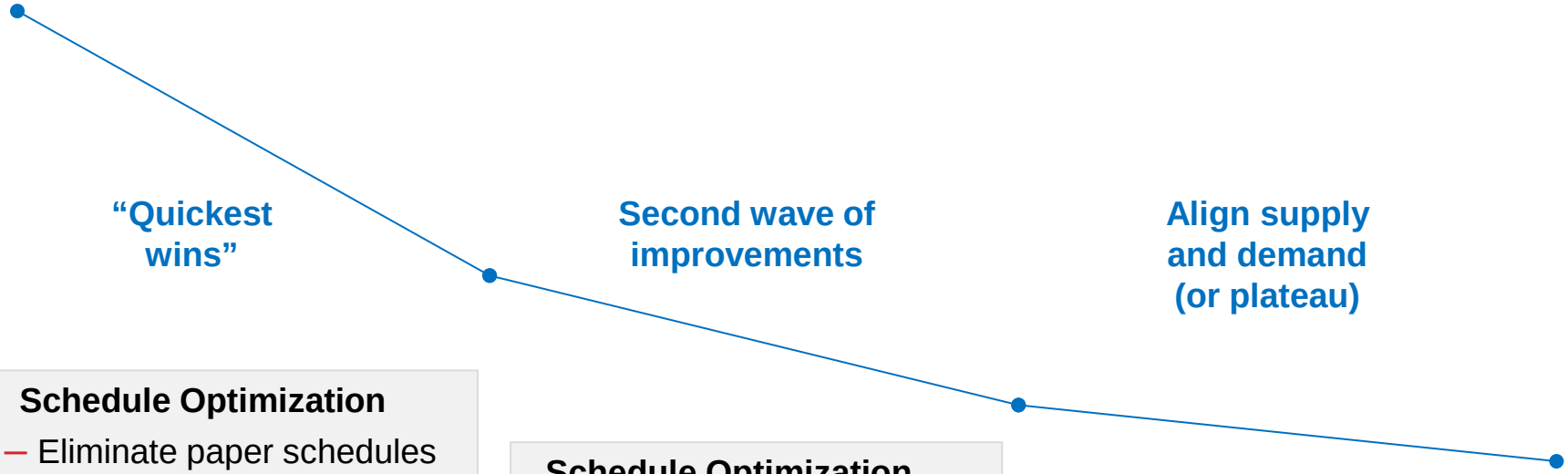


Across HHC, Patient satisfaction is rated lowest for "**Access**" and "**Moving Through the Visit**"

[1] 2014 data – Press Ganey

“Moving the Needle” on Access Performance?

Typical improvement journey



“Quickest wins”

Schedule Optimization
- Eliminate paper schedules
- Schedule hygiene/scrubbing
- Reallocate schedule slots

Second wave of improvements

Schedule Optimization
- Customize templates
- Simplify/automate overbooking

Improve No-Show Rates
- Deploy consistent appointment reminders

Increase Clinic Throughput
- Use “flow facilitator” to manage patient queue

Align supply and demand (or plateau)

Demand management
- Examine visit frequency and referral guidelines
- Guide “walk-ins” to appointments while still addressing urgent needs

If these levers are exhausted, then add capacity
- Add provider FTE
- Leverage community partners

Primary care access gap and strategies to meet the need

The access gap/need (Demand)

1. Meet needs of existing patients who face long appointment waits

~40 provider FTE needed

2. Serve unmet demand – like newly insured who are not yet patients
3. Transition reduce-able ED visits to primary care setting

~15-20 provider FTE needed

Strategies to meet the need (Supply)

1. Strengthen organizational capabilities to measure and improve access
2. Unlock capacity by optimizing scheduling practices, and route patients intelligently to places with more capacity

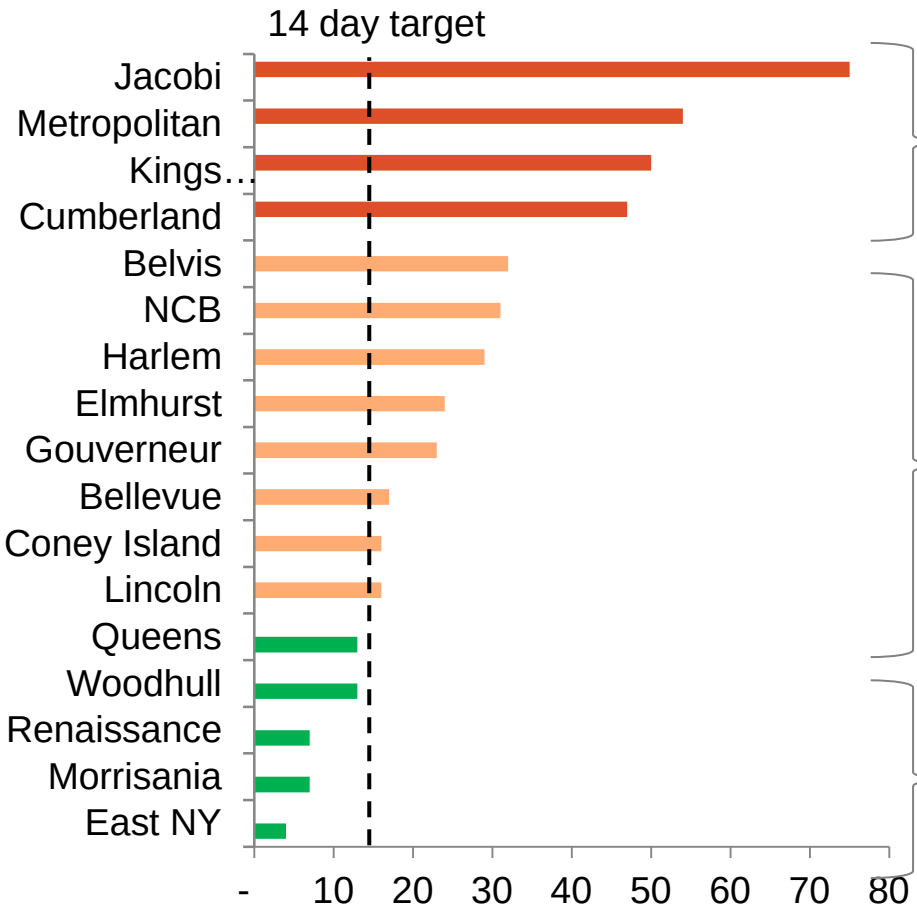
Unlock ~10-15 provider FTE

4. Add capacity through targeted hiring or community partnerships

Add ~45 provider FTE (immediate need: 25-30 FTE)

1 In adult medicine, access gaps lead to a reduced ability to see patients in clinic, suggesting a need for additional capacity

Adult Medicine Primary Care
Appointment wait time in Days (TNAA-New) [1]



Sites with 40+ day access do **~ 2.0** visits per active patient [2]

Sites with 14-40 day access do **~ 2.4** visits per active patient [2]

Sites with <14 days access do **~ 2.8** visits per active patient [2]

Addressing this access gap requires ~40 FTE worth of additional provider capacity (through either efficiency or hires)

[1] Data is from Dec 2014 to Feb 2015
[2] Based on annual visits and 18-month active patients, from Data GPS. ~3 visits per patient per year is consistent with CMS benchmark panel size of 1,500 patients per clinical FTE, assuming an FTE represents roughly 45 working weeks a year, 20-min appointment slots, 20-25 slots per day

2 Fill rate analysis indicates that some of this capacity need can still be captured through operational improvements

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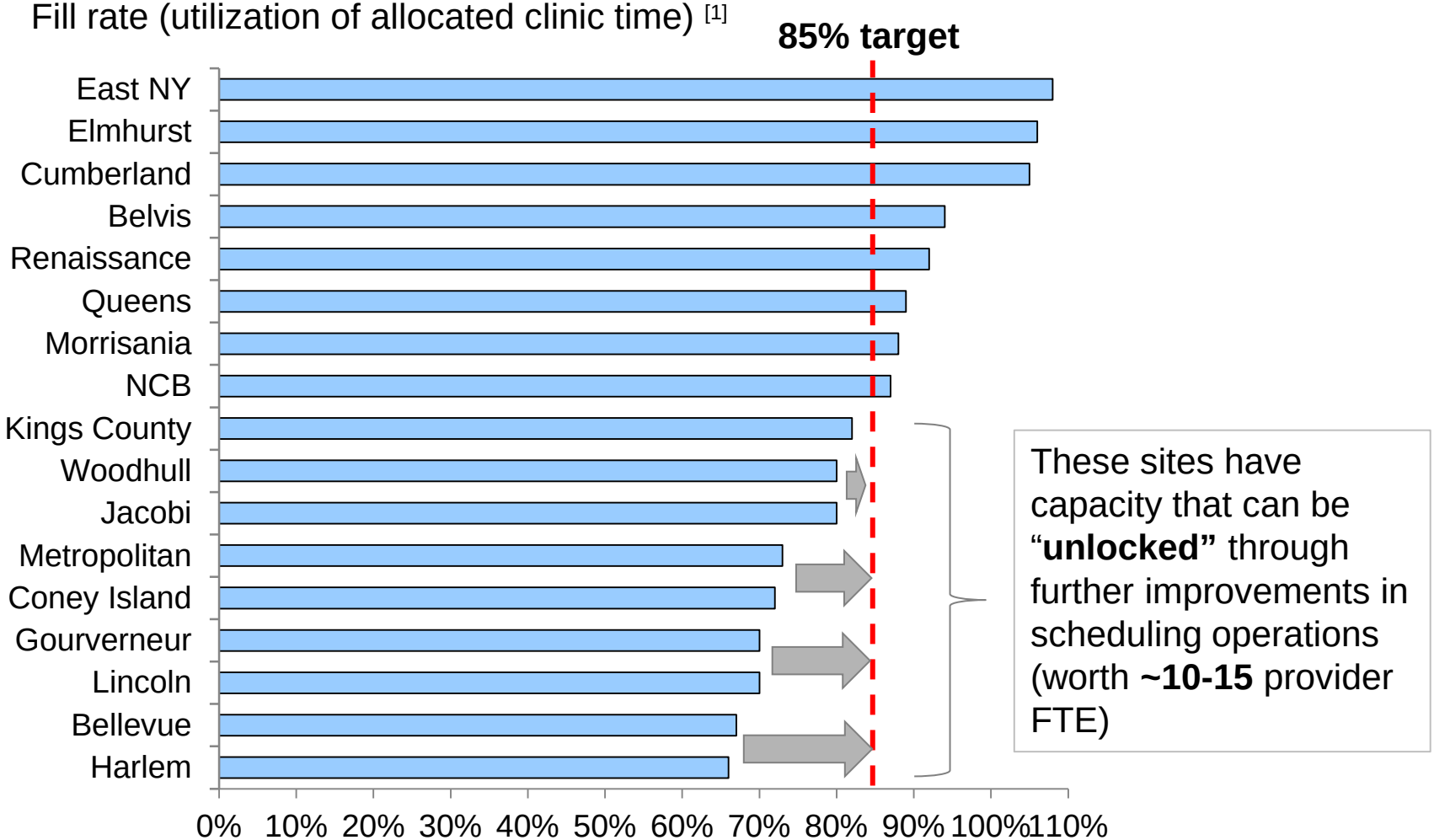
Fill rate (utilization of allocated clinic time) [1]

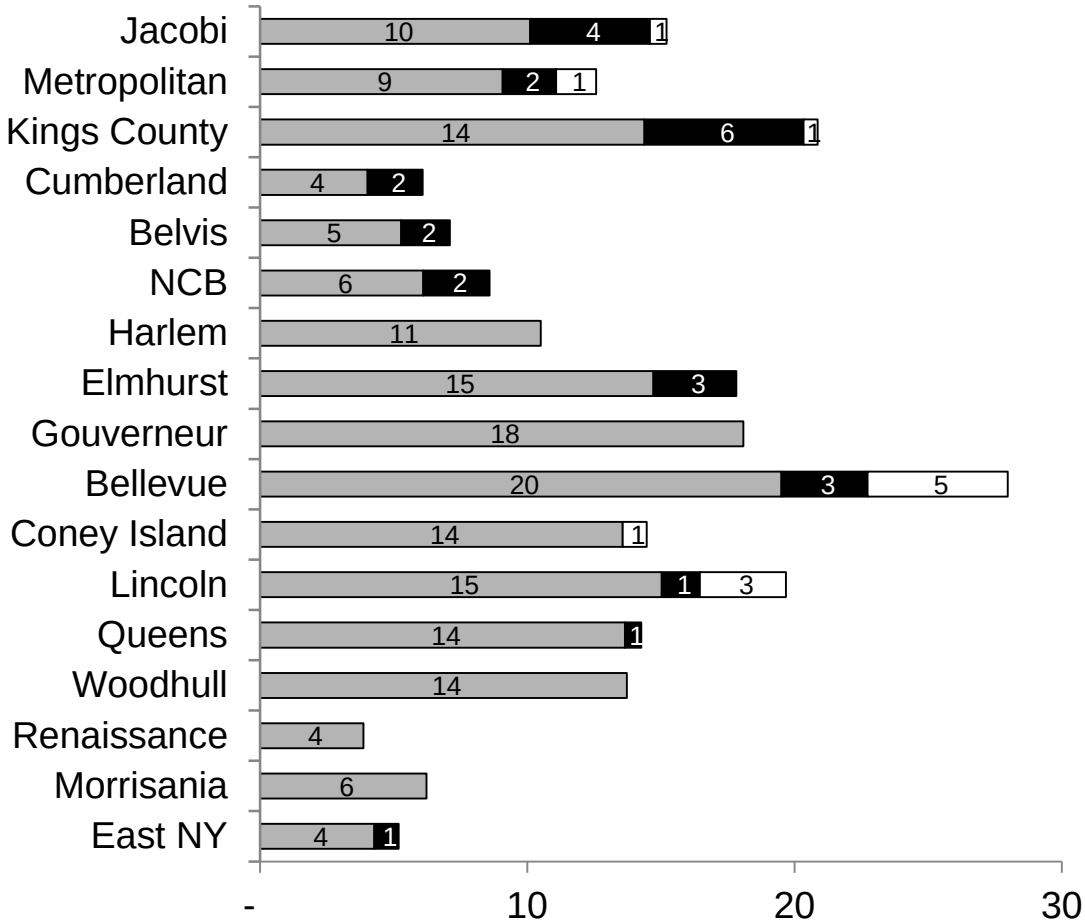


[1] Data is from Dec 2014 to Feb 2015. Primary care recently transitioned to automated access reporting through Soarian. Sites with less than 100% Soarian compliance have understated volume and fill rates, and have therefore been adjusted appropriately.

Our immediate gap in meeting current patient needs can be addressed through a combination of "unlocking" and "adding" provider FTE

Adult Medicine Primary Care

Capacity (FTE) – current, to hire, and to unlock



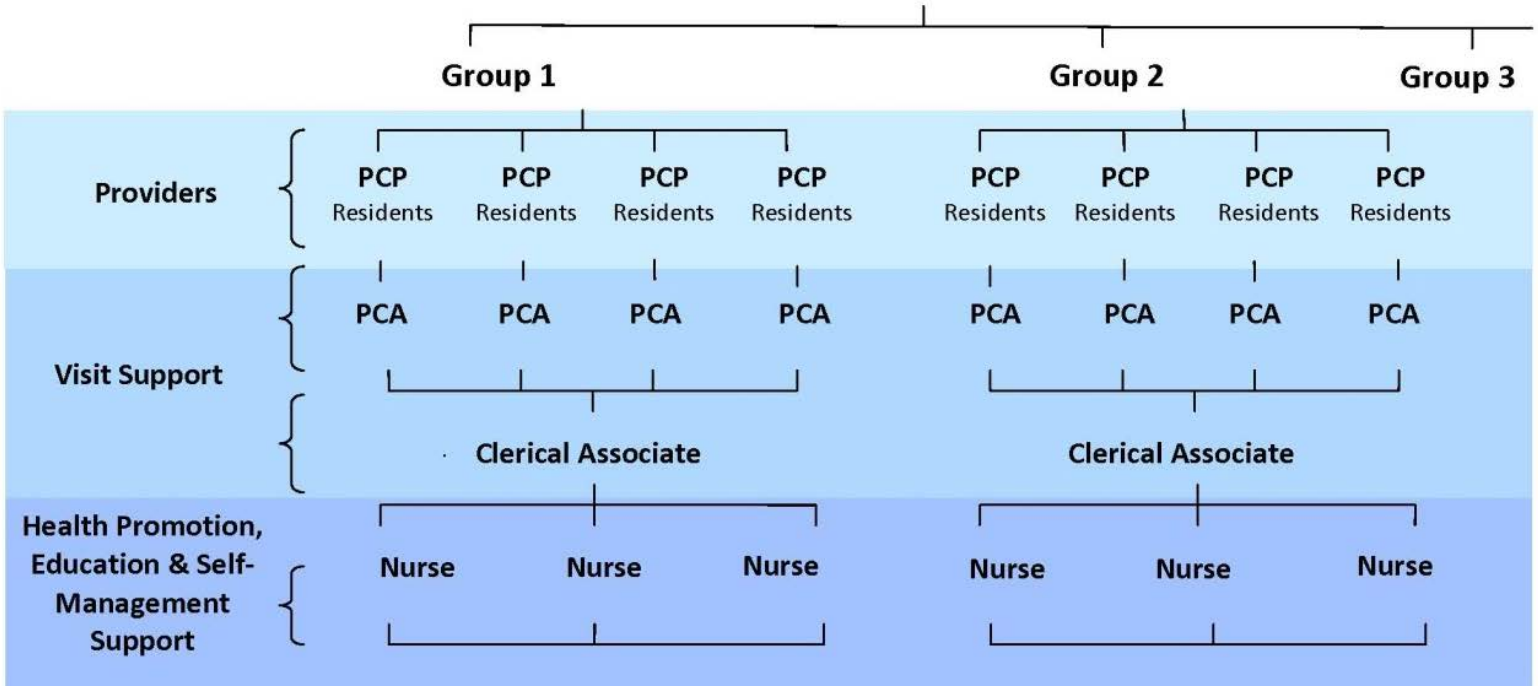
Provider capacity (FTE)

	Current [1]	Add	"Unlock"
JA	10	4	1
ME	9	2	1
KC	14	6	1
CU	4	2	-
BV	5	2	-
NO	6	2	-
HA	11	-	-
EL	15	3	-
GV	18	-	-
BE	20	3	5
CI	14	-	1
LI	15	1	3
QU	14	1	-
WO	14	-	1
RN	4	-	-
MO	6	-	-
EY	4	1	-
Total	182	28	13

[1] Current capacity is based on provider schedules submitted by the practice for access reporting, and typically excludes nurse visits, blood draws, and services that the practice does not think of as core primary care capacity. 20-minutes slots were then converted to FTE using the following assumptions for 1 FTE: 21 slots per day, 83% clinic time per week, 44 working weeks per year.

Provider capacity additions must be accompanied by appropriate PCMH care team staffing

Target primary care staffing – Adult Medicine



- Sites are currently in the process of clarifying/codifying their team structures as part of PCMH efforts
- Across the adult medicine sites that have submitted team structures, staffing ratios generally match this model today

Next steps

For sites that can unlock more capacity (white bars on the previous chart):

- ❑ Plan to improve Fill Rate
- ❑ Ensure that your Coach & Breakthrough resources are being deployed to support you on this

For sites that need to add capacity (black bars on the previous chart):

- ❑ Develop a capacity expansion plan that includes:
  - Validating existing provider clinical capacity
  - Assessing the number supporting care team staff needed (RN, PCA, Clerks)
  - Expanding capacity within existing space using after-hours and weekend sessions
  - Checking whether existing spaces can be converted to exam swing rooms
  - Checking whether other space exists in the facility for potential expansion
  - Assessing the remaining capacity need to be addressed through community partnerships