AGENDA

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE

Meeting Date: May 14th, 2015
Time: 9:00 AM
Location: 125 Worth Street, Room 532

BOARD OF DIRECTORS

CALL TO ORDER	**DR. CALAMIA**
ADOPTION OF MINUTES *April 16th, 2015*	
CHIEF MEDICAL OFFICER REPORT	**DR. WILSON**
METROPLUS HEALTH PLAN	**DR. SAPERSTEIN**
CHIEF INFORMATION OFFICER REPORT	**MR. GUIDO**

INFORMATION ITEMS:

I.	**EMR Implementation Update**	**MR. GUIDO**
II.	**Epic Day at HHC Facilities**	**MS. COUTS**
III.	**Update on Lab Project with North Shore**	**MS. FORD**

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

MINUTES

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE BOARD OF DIRECTORS

Meeting Date: April 16, 2015

ATTENDEES

COMMITTEE MEMBERS

Vincent Calamia, MD, Committee Chair
Josephine Bolus, RN
Ram Raju, President

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
Jennifer Bender, Assistant Director, Communication and Marketing
Marylee Burns, Senior Director, Office of Behavioral Health
Deborah Cates, Chief of Staff, Board Affairs
Tammy Carlisle, Associate Executive Director, Corporate Planning
Paul Contino, Chief Technology Officer, EITS
Megan Cunningham, Director, Accountable Care Organization
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
Janet Karageozian, Senior Director, Enterprise Information Technology Systems
Maxine Katz, Senior Assistant Vice President, Revenue Management
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
Jeff Morrow, Consultant, Enterprise Information Technology Systems
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
Brenda Schultz, Assistant Vice President, Enterprise Information Technology System
Jared Sender, Senior Director, Population Health EITS
Diane E. Toppin, Senior Director, M&PA Divisional Administrator
Tony Williams, Director, Enterprise Information Technology System

FACILITY STAFF:
Lillian Diaz, Chief Nurse Executive, Metropolitan Hospital Center
John Maese, MD, Medical Director, Coney Island Hospital
Andreea Mera, Special Assistant to the President, MetroPlus Health Plan, Inc.
John T. Pellicone, Chief Medical Officer, Metropolitan Hospital Center
Anthony Rajkumar Executive Director, Metropolitan Hospital Center
Arnold Saperstein, Executive Director, MetroPlus Health Plan, Inc.
Denise Soares, Executive Director, Harlem Hospital Center
Arthur Wagner, Senior Vice President, Southern Brooklyn/Staten Island Network

OTHERS PRESENT:
Moira Dolan, Senior Assistant Director, DC37
David N. Hoffman, Chief Compliance Officer, PAGNY
Shane Kielmeyer, 3M
Richard McIntyre, Siemens
Kristyn Raffaele, Analyst, OMB
Dhruneanne Woodrooffe, Analyst OMB

MEDICAL AND PROFESSIONAL AFFAIRS/
INFORMATION TECHNOLOGY COMMITTEE
Thursday, April 16, 2015

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

Care Management

The 2015 NYS Hospital Medical Home (HMH) Conference was held on March 19th, marking the end of HMH Demonstration pilot funded by the Centers for Medicaid and Medicare Services and the NYS Department of Health. 17 HHC facilities participated in the grant, which saw transformation in the care provided in their outpatient primary care clinics, and the reinforcement of medical home concepts in primary care resident training. 9 HHC presenters (8 facilities, 1 Central Office) participated in the conference poster session to showcase the achievements made by HHC facilities throughout the grant period in the areas of patient-centered medical home, clinical performance, residency continuity training programs, care integration and coordination projects, and inpatient quality and safety projects.

Laboratory Services

General

Cerner Laboratory Information Systems (LIS) - The Cerner Laboratory Master Validation/Implementation Plan has been developed. Initial review by the Laboratory Directors has been completed and finalization is expected by 10 April, 2015. All HHC facilities have named project Champions and technical/administrative subject matter experts. The project teams will support the completion of required activities necessary to implement the LIS. Additionally, clinical leads have been named in the areas of general laboratory, microbiology and anatomic pathology and will focus on standardization of operational activities throughout HHC labs.

Near Patient Testing (Point of Care)

An interdisciplinary project team has been formed to focus on near patient testing. Testing needs of Critical Care Services and outpatient Coumadin Clinics are of immediate interest. Available platforms were viewed by the POC project team during recent vendor presentations.

Office of Population Health

HHC has entered into a formal agreement with Health Leads, a 19-year old non-profit organization that connects patients to social supports. HHC will be re-launching a program with Health leads to address basic resource needs for pediatric patients and their families at 3 sites (Woodhull, Bellevue, Harlem). We will also be conducting a formal evaluation of the impact of these services.

Teen Health Conference

On April 15, HHC hosted a conference at Baruch College on Integration of behavioral health and adolescent primary care. This was a very successful event with more than 150 participants and speakers from within HHC as well as from our academic partners in the city.

E-prescribing

The Governor has signed into law legislation which delays for one year the mandate that medications be electronically prescribed. The new deadline is March 27, 2016. While measures had been put in place to meet the original timeline, this delay will allow us to move forward systematically in deploying e-prescribing across the corporation. Implementing this technology will not only reduce diversion of controlled substances but will also give clinicians valuable new information while affording real convenience to patients. We are on a timeline throughout the month of May to insure all providers are registered and using e-prescribing. On the same time-line, the facility medical, operational and IT leadership are working closely together to identify and address IT, logistic and workflow issues which may impede full implementation.

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 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).

CHIEF INFORMATION OFFICER REPORT

Sal Guido, Acting Corporate Chief Information Officer, Enterprise Information Systems provided the Committee with the following updates:

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.

Action Items:

A resolution was presented to the committee by Sal Guido, Acting Chief Information Officer, Enterprise Information System and Maxine Katz, Senior Assistant Vice President, Revenue Management.

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. Elements of the contract were expressed in a slide presentation.

This resolution was presented to the board and approved.

A resolution was presented to the committee by Sal Guido Acting Chief Information Officer, Enterprise Information System.

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. The EMR storage hardware, software and maintenance purchases backgrounds were shown through a slide presentation.

This resolution was presented to the board and approved.

Information Items

Access to Primary Care

Primary Care is the centerpiece of our population health strategy. It 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. In pediatrics, average appointment wait time for new patients has dropped from ~14 days to ~8 days, with ~65% of our sites currently under our 5-day target.

Graphs demonstrated:
HHC-wide Access performance: Days to Third Next Available Appointment – Adult Medicine/Pediatrics: New patient appointment wait time and Revisit appointment wait time.

Patient satisfaction: Overall patient satisfaction across HHC facilities is rated the lowest based on National PG average - Adult Medicine Primary Care.

Moving the Needle" on Access Performance? : Typical improvement journey: "Quickest wins"- Schedule Optimization; Second wave of improvements – Schedule Optimization, Improve no-show rates and increase clinic throughout; Align supply and demand (or plateau) – Demand management.

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

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
3. Add capacity through targeted hiring or community partnerships

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 - 14 day target

2. **Fill rate analysis indicates that some of this capacity need can still be captured through operational improvements:** Adult Medicine Primary Care – Fill rate (utilization of allocated clinic time) – 85% target

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

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

Next steps
For sites that can unlock more capacity: Plan to improve Fill Rate and
Ensure that Coach & Breakthrough resources are being deployed to support this effort

For sites that need to add capacity:

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; and, assessing the remaining capacity need to be addressed through community partnerships

There being no further business, the meeting was adjourned at 10:00 AM.

MetroPlus Health Plan, Inc.
Report to the
HHC Medical and Professional Affairs Committee
May 14, 2015

Total plan enrollment as of April 1, 2015 was 470,150. Breakdown of plan enrollment by line of business is as follows:

Medicaid	411,214
Child Health Plus	12,601
Family Health Plus	3
MetroPlus Gold	3,454
Partnership in Care (HIV/SNP)	4,770
Medicare	8,500
MLTC	854
QHP	28,093
SHOP	603
FIDA	58

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.

I have previously informed this committee that in light of our growth goal, in addition to aggressive marketing strategies, we are working to expand our network into Staten Island. Since I last reported on this topic, we have had discussions with the two hospitals in Staten Island – Staten Island University Hospital (SIUH) and Richmond University Medical Center (RUMC). Progress is slower than we had hoped. We will need to contract with both facilities for Medicaid LOBs at a minimum, but preferably for all lines of business. We are primarily targeting PCPs and high volume specialties (Cardiology, Gastroenterology, etc.) with a goal of having a minimum number of providers contracted and credentialed by July 1st. This will allow us to file a network that meets NYSDOH minimum access standards (two providers per county in each HPN specialty). While that standard is fine for filing a network, we recognize that many more providers will be needed to attract members and offer viable options to our members.

I had brought to this Committee's attention that starting in July 2015, plans were expected to contract for urgent and routine primary care with School Based Health Center (SBHC) sponsoring entities. In the interim, however, the State has announced that additional work is needed toward the transition. The Department of Health is therefore extending the transition implementation date from July 2015 to July 2016 to allow additional time to appropriately address the remaining operational issues related to the shift to managed care. The State has also noted that in order to minimize disruptions, they have agreed to maintain the current reimbursement that the SBHCs currently receive in the fee-for-service Medicaid system for at least two years after implementation. Of equal importance is to mention that reproductive health services provided by SBHCs will not be transitioned to the Medicaid managed care benefit package at this time. These services will instead remain covered by Medicaid fee-for-service for SBHCs enrollees of Medicaid managed care plans. The carve-out of reproductive health services may be re-

evaluated in the future when the SBHC workgroup can more fully address issues related to confidentiality and managed care plan pharmaceutical formularies.

An additional follow-up item I would like to update this committee on is coverage of transgender services. As of March 11, 2015, the Medicaid program covers transition-related care and services: cross-sex hormone therapy, surgical gender reassignment (including post-transition care), as well as counseling services (the Medicaid program has covered and will continue to cover counseling services for individuals with gender dysphoria).

In terms of Behavioral Health/HARP, we have been notified that the implementation dates have been delayed. The HARP line of business and SSI carve-in will go live in NYC on October 1, 2015. Passive enrollment will be in three phases, by birth-date over a three-month period, to begin July 1, 2015. Children's go-live is delayed until January 1, 2017. We also had to rename our HARP program as new guidance indicates that we cannot use "HARP" or "Health and Recovery Plan" in our HARP Plan Name. The new name is MetroPlus Enhanced.

Management Indicator Report # 1

For Enrollment Month 201504

Indicator #1A for Enrollment Month: April 2015

Disenrollments To Other Plans

		Enrollment Mont			Twelve Months Period		
		FHP	MCAD	Total	FHP	MCAD	Total
	INVOLUNTARY		27	27	27	451	478
	VOLUNTARY		38	38	27	550	577
Affinity Health Plan	**TOTAL**		**65**	**65**	**54**	**1001**	**1055**
	INVOLUNTARY		58	58	32	841	873
	VOLUNTARY		98	98	23	917	940
Amerigroup/Health Plus/CarePlus	**TOTAL**		**156**	**156**	**55**	**1758**	**1813**
	INVOLUNTARY		179	179	91	2355	2446
	VOLUNTARY		247	247	116	3092	3208
Fidelis Care	**TOTAL**		**426**	**426**	**207**	**5447**	**5654**
	INVOLUNTARY		283	283	105	3832	3937
	VOLUNTARY		529	529	126	5691	5817
Health First	**TOTAL**		**812**	**812**	**231**	**9523**	**9754**
	INVOLUNTARY		18	18	5	360	365
	VOLUNTARY		19	19	10	339	349
HIP/NYC	**TOTAL**		**37**	**37**	**15**	**699**	**714**
	INVOLUNTARY		61	61	22	693	715
	VOLUNTARY		39	39	13	451	464
United Healthcare of NY	**TOTAL**		**100**	**100**	**35**	**1144**	**1179**
	INVOLUNTARY		43	43	17	384	401
	VOLUNTARY		19	19	9	165	174
Wellcare of NY	**TOTAL**		**62**	**62**	**26**	**549**	**575**
	INVOLUNTARY		725	725	331	9447	9778
	VOLUNTARY		997	997	341	11318	11659
Disenrolled Plan Transfers	**TOTAL**		**1722**	**1722**	**672**	**20765**	**21437**
	INVOLUNTARY		41	41	31	722	753
	VOLUNTARY		61	61	3	568	571
Disenrolled Unknown Plan Transfers:	**TOTAL**		**102**	**102**	**34**	**1290**	**1324**
	INVOLUNTARY		14068	14068	7612	134289	141901
	UNKNOWN		10	10	147	378	525
	VOLUNTARY		103	103	15	1425	1440
Non-Transfer Disenroll Total:	**TOTAL**		**14181**	**14181**	**7774**	**136092**	**143866**
	INVOLUNTARY		14834	14834	7974	144458	152432
	UNKNOWN		10	10	176	384	560
	VOLUNTARY		1161	1161	359	13311	13670
Total MetroPlus Disenrollment:	**TOTAL**		**16005**	**16005**	**8509**	**158153**	**166662**

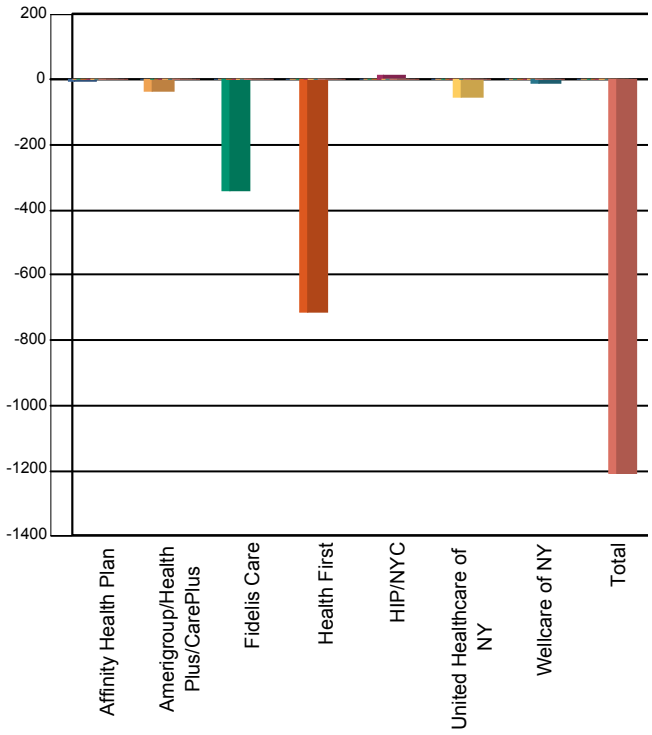
New MetroPlus Members Disenrolled From Other Plans

	FHP	MCAD	Total	Y FHP	Y MCAD	Y Total
Affinity Health Plan		63	63	29	1,070	1,099
Amerigroup/Health Plus/CarePlus		118	118	31	1,473	1,504
Fidelis Care		87	87	38	1,444	1,482
Health First		98	98	32	1,655	1,687
HIP/NYC		52	52	5	589	594
United Healthcare of NY		48	48	7	653	660
Wellcare of NY		48	48	20	704	724
Total		514	514	162	7,588	7,750
Unknown/Other (not in total)		3,008	3,008	287	56,460	56,747

Net Difference

	Enrollment Month			Twelve Months Period		
	FHP	MCAD	Total	FHP	MCAD	Total
Affinity Health Plan		-2	-2	-25	69	44
Amerigroup/Health Plus/CarePlus		-38	-38	-24	-285	-309
Fidelis Care		-339	-339	-169	-4,003	-4,172
Health First		-714	-714	-199	-7,868	-8,067
HIP/NYC		15	15	-10	-110	-120
United Healthcare of NY		-52	-52	-28	-491	-519
Wellcare of NY		-14	-14	-6	155	149
Total		-1,208	-1,208	-510	-13,177	-13,687

Enroll Month Net Transfers (Known)



MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 04/14/2015

Other Plan Name	Category	2014_05		2014_06		2014_07		2014_08		2014_09		2014_10		2014_11		2014_12		2015_01		2015_02		2015	2015	TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	MCAD	MCAD	
AETNA	INVOLUNTARY	0	3	1	1	1	6	0	6	0	9	1	4	0	4	0	7	1	8	0	8	6	10	76
	VOLUNTARY	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	TOTAL	0	3	1	2	1	6	0	6	0	9	1	4	0	4	0	7	1	8	0	8	6	10	77
Affinity Health Plan	INVOLUNTARY	11	90	0	19	5	92	3	20	1	23	3	24	0	37	2	23	2	36	0	29	31	27	478
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	3
	VOLUNTARY	0	1	4	79	0	0	7	52	6	93	6	53	3	62	0	43	1	45	0	34	50	38	577
	TOTAL	11	91	4	98	5	92	10	72	7	116	9	77	3	99	2	66	6	81	0	63	81	65	1,058
Amerigroup/ Health Plus/CarePlus	INVOLUNTARY	12	165	1	43	6	129	0	46	0	55	1	53	5	56	4	56	3	75	0	47	58	58	873
	UNKNOWN	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	VOLUNTARY	0	0	10	148	0	1	5	80	2	114	0	67	1	98	3	93	2	66	0	79	73	98	940
	TOTAL	12	165	11	191	6	131	5	126	2	169	1	120	6	154	7	149	5	141	0	126	131	156	1,814
BC/BS OF MNE	INVOLUNTARY	1	6	1	13	1	10	1	12	0	20	1	8	3	17	3	12	1	23	0	19	70	27	249
	VOLUNTARY	0	0	1	1	0	0	0	0	0	0	0	0	0	1	0	2	0	2	0	1	1	0	9
	TOTAL	1	6	2	14	1	10	1	12	0	20	1	8	3	18	3	14	1	25	0	20	71	27	258
CIGNA	INVOLUNTARY	0	5	0	1	0	1	1	4	0	0	0	0	0	5	0	0	0	2	0	5	7	1	32
	TOTAL	0	5	0	1	0	1	1	4	0	0	0	0	0	5	0	0	0	2	0	5	7	1	32
Fidelis Care	INVOLUNTARY	48	429	1	104	20	394	5	134	3	150	4	160	1	172	2	135	7	225	0	118	155	179	2,446
	UNKNOWN	0	0	1	0	0	0	0	0	0	0	0	0	2	0	1	0	1	0	0	0	1	0	6
	VOLUNTARY	0	0	42	418	0	0	10	314	22	404	16	298	11	334	7	341	8	280	0	199	257	247	3,208
	TOTAL	48	429	44	522	20	394	15	448	25	554	20	458	14	506	10	476	16	505	0	317	413	426	5,660

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 04/14/2015

		2014_05		2014_06		2014_07		2014_08		2014_09		2014_10		2014_11		2014_12		2015_01		2015_02		2015	2015	TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	MCAD	MCAD	
GROUP HEALTH INC.	INVOLUNTARY	1	4	0	3	0	7	0	3	1	5	0	4	0	6	0	5	0	7	0	6	2	8	62
	VOLUNTARY	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	1	2	1	6
	TOTAL	1	4	0	3	0	7	0	3	1	7	0	4	0	6	0	5	0	7	0	7	4	9	68
Health First	INVOLUNTARY	41	695	9	185	26	658	1	179	5	195	6	241	5	272	7	215	4	351	1	279	279	283	3,937
	UNKNOWN	0	0	1	0	0	0	1	0	0	1	2	1	2	1	1	0	0	0	0	0	0	0	10
	VOLUNTARY	0	2	39	749	0	0	25	521	18	733	18	523	12	561	10	649	4	511	0	361	552	529	5,817
	TOTAL	41	697	49	934	26	658	27	700	23	929	26	765	19	834	18	864	8	862	1	640	831	812	9,764
HEALTH INS PLAN OF GREATER NY	INVOLUNTARY	0	1	0	0	0	2	0	3	0	2	0	4	1	7	0	2	0	4	0	2	9	3	40
	VOLUNTARY	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	2
	TOTAL	0	1	0	0	0	2	0	3	0	3	0	5	1	7	0	2	0	4	0	2	9	3	42
HIP/NYC	INVOLUNTARY	4	57	0	21	1	71	0	18	0	19	0	29	0	26	0	24	0	39	0	19	19	18	365
	UNKNOWN	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	VOLUNTARY	0	1	2	59	0	0	1	33	2	37	2	38	1	33	1	28	1	34	0	24	33	19	349
	TOTAL	4	58	2	80	1	71	1	51	3	56	2	67	1	59	1	52	1	73	0	43	52	37	715
OXFORD INSURANCE CO.	INVOLUNTARY	0	3	0	0	1	1	1	2	0	6	0	3	1	5	0	2	0	3	0	3	7	1	39
	VOLUNTARY	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	2
	TOTAL	0	3	0	0	1	1	1	2	0	6	0	3	1	5	0	2	0	4	0	4	7	1	41
UNION LOC. 1199	INVOLUNTARY	4	13	1	4	1	8	0	4	1	1	0	3	2	4	0	3	0	4	0	4	2	6	65
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
	VOLUNTARY	0	0	1	10	0	0	1	14	8	23	5	7	1	9	0	5	0	15	0	3	1	7	110

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 04/14/2015

		2014_05		2014_06		2014_07		2014_08		2014_09		2014_10		2014_11		2014_12		2015_01		2015_02		2015	2015	TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	MCAD	MCAD	
UNION LOC.	**TOTAL**	4	13	2	14	1	8	1	18	9	24	5	10	3	13	0	8	1	19	0	7	3	13	176
United Healthcare of NY	INVOLUNTARY	3	86	1	33	6	70	0	40	1	47	0	62	4	49	2	58	5	80	0	49	58	61	715
	UNKNOWN	0	0	1	0	0	0	1	0	0	0	1	0	1	0	3	0	0	0	0	0	0	0	7
	VOLUNTARY	0	1	7	66	0	0	2	39	1	63	3	38	0	32	0	60	0	44	0	27	42	39	464
	TOTAL	3	87	9	99	6	70	3	79	2	110	4	100	5	81	5	118	5	124	0	76	100	100	1,186
Wellcare of NY	INVOLUNTARY	1	25	2	19	9	42	1	10	0	28	1	36	0	55	2	34	1	42	0	21	29	43	401
	UNKNOWN	0	0	0	0	2	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	4
	VOLUNTARY	0	0	0	12	0	0	0	26	3	21	5	14	1	13	0	14	0	12	0	15	19	19	174
	TOTAL	1	25	2	31	11	42	1	36	3	49	6	50	1	68	3	48	2	54	0	36	48	62	579
Disenrolled Plan Transfers	INVOLUNTARY	126	1,582	17	446	77	1,491	13	481	12	560	17	631	22	715	22	576	24	899	1	609	732	725	9,778
	UNKNOWN	0	0	3	0	2	1	2	0	1	1	3	1	5	1	6	0	6	0	0	0	1	0	33
	VOLUNTARY	0	5	106	1,543	0	1	51	1,079	62	1,491	55	1,039	30	1,143	21	1,235	16	1,010	0	745	1,030	997	11,659
	TOTAL	126	1,587	126	1,989	79	1,493	66	1,560	75	2,052	75	1,671	57	1,859	49	1,811	46	1,909	1	1,354	1,763	1,722	21,470
Disenrolled Unknown Plan Transfers	INVOLUNTARY	4	73	4	54	5	133	1	35	1	60	4	39	6	70	3	45	3	54	0	53	65	41	753
	UNKNOWN	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	2
	VOLUNTARY	0	10	0	51	0	19	1	43	0	52	2	78	0	66	0	46	0	41	0	41	60	61	571
	TOTAL	4	83	4	106	5	152	2	78	1	112	6	117	6	136	4	91	3	95	0	94	125	102	1,326
Non-Transfer Disenroll Total	INVOLUNTARY	950	11,432	860	10,577	850	10,494	799	10,900	778	9,864	1,061	10,869	1,286	10,313	364	8,155	655	13,098	9	10,981	13,538	14,068	141,901
	UNKNOWN	14	12	22	15	29	22	34	45	10	47	1	55	19	41	7	40	11	29	0	37	25	10	525
	VOLUNTARY	0	47	2	83	0	107	1	90	3	78	1	81	4	76	4	127	0	48	0	525	60	103	1,440

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 04/14/2015

		2014_05		2014_06		2014_07		2014_08		2014_09		2014_10		2014_11		2014_12		2015_01		2015_02		2015	2015	TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	MCAD	MCAD	
Non-Transfer	**TOTAL**	964	11,491	884	10,675	879	10,623	834	11,035	791	9,989	1,063	11,005	1,309	10,430	375	8,322	666	13,175	9	11,543	13,623	14,181	143,866
Total MetroPlus Disenrollment	INVOLUNTARY	1,080	13,087	881	11,077	932	12,118	813	11,416	791	10,484	1,082	11,539	1,314	11,098	389	8,776	682	14,051	10	11,643	14,335	14,834	152,432
	UNKNOWN	14	12	25	16	31	23	36	45	11	48	4	56	24	42	14	40	17	29	0	37	26	10	560
	VOLUNTARY	0	62	108	1,677	0	127	53	1,212	65	1,621	58	1,198	34	1,285	25	1,408	16	1,099	0	1,311	1,150	1,161	13,670
	TOTAL	1,094	13,161	1,014	12,770	963	12,268	902	12,673	867	12,153	1,144	12,793	1,372	12,425	428	10,224	715	15,179	10	12,991	15,511	16,005	166,662

MetroPlus Health Plan

New Member Transfer From Other Plans

	2014_05		2014_06		2014_07		2014_08		2014_09		2014_10		2014_11		2014_12		2015	2015	2015	2015	TOTAL
	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	MCAD	MCAD	MCAD	MCAD	
AETNA	0	3	1	4	0	3	0	8	0	6	0	7	1	9	0	8	7	1	1	11	70
Affinity Health Plan	8	113	7	112	1	88	3	95	5	101	2	86	1	87	2	118	63	68	76	63	1,099
Amerigroup/Health Plus/CarePlus	8	141	7	186	5	119	3	115	5	135	3	96	0	93	0	142	92	147	89	118	1,504
BC/BS OF MNE	0	6	0	11	0	7	0	19	0	30	0	25	0	49	0	44	28	18	12	14	263
CIGNA	0	3	0	5	0	6	0	0	0	1	0	4	0	1	0	1	1	0	1	2	25
Fidelis Care	5	163	10	144	9	146	6	115	6	137	2	116	0	97	0	113	113	123	90	87	1,482
GROUP HEALTH INC.	0	10	0	9	0	2	0	5	0	13	0	9	0	4	0	8	8	3	5	5	81
Health First	7	126	8	159	7	146	4	133	2	182	1	128	3	131	0	196	118	134	104	98	1,687
HEALTH INS PLAN OF GREATER N	0	2	0	5	0	3	0	8	0	8	1	3	0	10	0	15	10	2	6	5	78
HIP/NYC	2	64	1	72	2	43	0	36	0	53	0	55	0	50	0	52	36	46	30	52	594
OXFORD INSURANCE CO.	0	3	0	2	0	5	1	2	0	7	0	0	0	4	0	5	2	3	1	2	37
UNION LOC. 1199	4	19	1	21	3	8	2	12	1	18	0	17	2	3	0	6	14	2	0	4	137
United Healthcare of NY	3	56	4	66	0	54	0	43	0	56	0	55	0	63	0	54	44	56	58	48	660
Unknown Plan	161	4,756	72	6,032	14	4,724	9	4,365	5	5,222	14	4,811	4	5,171	8	5,908	6,006	3,517	2,940	3,008	56,747
Wellcare of NY	6	103	6	82	1	52	3	52	2	57	1	48	0	37	1	53	64	62	46	48	724
TOTAL	204	5,568	117	6,910	42	5,406	31	5,008	26	6,026	24	5,460	11	5,809	11	6,723	6,606	4,182	3,459	3,565	65,188

Report ID: MHP1268C
Report Run Date: 4/15/2015

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

April-2015

		Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15
Total Members	Prior Month	466,863	466,843	467,960	471,104	462,671	465,137	470,475
	New Member	19,069	19,937	19,429	26,825	17,892	22,697	16,776
	Voluntary Disenroll	1,496	1,642	1,695	1,982	1,868	1,609	1,452
	Involuntary Disenroll	17,593	17,178	14,590	33,276	13,558	15,750	15,649
	Adjusted	22	33	-249	-2,299	548	1,400	0
	Net Change	-20	1,117	3,144	-8,433	2,466	5,338	-325
	Current Month	466,843	467,960	471,104	462,671	465,137	470,475	470,150
Medicaid	Prior Month	387,274	391,199	396,445	403,686	409,626	411,038	412,829
	New Member	16,760	17,680	17,478	20,787	14,740	17,309	14,414
	Voluntary Disenroll	1,199	1,285	1,409	1,099	1,311	1,150	1,161
	Involuntary Disenroll	11,636	11,149	8,828	13,748	12,017	14,368	14,868
	Adjusted	12	24	-256	-2,293	525	1,308	0
	Net Change	3,925	5,246	7,241	5,940	1,412	1,791	-1,615
	Current Month	391,199	396,445	403,686	409,626	411,038	412,829	411,214
Child Health Plus	Prior Month	11,821	12,044	12,200	12,299	12,160	12,145	12,354
	New Member	825	696	708	846	550	853	631
	Voluntary Disenroll	49	99	99	525	152	251	58
	Involuntary Disenroll	553	441	510	460	413	393	326
	Adjusted	1	1	-1	9	24	67	0
	Net Change	223	156	99	-139	-15	209	247
	Current Month	12,044	12,200	12,299	12,160	12,145	12,354	12,601
Family Health Plus	Prior Month	12,412	9,427	5,894	3,537	79	9	3
	New Member	23	14	12	1	0	0	0
	Voluntary Disenroll	58	34	25	16	0	0	0
	Involuntary Disenroll	2,950	3,513	2,344	3,443	70	6	0
	Adjusted	1	1	2	-3	4	0	0
	Net Change	-2,985	-3,533	-2,357	-3,458	-70	-6	0
	Current Month	9,427	5,894	3,537	79	9	3	3

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

April-2015

		Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15
HHC	Prior Month	3,540	3,448	3,458	3,473	3,626	3,447	3,465
	New Member	67	30	60	197	16	38	5
	Voluntary Disenroll	0	0	0	0	170	0	0
	Involuntary Disenroll	159	20	45	44	25	20	16
	Adjusted	8	8	10	7	8	24	0
	Net Change	-92	10	15	153	-179	18	-11
	Current Month	3,448	3,458	3,473	3,626	3,447	3,465	3,454
SNP	Prior Month	5,095	5,013	4,957	4,936	4,899	4,839	4,799
	New Member	49	61	61	43	59	40	44
	Voluntary Disenroll	36	54	29	29	47	26	30
	Involuntary Disenroll	95	63	53	51	72	54	43
	Adjusted	0	-1	-3	-6	-4	-4	0
	Net Change	-82	-56	-21	-37	-60	-40	-29
	Current Month	5,013	4,957	4,936	4,899	4,839	4,799	4,770
Medicare	Prior Month	8,339	8,387	8,467	8,538	8,562	8,593	8,603
	New Member	306	359	291	443	296	281	317
	Voluntary Disenroll	154	169	133	313	187	181	202
	Involuntary Disenroll	104	110	87	106	78	90	218
	Adjusted	-1	-1	-1	-3	-2	8	0
	Net Change	48	80	71	24	31	10	-103
	Current Month	8,387	8,467	8,538	8,562	8,593	8,603	8,500
Managed Long Term Care	Prior Month	674	724	775	806	806	820	881
	New Member	66	84	55	37	41	82	53
	Voluntary Disenroll	0	1	0	0	0	0	0
	Involuntary Disenroll	16	32	24	37	27	21	80
	Adjusted	1	1	1	-8	-5	-2	0
	Net Change	50	51	31	0	14	61	-27
	Current Month	724	775	806	806	820	881	854

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

April-2015

		Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15
QHP	Prior Month	36,997	35,876	35,028	33,067	22,208	23,599	26,910
	New Member	933	987	719	4,434	2,162	4,067	1,255
	Voluntary Disenroll	0	0	0	0	0	0	0
	Involuntary Disenroll	2,054	1,835	2,680	15,293	771	756	72
	Adjusted	0	0	-1	-3	-3	-3	0
	Net Change	-1,121	-848	-1,961	-10,859	1,391	3,311	1,183
	Current Month	35,876	35,028	33,067	22,208	23,599	26,910	28,093
SHOP	Prior Month	711	725	736	762	701	634	613
	New Member	40	26	45	33	19	20	16
	Voluntary Disenroll	0	0	0	0	1	0	0
	Involuntary Disenroll	26	15	19	94	85	41	26
	Adjusted	0	0	0	1	1	2	0
	Net Change	14	11	26	-61	-67	-21	-10
	Current Month	725	736	762	701	634	613	603
FIDA	Prior Month	0	0	0	0	4	13	18
	New Member	0	0	0	4	9	7	41
	Voluntary Disenroll	0	0	0	0	0	1	1
	Involuntary Disenroll	0	0	0	0	0	1	0
	Adjusted	0	0	0	0	0	0	0
	Net Change	0	0	0	4	9	5	40
	Current Month	0	0	0	4	13	18	58

Epic EMR Implementation Update

Medical and Professional Affairs/IT Committee

Salvatore Guido, Interim Corporate Chief Information Officer

May 14, 2015

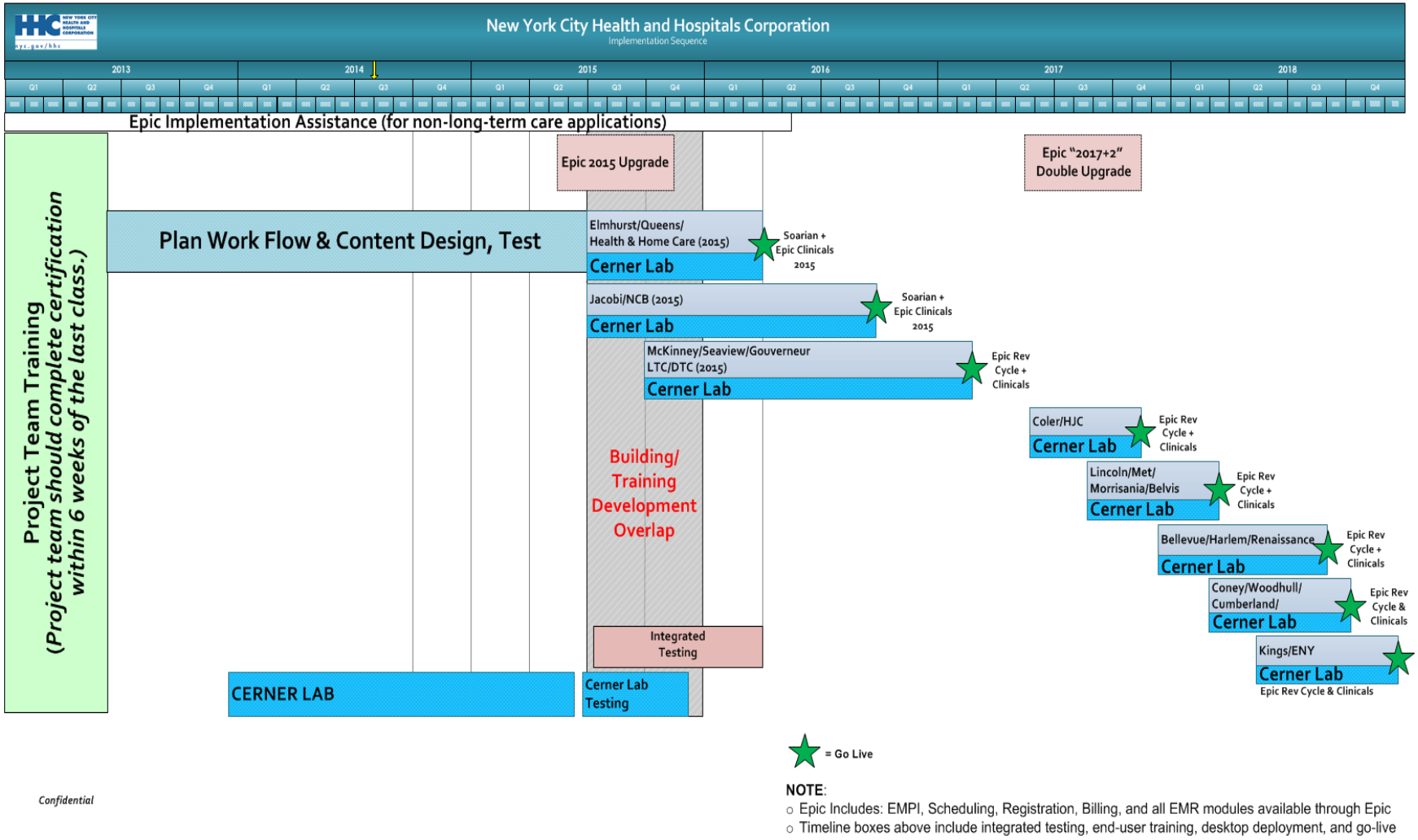
April/May 2015 Milestone Update

Content Build

Tracking according to plan
Potentially at risk
At risk

Major Milestones	Due Date	Status	Comments / Concerns
WORKFLOW SIGN OFF			
Clinical	5/30/15		
Revenue Cycle (Soarian)	4/30/2015		▪ ADT bidirectional interface decisions
APPLICATION BUILD			
Clinical Application Modules	7/14/15		▪ Clinical content is at 87% build complete
Revenue Cycle Application Modules	7/14/15		▪ Cadence scope needs to be determined ▪ Need to work with Finance for CDM build ▪ HH Billing
Cerner Lab Build	7/14/15		▪ Started weekly meeting between HHC, Cerner and NSLIJ
Interface Build	7/14/15		▪ ECM delayed due to procurement.
TESTING			
Application Testing	9/1/15		▪ Will begin 8/1/15
Integrated Testing	1/1/16		▪ Will begin 9/1/15
TRAINING			
Clinical	6/1/15		
Revenue Cycle	6/1/15		▪ Depending on scope for Cadence, may need to ramp up training
Curriculum Development	6/1/15		▪ Cross walk to 2015 upgrade starts in June
User Training	3/13/15		▪ Two weeks of personalization to proceed after the end of training

Revised Time Line (as of May 2015)



Confidential

NOTE:
- Epic Includes: EMPI, Scheduling, Registration, Billing, and all EMR modules available through Epic
- Timeline boxes above include integrated testing, end-user training, desktop deployment, and go-live

Initial 5 year cost projection for Revenue Cycle was an additional $100 million. Budget is under review. Further evaluation required.

Program Risks

Reason / Risks	Product	Cause	Remediation
Scoping / High	**Enterprise Master Patient Index (EMPI)**	Potential delays in decisions on Gold Standard, Merge Strategy and Plans, Data Quality Sampling Plans and Content Move Plans	• Formation and implementation of the Data Governance Steering Committee to ensure timely decisions • EITS has facilitated the creation of a Patient Record Governance Committee chaired by HIM, Finance and Clinical groups within HHC • The Patient Record Governance Committee has recently published a draft of HHC's Gold Standard for record matching and duplicate remediation
Scoping / High	**Soarian Integration**	Potential delays due to establishing scope on the minimum set of workflows for successful integration with Epic required for go-live Bi-directional integration between Soarian and Epic. Must have direct contact with Soarian technical resources to determine resource allocations	• Established focused technical sessions on weekly basis to track the development of the workflows, and identifying and managing all blockers and dependencies • The Soarian Team continues to cleanup the EMPI from a demographics point of view ongoing with the Soarian rollout • EITS is getting a copy of these de-duplicated files and loading them to correlate to the clinical records
Scoping / High	**Lab**	Potential delays in implementation of the plans due to conflicts in expectations around policies and reporting requirements relating to clinical and financial workflow needs	• Formal meetings as well as establishment of scope of work to govern and guide the development of workflows • Facility structure is being aligned between Epic and Cerner • ADT, Orders and Result Interface testing has began and has identified no issues

6 Year Epic Implementation

Budget vs. Expenditures (Paid or In Process)

			Total Implementation Dollars (In Millions)		
	Item	Description	Total Budget	Expenditures (Paid or in Process) as of 2/27/15	Balance
1	**Epic Contract**	Includes Software and Implementation and Training Services	$ 144	$ 56	$ 88
2	**Third Party & Other Software**	Includes Endoscopy, Fetal Monitoring Systems, ePrescribing, Patient Education	$ 30	$ 2	$ 28
3	**Hardware**	Includes Servers, Storage, Server Licensing, Network Switches	$ 84	$ 23	$ 61
4	**Interfaces**	Includes Interface Software/Biomed Middleware	$ 39	$ 3	$ 36
5	**Implementation Support**	Third party vendor staff augmentation, go-live support and training. (Includes costs associated with backfilling non IT staff and temps.)	$ 355	$ 28	$ 327
6	**Application Support Team**	New HHC FTE staff to be used through the implementation period including fringe benefits. These costs will become on-going after implementation period	$ 113	$ 23	$ 90
7	**Clinicals Total** *(Without Quadramed Transition / Existing Application/ Existing Staff Costs)*	**Clinicals Only Total**	**$ 764**	**$ 134**	**$ 630**

Note: Initial 5 year cost projection for Revenue Cycle was an additional $100 million. Budget is under review. Further evaluation required.

Budget Allocation By Project Phase

EMR Clinicals Six Year Budget

Project Phase	Project Time Period		Budget Allocation by Project Phase		Spend as of 2/27/2015 % of Total $764M Budget	
	Start	End	$ (Millions)	%	$ (Millions)	%
Build	1/1/2013	7/14/2015	$209	27%	$134	18%
Testing	8/1/2015	3/1/2016	$95	12%	$0	0%
Training	10/1/2015	12/31/2018	$46	6%	$0	0%
Deployment	4/1/2016	12/31/2018	$415	54%	$0	0%
Total			**$764**	**100%**	**$134**	**18%**

Note: Initial 5 year cost projection for Revenue Cycle was an additional $100 million. Budget is under review. Further evaluation required.

Projected 15 Year Total Cost of Ownership

			Total Dollars (In Millions)		
	Item	Description	Total Amount	Cash Burned & Pending Expenditures as of 2/27/15	Balance
1	Epic Contract	*This represents the contract Not To Exceed Amount.* Includes Software and Implementation and Training Services	$ 303	$ 56	$ 247
2	Third Party & Other Software	Includes Endoscopy, Fetal Monitoring Systems, ePrescribing, Patient Education	$ 65	$ 2	$ 64
3	Hardware	Includes Servers, Storage, Server Licensing, Network Switches	$ 141	$ 23	$ 118
4	Interfaces	Includes Interface Software/Biomed Middleware	$ 70	$ 3	$ 67
5	Implementation Support	Third party vendor staff augmentation, go-live support and training. (Includes costs associated with backfilling non IT staff and temps.)	$ 417	$ 28	$ 389
6	Application Support Team	New HHC FTE staff to be used through the implementation period including fringe benefits. These costs will become on-going after implementation period	$ 325	$ 23	$ 302
7	Clinicals (Without Qmed Costs)	**Clinicals Only Total**	**$ 1,322**	**$ 134**	**$ 1,188**
8	***Existing Staff*** *(in existing HHC budgets)*	Existing HHC Staff who work on Epic at least partially.	$ 28	$ 5	$ 23
9	***Quadramed Transition Costs & Existing Application Costs*** *(in existing HHC budgets)*	Quadramed Transition Costs - Current EMR system must be maintained until new Epic EMR is implemented and existing Applications Transition (e.g. current system that must be maintained until replacements system are put in place such Fetal Monitoring and Endoscopy) - Includes expenses from IT cost centers only.	$ 116	$ 36	$ 80
	Clinicals with Transition Costs	**Clinicals Only Total With Existing Quadramed Costs Included and Existing Staff**	**$ 1,465**	**$ 174**	**$ 1,291**

Note: Initial 5 year cost projection for Revenue Cycle was an additional $100 million. Budget is under review. Further evaluation required.

HHC / Epic Workshop

Agenda

Location: NYC Health and Hospitals Corporation, 125 Worth Street

- Friday, May 15th, 1 PM – 5 PM: HHC presentation of project plan and approach
- Friday, May 15th, 7 PM – 9 PM: Group dinner (details TBD)
- Saturday, May 16th 9 AM – 12 PM: Facilitate brainstorming amongst all participants and presentation of recommendations to HHC

EPIC Day at HHC Facilities

Medical & Professional Affairs/IT Committee
Terri Couts

May 14th, 2015

Overview

Goal:

EPIC Days consist of end-user engagement, workflow demo and content sign off. The objective is to engage end users at each HHC facility and generate excitement for the new EMR system. The activities are tentatively planned for the end of June

Set-Up:

- Sessions will take place at the acute care hospital of each network to accommodate and minimize the disruption of end-user schedules.
- Will occur over multiple days to try to hit everyone's schedules
- Integrated demo will be scheduled for every 2 hours
- Representatives from each application team will be stationed outside of the sessions to document comments from the attendees about the demonstrated workflows. Representatives will answer high-level questions, show application functionalities and to review content
- Comments will be categorized: *Patient Safety*, *Regulatory Requirements*, *Workflow-Critical*, *Future State*, *Nice-To-Have* and triaged accordingly

Sample Scenario

Emergency Department

- Victim of a construction site accident arrives at ED by ambulance
- Patient is triaged and assessed, trauma team is activated
- Patient receives blood transfusion and is intubated, then transferred to ICU

Medical ICU

- Patient receives interdisciplinary care in ICU
- Patient has a history of bipolar disorder and exhibits violence and paranoia
- Patient becomes medically stable and is transferred to IP psych

IP Behavioral Health

- Patient engages in therapeutic activities; medications administered and education provided on managing condition
- Patient is discharged home with follow up plans

OP Behavioral Health

- Patient follows up at an outpatient behavioral health clinic

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

EMR IMPLEMENTATION

Next Steps

- Secure space at each facility
- Work with Communications (Enterprise, EITS and Network/Facility) to promote EPIC Day
  - Examples: HHC Insider, Posters at Facilities, Facility Newsletters
- Proactively reach out to the different councils
  - Get on the agenda
  - Communication
  - Demo
- Investigating additional options for engagement. Possible examples include:
  - Continued Epic Days
  - Workflow walk thru
  - Dress Rehearsals

UPDATE HHC LAB PROJECT WITH NORTH SHORE

Vision

- Shared Consolidated Core Laboratory
  - Standardized Equipment across all Laboratories
  - Standardized Information System
  - Standardized Policies and Procedures
  - Standardized Quality Program
  - Seamless Integration
- Increased Quality and Depth of Service
- Reduce Cost
  - HHC - $23.1 million benefit annually by 2018
  - NSLIJ - $15 million benefit annually by 2018

Project History

Milestones

Joint Vertical Value Stream Mapping

HHC Board Approval

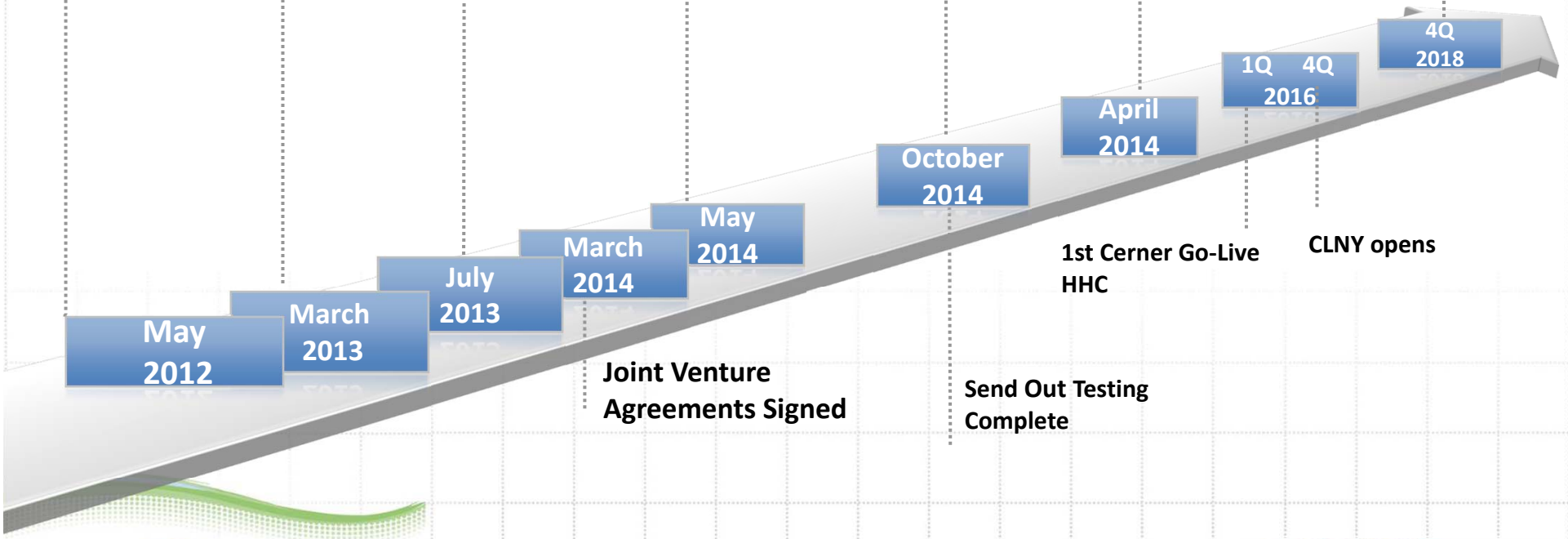
NSLIJ Board Approval

Cerner Agreement Signed

CLNY Board Meeting
- Finance Committee
- Executive Committee

First Meeting of Executive Committee

VISION
State of the art Infectious Disease Diagnostics Laboratory in Little Neck, Queens.



Joint Venture Agreements Signed

Send Out Testing Complete

1st Cerner Go-Live HHC

CLNY opens

CLNY Committees

Structure

Meet Semi-Annually

Board of Directors
Chairman – Mark Solazzo
Vice Chairman – Antonio Martin
President/CEO – Robert Stallone
Treasurer – Marlene Zurack
Asst. Treasure – John McGovern
Secretary – Larry Kraemer
Asst. Secretary – Salvatore Russo
CMO – James Crawford, MD, PhD

Executive Committee
Quarterly

Joint Standard Leadership
Monthly

Finance Committee
Monthly

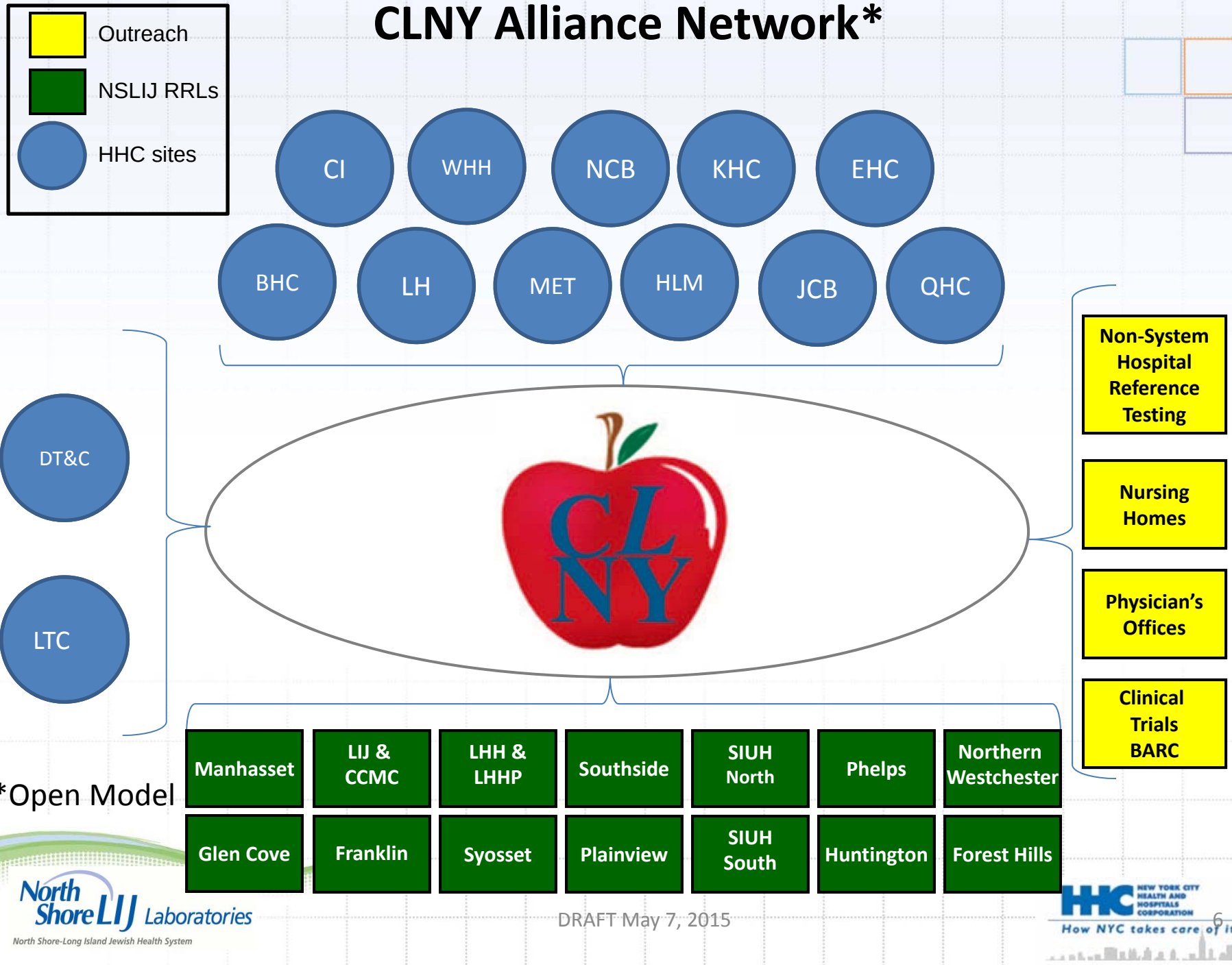
General Laboratory
\
Monthly

Molecular/Microbiology
Monthly

Committee Highlights

Progress
• Developed reference testing quality monitoring process • Jointly developed standardized equipment selection process and procurement Value Analysis activities • Building leases signed and architects hired and engaged. HHC team will be part of design phase. • HR planning for relocation of Micro staff in process • Lab licensure and Tax Statue Form 1023 in process

CLNY Alliance Network*



*Open Model

Reference Testing

Hub	Site	Status
1	Harlem/Renaissance	Live – 3/8/14
2	Jacobi/North Central Bronx	Live – 5/10/14
3	Queens/Elmhurst	Live – 6/28/14
4	Coney Island	Live – 7/19/14
5	Metropolitan/Lincoln/Belvis/Morissania	Live – 8/23/14
6	Woodhull/Cumberland	Live – 9/6/14
7	Bellevue/Coler/Henry J. Carter/Gouverneur	Live – 10/18/14
8	Kings County/East NY/McKinney	Live – 11/1/14

Building/Real Estate

- 2 Building Approach
  - Lake Success: Clinical Laboratory (90K sf)
  - Little Neck, Queens: Infectious Disease Testing Laboratory (65K sq + 65K sq parking garage)
- HHC Microbiology staff will work together with NSLIJ staff at the Little Neck location
- Architects (FLAD) have been engaged and are completing programming phase
- NSLIJ and HHC will jointly design the new facilities

Future: Infectious Disease Testing Laboratory

Thank you!