AGENDA

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE

Meeting Date: May 24, 2012
Time: 2:00 PM
Location: 125 Worth Street, Room 532

BOARD OF DIRECTORS

CALL TO ORDER — **DR. STOCKER**

ADOPTION OF MINUTES
-April 19, 2012: Medical & Professional Affairs/Information Technology Committee

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

METROPLUS HEALTH PLAN — **DR. DUNN**

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

ACTION ITEMS:

1. Authorizing the President of the New York City Health and Hospitals Corporation (the Corporation") to negotiate and execute an amendment to the Affiliation Agreement with New York University School of Medicine ("NYUSOM") for the provision of Health Services at Woodhull Medical and Mental Health Center and Cumberland Diagnostic and Treatment Center which terminates on June 30, 2014, to include the provision of General Care Health Services at Coler-Goldwater Specialty Hospital and Nursing Facility ("Coler-Goldwater"), consistent with the general terms and conditions and for the amounts indicated in Attachment A; AND
Further authorizing the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the amounts set forth in Attachment A. — **MS. CURTIS/ MR. HUGHES**

2. Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate and execute a contract with Microsoft Health Solutions Group to provide a care plan information system for HHC facilities throughout the five boroughs of New York City. The contract shall be for a period of five years with two, consecutive, one-year options to renew exercisable solely by the Corporation, in an amount not to exceed $16.1 million for a five year term with two, consecutive, one-year options to renew, for a total term of seven years;
AND
Further authorizing the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy. — **DR. WILSON/ MR. ROBLES**

INFORMATIONAL ITEMS:

1. Readmissions — **DR. WILSON**
2. ED Whiteboard — **DR. WILSON**

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: April 19, 2012

ATTENDEES

COMMITTEE MEMBERS:

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

OTHER BOARD MEMBERS:

Vincent Calamia, MD

HHC CENTRAL OFFICE STAFF:

Deborah Cates, Chief of Staff, Board Affairs
Louis Capponi, MD, Chief Medical Informatics Officer
Paul Contino, Chief Technology Officer
Diane Conyers, Corporate Risk Manager
Marisa Salamone-Greason, Assistant Vice President, Corporation Information Technology Services
Evelyn Hernandez, Director, Media Relations
Erin Hughes, Director, Media Relations
Caroline Jacobs, Senior Vice President, Safety & Human Development
Lauren Johnston, Senior Assistant Vice President/Chief Nursing Officer, Patient Centered Care
Irene Kaufmann, Senior Assistant Vice President, Community Physician Services
Mei Kong, Assistant Vice President, Patient Safety
Robert Kurtz, MD, Senior Clinical Advisor to Chief Medical Officer
Patricia Lockhart, Secretary to the Corporation
Irina Manarova, Assistant Director, Corporate Planning
Susan Meehan, Assistant Vice President, Medical & Professional Affairs
John Morley, MD, Deputy Chief Medical Officer
Joseph Quinones, Senior Assistant Vice President, Operations
Enrick Ramlakhan, Assistant Vice President, Business Applications
Bert Robles, Senior Vice President, Information Technology/Corporate Chief Information Officer
Salvatore Russo, General Counsel, Legal Affairs
David Stevens, MD, Senior Director, Health Care Improvement
Joyce Wale, Senior Assistant Vice President, Behavioral Health
Katie Walker, Assistant Vice President, Institute for Medical Simulation & Advanced Learning
Manasses Williams, Assistant Vice President, Affirmative Action/EEO
Ross Wilson, MD, Senior Vice President/Corporate Chief Medical Officer, Medical & Professional Affairs

FACILITY STAFF:

Machelle Allen, Interim Medical Director, Bellevue Hospital Center
Chris Constantino, MD, Executive Director, Elmhurst Hospital Center
Lynda D. Curtis, Senior Vice President, South Manhattan Network
Iris Jimenez-Hernandez, Senior Vice President, Generations +/Northern Manhattan Network
George Proctor, Senior Vice President, Central & Northern Brooklyn Network
Arnold Saperstein, Executive Director, MetroPlus Health Plan, Inc.
Denise Soares, Executive Director, Harlem Hospital Center
Arthur Wagner, Senior Vice President, Southern Brooklyn/SI Network
William Walsh, Senior Vice President, North Bronx Healthcare Network
Meryl Weinberg, Executive Director, Metropolitan Hospital Center
Roslyn Weinstein, Acting Executive Director, Kings County Hospital Center
Julius Wool, Executive Director, Queens Hospital Center

OTHERS PRESENT:

Melissa Dubowski, Analyst, Office of Management and Budget
Scott Hill, Account Executive, QuadraMed Corp.
Richard McIntyre, Key Account Executive, Siemens
Tamara Robinson, Contract Administrator, CIR/SEIU

**MEDICAL AND PROFESSIONAL AFFAIRS/
INFORMATION TECHNOLOGY COMMITTEE
Thursday, April 19, 2012**

Michael A. Stocker, MD, Chairman of the Board, called the meeting to order at 2:34 P.M. The minutes of the March 22, 2012 Medical & Professional Affairs/IT Committee meeting were adopted.

CHIEF MEDICAL OFFICER REPORT:

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

1. Implementation of Behavioral Health Organization (BHO) and Facility Communication

New York State (NYS) began the mandatory reporting of Inpatient Psychiatry and Detox admissions, treatment updates and discharge plans as part of the readiness activities for mandatory managed care for patients with serious and persistent mental illness. As a communication tool among facilities to highlight new information from the NYS and BHO as well as to share best practices, the Office of Behavioral Health this month launched a BHO Share Point site for HHC facilities with access to utilization management, Departments of Psychiatry and others as requested. A Share Point site provides the ability much like a blog to post information and sharing of questions, answers and comments. This new tool available at HHC will change its ability to share information and better foster a learning environment for its facilities. Two training sessions were held by Corporate IT and the Office of Behavioral Health and they will continue to promote the use of this new tool and strive for improving the care for HHC's patients.

2. Corser Symposium on Bioethics

The annual Corser Symposium on Bioethics will be held on May 9th at Harlem Hospital Center with a broad program. A key note speaker will be Dr. Bruce Vladeck, a previous Administrator for the Centers for Medicare & Medicaid Services (CMS). One section of the program will deal with the new HHC policy on the determination of brain death, to align with the recent change in NYS policy from two assessments to one assessment to determine brain death.

3. Designation of Health Home

HHC & MetroPlus Health Plan, Inc were designated by the New York State Department of Health (NYS DOH) as a Health Home in Queens, in addition to the existing designations we have for Brooklyn and the Bronx. We are awaiting their decision for Manhattan, and further discussion of the per member, per month rates for health home services.

4. HHC Joins the New York City Health Department's New Initiative On Exclusive Breast Feeding

HHC has joined the New York City's health department in this important voluntary initiative to improve the health of babies born at HHC by increasing their likelihood to be breast fed. This continues previous efforts in this area, working towards the spread of "baby friendly hospital" status across the City.

5. Support from the Committee for Interns and Residents

HHC acknowledges further generous support from the Trustees for Committee of Interns and Residents (CIR) to purchase of medical equipment and educational tools that will improve the quality and safety of care. The list of equipment being provided was finalized after input from all of our facilities.

METROPLUS HEALTH PLAN, INC.

Dr. Arnold Saperstein, Executive Director, MetroPlus Health Plan, Inc. presented to the Committee. Dr. Saperstein informed the Committee that the total plan enrollment as of March 27, 2012 was 426,364. Breakdown of plan enrollment by line of business is as follows:

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

Dr. Saperstein provided the Committee with reports of members disenrolled from MetroPlus due to transfer to other health plans, as well as a report of new members transferred to MetroPlus from other plans. In addition, Dr. Saperstein provided a graph showing net transfers for the month of March 2012 for Medicaid and Family Health Plus (FHP).

At each meeting Dr. Saperstein reports on the number of members that transfer in and out of MetroPlus every month. An analysis of the 5,870 members that transferred from MetroPlus to Health First in 2011 revealed that only 21.8% of these continued to receive their care at HHC. The balance transferred not only to Health First, but to a physician not affiliated with HHC or MetroPlus. Mr. Aviles inquired as to what is the number of these that are auto-enrolled. Dr. Saperstein will further drill down into the data and report back to the next meeting.

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

In the recent New York State Budget negotiations several groups were pushing for the introduction of "Prescriber Prevails" language related to the Medicaid managed care prescription benefit. The prescriber prevails coverage was previously included in the fee-for-service Medicaid pharmacy benefit. Prescriber prevails allows the prescribing provider to determine what drug/medication their patient would receive, regardless of any authorization or formulary requirements required by the patient's managed care plan. Member advocates and certain groups funded by the pharmaceutical industry argued that providers should

have final say in what medications members receive. The coalition of health plans argued that implementing prescriber prevails undercuts the appropriate review and screening of prescription and drug use. The Health Plan Association had reviewed claims data, and found that many of the denials made by plans are for issues related to inappropriate and potentially harmful prescribing. The MetroPlus Prior Approval process, Step Therapy, and Quantity Limits are in place to ensure that medications are being prescribed and dispensed in a safe, appropriate manner. The State also already considers certain drug classes "protected" and not subject to plan formulary or prior authorization requirements. As of the writing of this report, there was an agreement at the State level to include prescriber prevails language for antipsychotics.

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

INFORMATION ITEMS:

1. Supply Chain Management Technology Transformation

Presenting to the Committee was Enrick Ramlakhan, Assistant Vice President, Business Applications and Joseph Quinones, Senior Assistant Vice President, Contract Administration & Control.

In the past, HHC 's supply chain management contracting and practices were decentralized at the local facility level. There were operational inefficiencies whereby the 'item master' per facility for regularly purchased items varied from facility to facility on a daily basis versus having an electronic database of commonly purchased items across the Corporation. There was also a lack of transparency on line item purchasing across the Corporation electronically – reports per vendor and cost were available, but not for the purchases made on a line item basis. Accountability is important in purchasing to ensure we are making the best decisions at the best prices when purchasing, how we purchase and are we saving money. Therefore, it was in the best interest of the Corporation to obtain a system in which one could obtain a Corporate-wide perspective on HHC's purchasing habits in a supply chain management perspective.

The first step to implementing ***psBlue*** was to begin managing the Corporation's supply chain as one supply chain versus 21 different ones. An HHC Supply Chain Council (representation from each Network) was established using Breakthrough to improve the medical supply purchasing process by deciding what functionality was needed in HHC's procurement and requisitioning system. The system selected by the Council was GHX, now branded as ***psBlue***, which contains a suite of applications resulting in improvement in the following areas: transparency of expenditures on a line item basis; allowed us to do better contracting and standardization thus yielding savings; user compliance – one of the things we felt we absolutely had to have was 'friendliness of use' – users of the system had to be able to use it in an 'easy to use tool' similar to Amazon.com experience; sustained performance means we continually get data from the system to make decisions that we should be held accountability for which saves the organization money while providing the best patient safety related products; due to the fact that manual systems were no longer being used with the ***psBlue*** system we saw productivity gains by eliminating the back office functions and labor of faxing and phone ordering; and multi-disciplinary collaboration of purchasers, physicians, nurses and end product users which enabled us to standardize items/equipment/supplies that needed to be ordered which will be highlighted later on in the presentation.

Mr. Quinones then provided the Committee with a slide that demonstrated the cost savings garnered prior to our targeted aggregation of savings for FY 2013 which has not begun. To date, $9 million in annualized savings has been garnered in Fiscal Year 2012 versus target of $14 million in Fiscal Year 2013 as a result of

the data obtained when we began using one standardized system and committee's reviewing prior purchasing practices. The slide demonstrates that by standardizing IV pumps, supplies and services we saved $1,471,603 and for NY blood and services we saved $3,422,631, just to name a few.

Dr. Amanda Parsons states that as early stage savings are coming from a Corporate-wide organization versus 21 different organizations she wondered as we get further along and prior rationalization becomes more inevitable who is responsible for balancing our responsibility for achieving the most savings versus not shutting out smaller suppliers such as minority women suppliers. Mr. Quinones responded that for the most part savings are being obtained from the med-surg product lines which are obtained from very large companies. Mr. Aviles added that there are times they might be a conflict in meeting goals for minority vendors in access to the procurement process with our desire to leverage our buyer efforts in order to award contracts to obtain the lowest cost possible. Dr. Vincent Calamia inquired as to whether there have been issues with standardization raised by staff. Mr. Ramlakhan explained to the Committee that the HHC Supply Chain Council is comprised of clinical representation and when faced with evaluating the clinical products they use a value analysis such as value to the patient, the organization and for the providers and clinicians as well – input and buy-in before implementation of various product standardization eliminated most issues upfront.

Mr. Quinones stated that while we need to talk about and address our challenges we must also note our successes. Our inventory started out at over $10.5 million across the Corporation which is now down to less than $5 million due to the controls put in place, the tracking of what is being ordered and standardizing best practices of what products should be ordered across the Corporation.

The staff productivity gains since implementation of ***psBlue*** is that the standard work was changed due to: development of a contract repository and item master for standardized ordering of products; reduced processing errors for requisitions, purchase orders (POs) and vendor invoicing; and ordering process no longer relies on faxes and phone calls. In addition, we are reducing current staffing from 85 to 57 by June 20, 2012 through attrition and realignment by implementing this automated system.

Using the GHX system affords us validation and tracking of product purchases across the Corporation, yielding transparency which allows for monitoring of implementation of the system. GHX is used by over 3,500 hospitals across the United States. When they average out the amount of orders that are aligned to contracts Nationwide the average is 40% - however, HHC is at 70% of orders on contract which is a great achievement and HHC sets the benchmark for the National GHX customer base. Prior to implementation of the ***psBlue*** system that was a large number of special purchase requests (requests outside of the system or 'item master'), however, after seven months of full implementation HHC has thus far achieved 50% of HHC item master purchases via approved catalogue. As of February 2012, HHC is currently purchasing a total of $41 M monthly transactions through the psBlue system.

The multi-disciplinary Supply Chain Council meets every two weeks and its approach impacts: standardization through the newly revised Operating Procedure 100-5; standardization of products; clinical effectiveness of new or standardized products; improved reporting; and training of staff. Town hall type meetings were held to be transparent of changes, obtain buy-in and share issues of current purchasing processes.

A user acceptance and satisfaction survey was conducted in November 2011 of requistioners throughout the Corporation. Eighty-nine percent of the 73 requistioners surveyed responded that the ***psBlue*** was a valuable tool and 74% responded that ***psBlue*** helps to make their job easier. It should be noted that antidotically these results were confirmed through the Town Hall meetings that were held.

In order to sustain the ***psBlue*** transformation we need to: continue the challenge of aligning the Legacy system with ***psBlue***; engage staff to use the tool through training; leverage Greater New York Hospital Association (GNYHA) resources/expertise; and continued leveraging of group purchasing contracts. We need to continuously communicate to staff on this new initiative and obtain employee feedback as to what is working and what is not to further enhance the system. Compliance with using the system is key for us to maintain objectives and successes of cost reduction which is achieved through lower number of vendors one has to select from and accurate data collection and reporting so that reports are actionable for the Supply Chain to make decisions.

2. Meaningful Use Update

Presenting to the Committee was Louis Capponi, MD, Chief Medical Informatics Officer. To set the stage, Dr. Capponi noted that meaningful use is part of the stimulus package to roll out electronic medical records in a meaningful way throughout the Country. The purpose of which is to: improve quality, safety, efficiency, and reduce health disparities; engage patients and families; improve care coordination; protect privacy and security of personal health information; and improve population and public health.

In the steps for meaningful use we must use a certified employee health record, and use it in a meaningful way by achieving fifteen (15) core objectives as outlined on the attached slide (Attachment A) [14 for hospitals] as well as five (5) menu objectives out of the ten (10) menu objectives (Attachment B highlights the 5 objectives that HHC selected).

Since the last report Dr. Capponi noted that HHC has come a long way down this path to achieve meaningful use which across the Corporation is worth $120,000 million in incentives on the hospital side. Dr. Capponi moved on to highlight the project status report and demonstrated progress to date compared to the last three updates to this Committee as follows: tasks completed to date have been the Cache update, 5.1 & 5.2 upgrades, and registration. As of yesterday, all tests for exchange of key clinical information to an outside of HHC provider or entity was completed, along with the security assessment. The attestation period will be completed in the next couple of weeks with mitigation plans ongoing. Dr. Capponi noted that this information only pertains to the inpatient side at this point.

As a reminder HHC will be in stage 2 of meaningful use implementation this year, for 90 days, in Federal Fiscal Year (FFY) 2012 and starting on October 1, 2012 which is the next cycle of FFY we will have to maintain the achievements for all thresholds for the entire year. The monitoring and gains really are just beginning, we have to continue to achieve on all the core objectives/measures and ensure they are met throughout the new FFY.

Dr. Capponi noted that since HHC has been successful in electronic CCDs documents will mean that the doctors who are in MetroPlus and the community will have an easier way to refer patients into HHC and HHC will have an easier way to transmit information back and forth seamlessly.

On February 23, 2012, Centers for Medicare and Medicaid Services (CMS) released the Notice of Proposed Rulemaking (NPRM) for meeting meaningful use in Stage 2 which includes new measures. In 2014, meaningful use will require electronic reporting of new (2014) quality requirements and to avoid penalties in 2015, you must be a meaningful user in 2013 and must have attested by July 1, 2014 (hospitals) or October 1, 2014 (physicians). The thresholds for Stage 2 of meaningful use are much more aggressive and thresholds will be increased, for example, demographics must be recorded for 80% of patients versus 50% in stage 1. Almost all Stage 1 menu requirements will be core which include items that were often deferred by organizations during Stage 1 such as: summary of care at transitions (92% deferred); syndromic surveillance

(82% *deferred*) ; reportable lab results for public health (77% *deferred*); medication reconciliation (74% *deferred*); and provide educational resources (62% *deferred*).

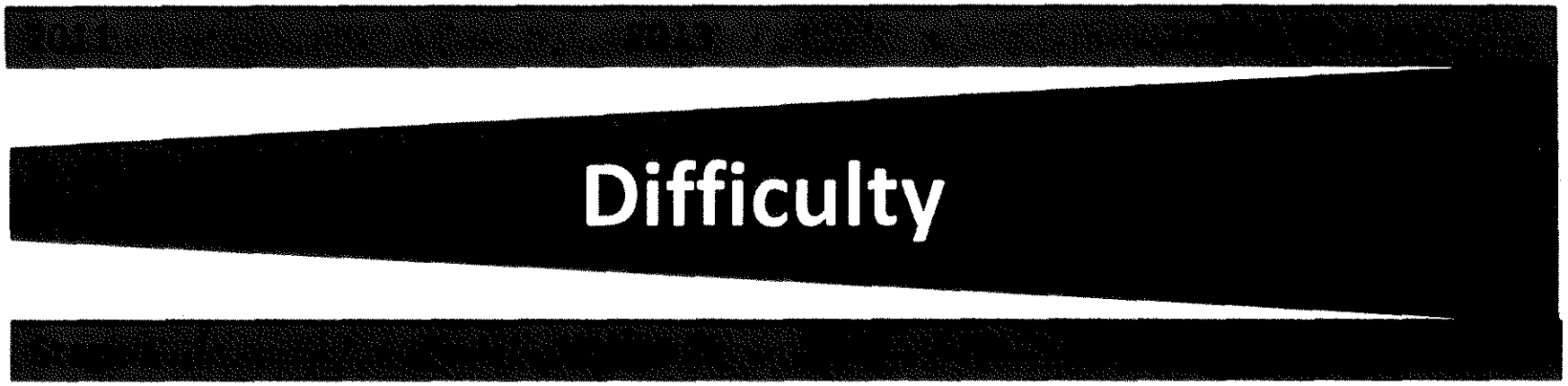
Due to time constraints the remaining slides in the presentation will be presented again at a future meeting and the entire presentation is attached hereto.

There being no further business the meeting adjourned at 3:56 P.M.

ATTACHMENT A: Stage 1

15 Core Objectives/Criteria:

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



ATTACHMENT B: 10 Menu Objectives/Criteria: must select 5

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

HHC
Meaningful Use Update

Medical & Professional Affairs / IT Committee

Board of Directors

April, 2012

Purpose of Meaningful Use

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

Key Applications Needed to Meet Stage 1 Meaningful Use Requirements

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

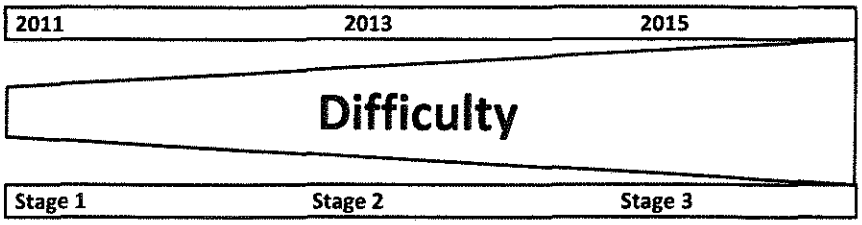
Meaningful Use...

1. Use a Certified EHR – QuadraMed version 5.2
2. Use it in a meaningful way:
   - ❑ **15 Core objectives-criteria** (**14** for Hospitals)
   - ❑ **5 Menu objectives-criteria** are required for hospitals (out of a total of **10** objectives)
3. Quality Measures or criterion need to show a percentage of patients
4. ED processes (POS 23) are included along with inpatient processes (POS 21)

Stage 1

15 Core Objectives/Criteria:

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

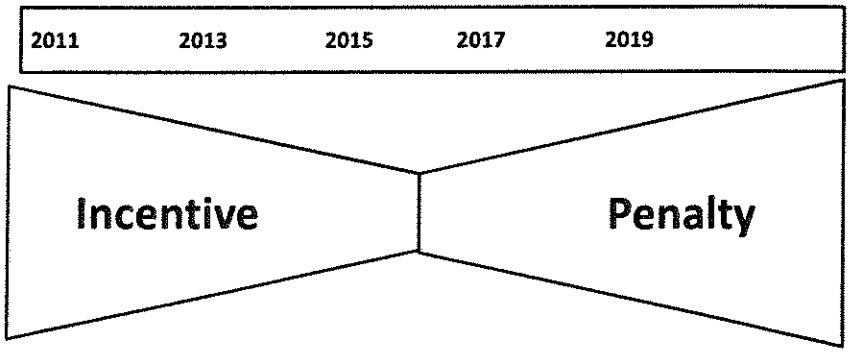


10 Menu Objectives/Criteria: must select 5

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

Financial Incentives

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



Project Status

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

Timeframe Payment Year

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

MU Stage 2 Overview

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

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

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

MU Stage 2 Overview

- Medication reconciliation for 65% of patients (was 50%)
- Summary-of-care record at 65% of transitions in care (was 50%). 10% must be electronic transfer; many required data elements
- 55% of lab results recorded as structured data (was 40%)
- Identify and provide educational materials to 10% of all patients using the EHR. (Note: materials can be stored elsewhere)
- Implement drug-drug and drug-allergy checking *and implement 5 decision* interventions related to quality measures (combined recommendations, increased from 1 rule to 5)
- Generate list of patients for quality improvement (from menu to core)
- Submit immunization data (from menu to core)

MetroPlus Health Plan, Inc.
Report to the
HHC Medical and Professional Affairs Committee
May 14, 2012

Total plan enrollment as of April 24, 2012 was 427,245. Breakdown of plan enrollment by line of business is as follows:

Medicaid	359,414
Child Health Plus	17,131
Family Health Plus	36,295
MetroPlus Gold	3,084
Partnership in Care (HIV/SNP)	5,733
Medicare	5,588

For the first time in many months, we had a decline in enrollment. From March to April we dropped 675 members overall, 230 in Medicaid, 391 in Child Health Plus and 117 in Medicare. The reduction in Medicaid was due to a lower rate of applications, while the reduction in Child Health Plus was due to loss of eligibility. For Medicare, we had 250 members disenrolled for failing to pay their premiums since January after a 90 day grace period.

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.

Each month, I have shared data with the Committee that reflects members that have disenrolled from MetroPlus and have transferred to Health First. In collaboration with HHC Finance, these transfers were studied, and 80% of those who transferred were no longer receiving care at HHC. A sample survey was done on those individuals who transferred. Eight hundred and fifty one members with valid phone numbers received outreach. Two hundred and forty two or 28% of those were reached. The two main reasons for members leaving MetroPlus and HHC were desire to receive care from providers not in our plan, and problems with accessing care. 76.6% reported leaving to go to a non network provider. 17.9% left due to difficulties accessing care.

MetroPlus also conducted a survey of Medicare members that voluntarily disenrolled in January and February 2012. Of the members disenrolled, approximately 12 percent were reached and a disenrollment survey was completed. The main reason given for disenrolling was dissatisfaction with benefits offered by the Plan. We are currently finalizing a renegotiation of provider contracts that should allow us some flexibility in offering enhanced value added benefits.

On the other hand, MetroPlus will continue to face challenges in our ability to offer additional services to our Medicare population. Based on current federal legislation there will be a projected 19.28% base premium reduction in MetroPlus' Medicare Advantage rates over the next 5 years. The Affordable Care Act requires that counties such as those within New York City that are above the national fee-for-service (FFS) average reduce costs to 95% of FFS. Re-evaluated annually, county rates will be reduced over a maximum of 6 years to achieve these rate reductions.

The New York State Department of Health (SDOH) will be providing 2012-2013 rates in two phases. In Phase I (early May), plans can expect the April 1st base Medicaid and FHP medical rates. Regional trends are about 5% vs. 7% last year. This is before SDOH applies the legislative cuts from last year (it was a 2 year deal for managed care plans). These include a 1.7% trend reduction and a 2% overall reduction, leaving an approximately 1.3% trend. Separately, pharmacy rates are being reduced from the October carve-in to reflect an increase in the expected generic dispensing rate (from 72% to 77%) and an elimination of the funded carve-in transition period. An analysis of these new pharmacy rates reveal that MetroPlus will receive approximately 36 million dollars less in pharmacy revenue over the next year. In Phase II, MRT adjustments will be funded and include the carve-in of new populations and expenses, including low weight and disabled (SSI) babies, homeless recipients, and dental. All of these will come with incremental revenue and cost. SDOH is still developing those rates and those will probably not be available until mid-year.

On April 12, 2012, Governor Cuomo issued an Executive Order to establish a statewide Health Exchange, an online marketplace where individuals and small businesses can choose among competing health insurance plans. The Governor stated that this will reduce cost of coverage for individuals, small businesses and local governments.

MetroPlus Health Plan

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

April-2012

		Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12
Total Members	Prior Month	418,250	418,394	421,521	423,021	424,565	427,132	427,920
	New Member	15,106	19,128	17,020	17,940	18,431	16,986	15,244
	Voluntary Disenroll	1,558	2,588	1,855	2,046	1,987	2,028	1,820
	Involuntary Disenroll	13,404	13,413	13,665	14,350	13,877	14,170	14,099
	Adjusted	-242	-139	-104	-44	356	1,557	0
	Net Change	144	3,127	1,500	1,544	2,567	788	-675
	Current Month	418,394	421,521	423,021	424,565	427,132	427,920	427,245
Medicaid	Prior Month	350,529	350,296	353,093	354,656	356,098	358,549	359,644
	New Member	11,926	15,530	14,094	14,351	15,331	13,881	12,306
	Voluntary Disenroll	1,257	1,951	1,520	1,460	1,630	1,684	1,476
	Involuntary Disenroll	10,902	10,782	11,011	11,449	11,250	11,102	11,060
	Adjusted	-228	-134	-101	-55	343	1,495	0
	Net Change	-233	2,797	1,563	1,442	2,451	1,095	-230
	Current Month	350,296	353,093	354,656	356,098	358,549	359,644	359,414
Child Health Plus	Prior Month	18,855	18,896	18,876	18,700	18,209	17,804	17,522
	New Member	713	775	572	431	434	527	511
	Voluntary Disenroll	45	43	37	21	36	29	28
	Involuntary Disenroll	627	752	711	901	803	780	874
	Adjusted	0	1	-1	2	-8	-16	0
	Net Change	41	-20	-176	-491	-405	-282	-391
	Current Month	18,896	18,876	18,700	18,209	17,804	17,522	17,131
Family Health Plus	Prior Month	35,101	35,337	35,557	35,554	35,863	36,283	36,220
	New Member	2,092	2,360	1,940	2,280	2,261	2,232	2,079
	Voluntary Disenroll	131	437	175	122	146	188	170
	Involuntary Disenroll	1,725	1,703	1,768	1,849	1,695	2,107	1,834
	Adjusted	-12	-4	0	-1	-4	38	0
	Net Change	236	220	-3	309	420	-63	75
	Current Month	35,337	35,557	35,554	35,863	36,283	36,220	36,295

MetroPlus Health Plan

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

April-2012

		Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12
HHC	Prior Month	2,985	2,975	2,999	2,990	3,102	3,123	3,096
	New Member	20	42	20	284	29	17	0
	Voluntary Disenroll	3	2	0	153	0	0	0
	Involuntary Disenroll	27	16	29	19	8	44	12
	Adjusted	-1	0	0	11	21	18	0
	Net Change	-10	24	-9	112	21	-27	-12
	Current Month	2,975	2,999	2,990	3,102	3,123	3,096	3,084
SNP	Prior Month	5,396	5,430	5,497	5,544	5,667	5,724	5,733
	New Member	142	208	165	243	191	134	102
	Voluntary Disenroll	31	39	37	36	41	28	33
	Involuntary Disenroll	77	102	81	84	93	97	69
	Adjusted	-1	-2	-2	-3	1	20	0
	Net Change	34	67	47	123	57	9	0
	Current Month	5,430	5,497	5,544	5,667	5,724	5,733	5,733
Medicare	Prior Month	5,384	5,460	5,499	5,577	5,626	5,649	5,705
	New Member	213	213	229	351	185	195	246
	Voluntary Disenroll	91	116	86	254	134	99	113
	Involuntary Disenroll	46	58	65	48	28	40	250
	Adjusted	0	0	0	2	3	2	0
	Net Change	76	39	78	49	23	56	-117
	Current Month	5,460	5,499	5,577	5,626	5,649	5,705	5,588

MetroPlus Health Plan

New Member Transfer From Other Plans

	2011_05		2011_06		2011_07		2011_08		2011_09		2011_10		2011_11		2011_12		2012_01		2012_02		2012_03		2012_04		TOTAL
	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
Affinity Health Plan	0	0	0	1	1	5	51	263	16	194	21	174	23	203	17	190	13	207	19	194	20	255	30	242	2,139
CarePlus Health Plan	0	0	0	2	1	4	29	222	25	196	25	134	28	177	12	147	13	145	25	130	22	204	31	193	1,765
Fidelis Care	0	0	0	6	1	6	26	292	19	233	24	173	19	232	18	217	17	183	10	171	16	210	17	191	2,081
Health First	0	0	0	1	0	1	26	240	25	146	14	186	26	217	13	198	22	165	8	187	17	253	20	214	1,979
Health Plus	0	0	3	1	0	3	30	342	33	258	36	255	32	253	29	275	26	300	19	218	33	357	33	304	2,840
HIP/NYC	0	0	0	1	0	3	15	113	10	117	6	93	7	102	5	104	11	97	8	89	10	130	7	118	1,046
Neighborhood Health Pr	0	4	0	1	0	4	15	175	25	139	26	149	24	171	29	125	16	206	18	165	18	234	22	191	1,757
United Healthcare of NY	0	0	0	0	1	1	11	76	10	82	6	72	8	103	10	122	8	101	14	91	10	127	10	92	955
Unknown PLan	2,364	11,416	2,773	15,498	2,349	11,730	2,145	11,430	2,023	9,714	1,928	9,395	2,189	12,785	1,822	11,459	2,162	11,747	2,153	13,041	2,066	11,401	1,913	10,643	166,146
Wellcare of NY	0	0	0	0	0	1	21	157	11	126	20	146	28	142	15	125	19	138	14	99	31	122	23	148	1,386
TOTAL	**2,364**	**11,420**	**2,776**	**15,511**	**2,353**	**11,758**	**2,369**	**13,310**	**2,197**	**11,205**	**2,106**	**10,777**	**2,384**	**14,385**	**1,970**	**12,962**	**2,307**	**13,289**	**2,288**	**14,385**	**2,243**	**13,293**	**2,106**	**12,336**	**182,094**

Report ID: MHP1268C
Report Run Date: 4/15/2012

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 04/14/2012

Other Plan Name	Category	2011_05		2011_06		2011_07		2011_08		2011_09		2011_10		2011_11		2011_12		2012_01		2012_02		2012_03		2012_04		TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
Affinity Health Plan	INVOLUNTARY	0	2	0	3	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8
	VOLUNTARY	12	139	11	143	18	97	10	126	13	99	10	137	22	124	19	99	10	108	15	90	6	71	7	130	1,516
	TOTAL	12	141	11	146	19	99	10	126	13	99	10	137	22	124	19	99	10	108	15	90	6	71	7	130	1,524
CarePlus Health Plan	INVOLUNTARY	0	4	1	5	2	5	0	0	0	0	0	0	2	1	0	0	0	0	0	0	0	1	0	0	21
	VOLUNTARY	2	29	6	33	2	34	4	26	3	33	2	24	5	43	2	42	1	27	3	25	3	19	1	28	397
	TOTAL	2	33	7	38	4	39	4	26	3	33	2	24	7	44	2	42	1	27	3	25	3	20	1	28	418
Fidelis Care	INVOLUNTARY	0	8	1	3	0	3	0	0	0	0	1	1	0	1	0	0	0	1	0	2	0	1	0	0	22
	VOLUNTARY	27	196	32	280	27	211	41	253	20	176	22	203	27	254	27	234	26	223	33	268	17	147	22	264	3,030
	TOTAL	27	204	33	283	27	214	41	253	20	176	23	204	27	255	27	234	26	224	33	270	17	148	22	264	3,052
Health First	INVOLUNTARY	3	13	2	2	0	1	0	0	0	0	0	1	0	2	0	1	1	5	0	1	1	0	0	1	34
	UNKNOWN	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	VOLUNTARY	29	465	45	538	35	419	46	501	33	411	38	407	42	488	39	461	27	514	42	548	30	300	52	478	5,988
	TOTAL	32	479	47	540	35	420	46	501	33	411	38	408	42	490	39	462	28	519	42	549	31	300	52	479	6,023
Health Plus	INVOLUNTARY	1	6	2	4	2	5	0	0	0	0	0	0	0	8	0	1	0	2	0	0	0	0	0	0	31
	VOLUNTARY	18	191	13	208	13	160	22	207	18	185	20	145	24	216	25	189	10	176	14	241	11	109	19	172	2,406
	TOTAL	19	197	15	212	15	165	22	207	18	185	20	145	24	224	25	190	10	178	14	241	11	109	19	172	2,437
HIP/NYC	INVOLUNTARY	1	3	0	1	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	9
	VOLUNTARY	9	75	3	102	10	72	8	84	6	90	12	55	12	77	12	86	10	92	9	90	8	54	16	113	1,105
	TOTAL	10	78	3	103	10	75	8	84	6	90	12	55	12	77	12	86	10	92	9	91	8	54	16	113	1,114
Neighborhood	INVOLUNTARY	1	3	0	0	2	2	0	0	0	0	0	0	0	2	0	1	0	2	0	1	0	1	0	1	16

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 04/14/2012

		2011_05		2011_06		2011_07		2011_08		2011_09		2011_10		2011_11		2011_12		2012_01		2012_02		2012_03		2012_04		TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
Neighborhood Health Provider	VOLUNTARY	11	118	12	124	21	115	8	169	8	120	8	114	15	144	14	130	15	95	11	122	7	75	14	94	1,564
	TOTAL	12	121	12	124	23	117	8	169	8	120	8	114	15	146	14	131	15	97	11	123	7	76	14	95	1,580
United Healthcare of NY	INVOLUNTARY	1	3	1	0	0	1	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	1	0	0	9
	VOLUNTARY	5	74	11	107	11	69	13	68	10	72	7	48	18	111	16	76	14	70	8	81	7	50	8	68	1,022
	TOTAL	6	77	12	107	11	70	13	68	10	72	7	48	18	112	16	76	14	71	8	81	7	51	8	68	1,031
Wellcare of NY	INVOLUNTARY	1	2	0	3	0	5	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	12
	VOLUNTARY	1	29	4	26	2	33	2	27	3	22	8	18	0	9	2	29	0	20	2	25	1	13	1	18	295
	TOTAL	2	31	4	29	2	38	2	27	3	22	8	18	0	9	2	29	0	21	2	25	1	13	1	18	307
Disenrolled Plan Transfers	INVOLUNTARY	8	44	7	21	7	27	0	0	0	0	1	2	2	15	0	3	1	12	0	5	1	4	0	2	162
	UNKNOWN	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	VOLUNTARY	114	1,316	137	1,561	139	1,210	154	1,461	114	1,208	127	1,151	165	1,466	156	1,346	113	1,325	137	1,490	90	838	140	1,365	17,323
	TOTAL	122	1,361	144	1,582	146	1,237	154	1,461	114	1,208	128	1,153	167	1,481	156	1,349	114	1,337	137	1,495	91	842	140	1,367	17,486
Disenrolled Unknown Plan Transfers	INVOLUNTARY	1	67	4	51	6	46	5	47	3	35	7	53	5	36	3	26	2	37	2	31	4	20	1	36	528
	UNKNOWN	1	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	4
	VOLUNTARY	0	21	0	24	3	40	5	47	7	63	4	52	20	99	17	114	7	54	8	79	19	66	28	71	848
	TOTAL	2	89	4	75	9	86	10	95	10	98	11	105	25	135	20	140	9	91	10	110	23	87	29	107	1,380
Non-Transfer Disenroll Total	INVOLUNTARY	1,235	9,826	1,176	8,727	1,359	10,100	1,033	9,713	1,112	10,295	1,011	9,917	1,023	9,743	1,155	10,151	1,160	10,286	1,019	10,222	1,253	10,134	1,067	10,089	132,806
	UNKNOWN	0	7	1	1	1	0	1	2	1	3	1	3	1	5	1	6	1	5	1	13	2	8	1	8	73
	VOLUNTARY	0	67	0	61	0	42	0	52	0	52	1	55	252	386	2	60	2	81	1	60	79	780	2	40	2,075
	TOTAL	1,235	9,900	1,177	8,789	1,360	10,142	1,034	9,767	1,113	10,350	1,013	9,975	1,276	10,134	1,158	10,217	1,163	10,372	1,021	10,295	1,334	10,922	1,070	10,137	134,954

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 04/14/2012

		2011_05		2011_06		2011_07		2011_08		2011_09		2011_10		2011_11		2011_12		2012_01		2012_02		2012_03		2012_04		TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
Total MetroPlus Disenrollment	INVOLUNTARY	1,244	9,937	1,187	8,799	1,372	10,173	1,038	9,760	1,115	10,330	1,019	9,972	1,030	9,794	1,158	10,180	1,163	10,335	1,021	10,258	1,258	10,158	1,068	10,127	133,496
	UNKNOWN	1	9	1	1	1	0	1	3	1	3	1	3	1	5	1	6	1	5	1	13	2	9	1	8	78
	VOLUNTARY	114	1,404	137	1,646	142	1,292	159	1,560	121	1,323	132	1,258	437	1,951	175	1,520	122	1,460	146	1,629	188	1,684	170	1,476	20,246
	TOTAL	1,359	11,350	1,325	10,446	1,515	11,465	1,198	11,323	1,237	11,656	1,152	11,233	1,468	11,750	1,334	11,706	1,286	11,800	1,168	11,900	1,448	11,851	1,239	11,611	153,820

Bert Robles
Senior Vice President, Information Technology Services
Report to the M&PA/IT Committee to the Board
Thursday May 24, 2012 – 2:00 PM

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

1. **Meaningful Use (MU) Stage II :**

On February 23, the Centers for Medicare and Medicaid Services (CMS) released a Notice of Proposed Rule Making for Eligible Hospitals and Eligible Providers to meet Meaningful Use (MU) in the program's second stage. As we have presented to the Board previously, the Corporation has made steady progress towards Stage I MU for our Hospitals and HHC is currently meeting thresholds for all stage I measures.

Stage II introduces the following significant changes to the program:

1. Hospitals will have 16 core items and can pick two of four menu items where previously they had 14 and could choose five out of ten. Eligible providers will have 17 core and can pick three of five menu items.

2. Most thresholds for MU will be increased. For example, patient demographics must be recorded for 80% of patients, where previously it was for 50%. The threshold for assessing smoking status is also up to 80% from 50% and the requirements for decision support rules are increased to five from one.

3. Almost all Stage I menu requirements will be core including the requirement for *Summary of care at transitions,* Syndromic surveillance, Reportable lab results for public health, Medication Reconciliation, and providing educational resources to patients.

4. The Summary of care Document must be provided for at least sixty-five percent of transitions and referrals **and** would have to be electronically exchanged between the hospital and a provider that is **not** affiliated with the hospital and is using a **different** EHR vendor product. This proposed

requirement may present particular difficulties for integrated delivery systems, where a large majority of referrals are within the system and using the same EHR. Professional Organizations such as the Greater New York Hospital Association (GNYHA), National Association of Public Hospitals (NAPH), the American Hospital Association (AHA) and the Hospital Association of New York State (HANYS) have identified this as an unreasonable request for their constituents. HHC concurs with their position.

5. CMS proposes that at least ten percent of a hospital's patients would need to view or download information about their hospital stay, or electronically transmit their information to a third party. This requirement would make providers accountable for patients using computer technology. While GNYHA, NAPH, AHA and HANYS encourage electronic interaction with patients through the use of computer technology, they have found this requirement to be untenable. HHC concurs with their opinion.

6. A new menu objective for Hospitals is to generate and transmit permissible discharge prescriptions electronically (eRx) for more than 10% of patients. This requirement could cost HHC an additional two million dollars annually for fees related to eRx and accelerate the planned implementation of eRx in the inpatient setting.

7. A new objective for Eligible Professionals would mandate that secure electronic messaging be used to communicate with more than 10 % of unique patients seen during the EHR reporting period. Although the requirement does not require the patient to respond, a requirement to electronically communicate with one out of ten patients may not be appropriate in many cases.

In addition to the new measures and thresholds, all hospitals will be required to submit quality metrics electronically in 2014.

The Notice of Proposed Rule Making also articulates the timetable where penalties will begin to be levied on providers who are not meaningful users. A one percent reduction in Medicare rates will commence in 2015 for Hospitals who have not attested to meaningful use by July 1 of 2014. Unexpectedly, Eligible Providers who elect to attest under the Medicaid Program will nevertheless be subject to Medicare Part B penalties if they have not attested by October 1, 2014. This is despite the fact that the Medicaid Program allows Eligible Providers to begin meaningful use as late

as 2016, without reduction in incentive funding. Thus the program, on one hand recognizes that Medicaid Eligible Professionals may need more time to reach meaningful use and gives them until 2016 to start, but on the other hand penalizes what limited Medicare revenue they receive if they don't start by 2014.

2. Enterprise Business Intelligence (BI) Initiative:

EITS is embarking on one of the most critical initiatives for HHC-establishing an Enterprise Business Intelligence (BI) strategy.

BI is widely viewed as a key strategic imperative for the success of information driven organizations. With the explosion of information technology in healthcare and the accelerated pace of health care reform, we are grappling with enormous amounts of data and an incredible pace of change that requires new and sophisticated ways to allow us to timely and effectively analyze and model.

At its core, BI is about decision making. BI converts enormous volumes of data into meaningful analytics and metrics about HHC's current business and clinical operations. It identifies evolving patterns that allow us to be more responsive to changing conditions and therefore, make more informed decisions.

Some of the key objectives of the BI initiative will be to:

- Strengthen data and information governance.

- Integrate data from diverse systems to enable advanced, comprehensive analytics to drive clinical, financial and operational improvement.

- Streamline the data reporting process flow and improve efficiency and service levels.

- Deploy meaningful reporting, dashboards and alerts for various user levels that track and monitor key performance indicators.

- Provide both retrospective and predictive forecasting capabilities to answer not only what happened but why did it happen.

• Enable self-service reporting analytics and the ability to drill down into key performance indicators for better evidence-based decision-making.

Our goal in deploying this Business Intelligence and Analytics strategy is to greatly enhance our ability to execute on our corporate objectives and mission.

3. Patient Centered Medical Home (PCMH):

EITS is working in partnership with Medical and Professional Affairs on another of HHC's most critical strategic initiatives- the implementation of Patient Centered Medical Home (PCMH). Presently, HHC has a primary care population of more than 477,000 adult and pediatric patients.

The primary goal of the PCMH initiative is to improve patient outcomes through improved care management and care coordination. All of our acute care facilities and diagnostic and treatment centers, 17 separate sites in all, have received designation as Patient-Centered Medical Homes (PCMH) by the National Committee for Quality Assurance (NCQA) and awarded each the highest, Level 3, PCMH Recognition. HHC is in the process of PCMH designation for 22 community health centers and extension clinics. If all of our primary care sites ultimately receive Level 3 NCQA Recognition status, HHC will ultimately qualify for at least $15 million annually in enhanced Medicaid reimbursement rate increases.

5. IT Asset Management:

EITS' Service Management Office is in the process of developing and implementing IT Asset Management for the division.

Very briefly, IT Asset Management is a set of business practices that leverage financial, contractual and inventory functions to support life cycle management and decision making for the IT environment. This is especially critical for EITS as budget dollars shrink and demand for IT services increases. There are multiple benefits of implementing this type of program for EITS. They include but are not limited to: accurate budgeting, cost and risk reduction and increased asset utilization. Presently, the Service Management Office team is implementing Asset Management at the Jacobi Data Center with implementation at both Queens and South Manhattan Networks targeted for the end of this Fiscal Year. The remaining networks (North Bronx, Generations+, North &Central Brooklyn and South Brooklyn

Networks) will be completed by the end of this calendar year. Successfully implemented, IT Asset Management will enable EITS to support user demands quickly while rationalizing the cost of services.

This completes my report to the Committee today. Thank you.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and execute an amendment to the Affiliation Agreement with New York University School of Medicine ("NYUSOM") for the provision of Health Services at Woodhull Medical and Mental Health Center and Cumberland Diagnostic and Treatment Center which terminates on June 30, 2014, to include the provision of General Care Health Services at Coler-Goldwater Specialty Hospital and Nursing Facility ("Coler-Goldwater"), consistent with the general terms and conditions and for the amounts indicated in Attachment A;

AND

Further authorizing the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the amounts set forth in Attachment A.

WHEREAS, the Corporation has for some years entered into affiliation agreements pursuant to which various medical schools, voluntary hospitals and professional corporations provided General Care and Behavioral Health Services at Corporation facilities; and

WHEREAS, the current Affiliation Agreement with Coler-Goldwater expires on June 30, 2012; and

WHEREAS, the Corporation's Board of Directors at its June 2011 meeting approved a three-year agreement, effective July 1, 2011, to permit NYUSOM to provide health services at Woodhull Medical and Mental Health Center and Cumberland Diagnostic and Treatment Center; and

WHEREAS, NYUSOM has agreed to continue to provide the services previously supplied by the prior affiliate, Roosevelt Island Medical Associates, P.C. starting July 1, 2012; and terminating on June 30 2014; and

WHEREAS, a summary of the terms and conditions of the amendment to the current Affiliation Agreement with NYUSOM is set forth in Attachment A; and

WHEREAS, the respective Community Advisory Boards of Coler-Goldwater have been consulted and apprised of such proposed general terms and conditions; and

WHEREAS, the Corporation, in the exercise of its powers and fulfillment of its corporate purposes, now desires that NYUSOM begin to provide General Care Health Services at Coler-Goldwater.

NOW, THEREFORE, BE IT

RESOLVED, that the President of the New York City Health and Hospitals Corporation ("the Corporation") is hereby authorized to negotiate and execute an amendment to the Affiliation Agreement with New York University School of Medicine ("NYUSOM") for the provision of Health Services at Woodhull Medical and Mental Health Center and Cumberland Diagnostic and Treatment Center which terminates on June 30, 2014, to include the provision of General Care Health Services at Coler-Goldwater Specialty Hospital and Nursing Facility ("Coler-Goldwater"), consistent with the general terms and conditions and for the amounts indicated in Attachment A; and,

BE IT FURTHER RESOLVED that the President is hereby authorized to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the amounts set forth in Attachment A.

Attachment A

Summary of the Proposed Contract Amendment Between the New York City Health and Hospitals Corporation ("the Corporation") and New York University School of Medicine (NYUSOM) for the Provision of Services at Coler-Goldwater Specialty Hospital and Nursing Facility ("Coler-Goldwater")

General Terms and Synopsis:

The proposed contract amendment covers a two-year term commencing July 1, 2012. The proposed contract amendment is for the provision of direct patient care services, administration of the provision of services, supervision of post-graduate trainees and students, administration and provision of rehabilitation therapy services and technical services to support the operations at Coler-Goldwater. The proposed contract amendment will compensate NYUSOM on a non-workload basis. The proposed contract amendment includes newly created pay-for-performance indicators with financial incentives attached. The pay-for-performance indicators were jointly created with medical staff leadership to address patient safety and the effective management in these facilities.

Anticipated Goals and Achievements

- Successful regulatory surveys
- Patient safety initiatives
- Participation in strategic planning and program development
- Participation in the relocation of Coler-Goldwater operations
- Development of performance improvement activities
- Participation in HHC Breakthrough activities
- State of the art technology advances, including electronic medical record migration
- A pay for performance program that aligns incentives with quality outcomes and other business objectives

Financial Terms

Proposed Contract Amendment Costs
FY 2013 – FY 2014

Contract Year	Coler-Goldwater
FY 2013	$27,500,000
FY 2014	$27,500,000
TOTAL	$55,000,000

- As in the current Affiliation Agreement, proposed payment to NYUSOM is based on costs.

- The costs reported assume no material change in patient volume or services provided and no additional impact from managed care programs or other third-payer developments

- Any change to the budget must be approved by JOC and the Corporation as per policy.

- The Corporation retains the right to bill all patients and third-party payers for services rendered.

- Payments are subject to adjustment due to new initiatives for expanded programs or services, elimination or downsizing of programs, services or other reductions, market recruitment, retention-based salary adjustments, service grants or other designated programs consistent with the terms of the agreement.

Performance Indicators

A pay-for-performance program will be implemented that address patient safety and effective management. An incentive up to $498,000 in incremental compensation to the Affiliate will be provided annually if all goals are met

Pay-for-performance indicators subject to incentive include:

- ✓ Informed Consent
- ✓ Consultation/Specialty Referral Request
- ✓ Consultation/Specialty Referral Response
- ✓ Influenza Vaccine Administration
- ✓ Pneumococcal Vaccine Administration

Transfers and Referrals

- Patients will be transferred and referred to other facilities when the required services are not available, if a third-party payer does not authorize reimbursement or at the patient's request.

- If a service is not available, such transfers and referrals will be made to other HHC facilities.

- Transfers and referrals to non-HHC facilities will only be made with the approval of the Executive Director or his/her designee and if an agreement with the receiving facility is in place.

- Transfer and referral activity will be monitored monthly.

South Manhattan Health Care Network
Coler-Goldwater Specialty Hospital and Nursing Facility

Proposed Contract Amendment
of the
Woodhull Cumberland Agreement
with
New York University School of Medicine

Presented by

Lynda D. Curtis
Sr. Vice President, SMHN

Robert K. Hughes
Executive Director

MAY 24, 2012

Affiliation Transition Overview

- Since July 1997, Roosevelt Island Medical Associates, P.C. (RIMA) served as the affiliate for the consolidated Coler-Goldwater Specialty Hospital and Nursing Facility (Coler-Goldwater)
- Effective, July 1, 2012, New York University School of Medicine (NYUSOM) will serve as the affiliate for Coler-Goldwater

Affiliation Transition Overview (Cont.)

- RIMA staff on payroll, as of July 1, 2012, will become NYUSOM employees
- Doctors Council will continue to represent the non-managerial physicians
- NYUSOM to continue the sub-contracts for services established by RIMA

Services Provided

- Long Term Care Hospital Medicine
  - Virology
  - Wound Care
  - Ventilator Care
  - General Medicine
- Nursing Facility Medicine
- Rehabilitation Medicine
  - Cardiac Rehabilitation
  - Pulmonary Rehabilitation
  - General Rehabilitation

Services Provided (Cont.)

- Dentistry
- Consultative and Liaison Specialties
- Rehabilitative Therapy Services (Occupation Therapy, Physical Therapy, Speech Pathology & Audiology)
- Occupational Health Services

Current Affiliate Workforce Summary

- 67% Minorities
- 52% Women
- 95% Board Certified Physicians
  - Remainder have HHC Waivers
  - 30% of Boarded Physicians have Multiple Board Certifications

Post-Graduate Training Programs

- Coler-Goldwater/Bellevue Hospital Center Dental Residency Program
  - Applicants are culturally and geographically diverse
- Kingsbrook Jewish Medical Center Resident Pulmonary Rehabilitaton Rotation Site
- Interfaith Medical Center Pulmonary Fellowship Rotation Site

Projected Goals

- Successful regulatory surveys
- Participation in strategic planning and program development
- Participation in the relocation of Coler-Goldwater operations
- Participation in Breakthrough Initiatives
- Development of performance improvement activities

Projected Goals (Cont.)

- Medical Director leads the Patient Safety Program
  - JC National Patient Safety Goal compliance
  - Root Cause Analysis and FMEA oversight
- State of the art technology advances, including electronic medical record migration
- A pay-for-performance program that aligns incentives with quality outcomes and other business objectives

Proposed Contract Amendment Terms

- Services will be provided from July 01, 2012 through June 30, 2014
- Compensation will be based on costs
- The costs reported assume no material change in patient volume or services provided and no additional impact from managed care programs or other third-party payer developments
- Any change to the affiliate budget must by approved by the Joint Oversight Committee and the Corporation as per policy

Proposed Contract Amendment Terms (Cont.)

- The Corporation retains the right to bill all patients and third-party payers for services rendered
- Payments are subject to adjustment due to new initiatives for expanded programs or services, elimination or downsizing of programs, services or other reductions, market recruitment, retention-based salary adjustments, service grants or other designated programs consistent with the terms of the agreement

Proposed Contract Costs*

Contract Year	Coler-Goldwater
FY 2013	$27,500,000
FY 2014	$27,500,000
Total	$55,000,000

* NYU will be paid $535,800 less (2%) in FY 2013 than the FY 2012 payments to RIMA after taking into consideration adjustments made due to differences in contract services.

Pay-For-Performance Program

- A pay-for-performance program will be implemented that address patient safety and effective management
- An incentive up to $498,000 in incremental compensation to the Affiliate will be provided annually if all goals are met

Pay-For-Performance Program (Cont.)

The pay-for-performance indicators eligible for incentives include:

- ✓ Informed Consent
- ✓ Consultation/Specialty Referral Request
- ✓ Consultation/Specialty Referral Response
- ✓ Influenza Vaccine Administration
- ✓ Pneumococcal Vaccine Administration

Transfers and Referrals

- Patients will be transferred and referred to other facilities when the required services are not available, if a third-party payer does not authorize reimbursement or at the patient's request
- If a service is not available, such transfers and referrals will be made to other HHC facilities

Transfers and Referrals (Cont.)

- Transfers and referral to non-HHC facilities will only be made with the approval of the Executive Director or his/her designee and if an agreement with the receiving facility is in place
- Transfer and referral activity will be monitored monthly

Thank You!

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate and execute a contract with Microsoft Health Solutions Group to provide a care plan information system. The contract shall be for a period of five years with two, consecutive, one-year options to renew exercisable solely by the Corporation, in an amount not to exceed $16.1 million for a five year term, with two, consecutive, one-year options to renew, for a total term of seven years.

AND

Further authorizing the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy.

WHEREAS, the Corporation seeks to enter into a contract to provide a care information system to support care coordination services in the HHC facilities throughout the five boroughs of New York City; and

WHEREAS, a Request for Proposal ("RFP") was issued on March 19, 2012 in accordance with the Corporation's operating procedures; and

WHEREAS, the selection committee rated the proposal using criteria specified in the RFP, and the committee recommended the Microsoft Health Solutions Group to be awarded the contract; and

WHEREAS, the Corporation enters into a contract of five years with two, consecutive, one -year renewal options; and

WHEREAS, the overall responsibility for monitoring the contract shall be under the Senior Vice President, Information Services and the Senior Vice President/Corporate Chief Medical Officer, Division of Medical & Professional Affairs.

Now, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation ("the Corporation") be and hereby is authorized to negotiate and execute a contract with the Microsoft Health Solutions Group to provide a care plan information system to the New York City Health and Hospitals Corporation. The contract shall be for a period of five years with two, consecutive, one-year options to renew, exercisable solely by the Corporation, in an amount not to exceed $16.1 million for a five year term, with two, consecutive, one-year options to renew, for a total term of seven years; and

BE IT FURTHER RESOLVED, that the President is hereby authorized to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy.

Executive Summary
Proposed Contract with Microsoft Health Solutions Group

The Office of Ambulatory Care Transformation and Clinical Information Systems of the New York City Health and Hospitals Corporation ("HHC") are proposing to enter into a contract with Microsoft Health Solutions Group ("Microsoft") to provide a customized care plan information system, software, support, and maintenance for the provision of care coordination services to support the Patient Centered Medical Home and Health Home programs in HHC's facilities. This system will enable HHC to identify, manage, collect data on patient cohorts as well as individual patients, and then analyze that data for quality of care and clinical outcomes.

To this end, the customized care plan information system will enable HHC to improve patient outcomes through improved care [plan] management and care coordination for Medical Home patients inclusive of high cost, high need Medicaid enrollees.

A Request for Proposal ("RFP") was issued on March 19, 2012 in accordance with the Corporation's operating procedures. Ten proposals were submitted and evaluated by a selection committee using criteria specified in the RFP. Five of the proposals did not meet the minimum requirements as specified in the RFP. Each of the remaining qualified vendors demonstrated their systems for the committee. On the basis of the submitted proposal and system performance, Microsoft's proposal and system was ranked the highest overall and was deemed the most advantageous to HHC by the committee.

The contract shall be for a period of five years with two consecutive one-year options in an amount not to exceed $16.1 million covering a population scaling up to 500,000 patients. (See cost analysis detail). The two consecutive one-year options for optional years 6 and 7 will be exercisable solely by HHC. These funds will be utilized to provide payment to Microsoft for development, support, maintenance, training, and implementation of the care plan system.

In addition, the resolution requests authorization for the President to make adjustments to the contract amounts, providing such adjustments are consistent with HHC's financial plan, professional standards of care, and equal employment opportunity policy.

HHC and Microsoft have come to a mutual understanding of Microsoft's licensing fees, scope of work and time frames for completion of deliverables

Microsoft will assume full responsibility for the satisfactory completion of all work performed.

Costs Analysis

Fixed Patient Population

	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	TOTAL
Enrollment Assumptions	50,000	50,000	50,000	50,000	50,000	
Software Licensing	$2,140,000					$2,140,000
Support & Maintenance (base)		$428,000	$428,000	$428,000	$428,000	$1,712,000
Implementation	$1,043,000					$1,043,000
Language support	$125,000					$125,000
Training	$42,800	$21,400	$21,400	$21,400	$21,400	$128,400
Professional Services	$150,000	$50,000				$200,000
Server/Storage/Infrastructure	$100,000				$100,000	$200,000
Total	$3,600,800	$499,400	$449,400	$449,400	$549,400	$5,548,400

Expanded Patient Population

	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	TOTAL
Enrollment Assumptions	50,000	100,000	250,000	350,000	500,000	
Software Licensing	$2,140,000	$1,550,000				$3,690,000
Tiered Pricing						
next 50,000		$200,000	$200,000	$200,000	$200,000	$800,000
next 150,000		$-	$600,000	$600,000	$600,000	$1,800,000
next 100,000		$-	$-	$300,000	$300,000	$600,000
next 250,000					$450,000	$450,000
next 500,000						
Support & Maintenance (base)		$428,000	$428,000	$428,000	$428,000	$1,712,000
20% of license fees			$160,000	$220,000	$310,000	$690,000
Implementation	$1,043,000					$1,043,000
Language support	$125,000					$125,000
Training	$42,800	$21,400	$21,400	$21,400	$21,400	$128,400
Professional Services	$150,000	$50,000				$200,000
Server/Storage/Infrastructure	$100,000				$100,000	$200,000

Total	$3,600,800	$2,249,400	$1,409,400	$1,769,400	$2,409,400	$11,438,400

Option Years

	YEAR 6	YEAR 7
Enrollment Assumptions	500,000	500,000
Software Licensing		
Tiered Pricing		
next 50,000	$200,000	$200,000
next 150,000	$600,000	$600,000
next 100,000	$300,000	$300,000
next 250,000	$450,000	$450,000
next 500,000		
Support & Maintenance (base)	$428,000	$428,000
20% of license fees	$310,000	$310,000
Implementation		
Language support		
Training	$21,400	$21,400
Professional Services		
Server/Storage/Infrastructure		

Total	$2,309,400	$2,309,400

CONTRACT FACT SHEET

New York City Health and Hospitals Corporation

Contract Title: CARE PLAN INFORMATION SYSTEM

Project Title & Number: Care Plan Information System; DCN 1995

Project Location: 125 Worth Street, Room 410, New York, New York 10013

Requesting Dept.: Office of Ambulatory Care Transformation

Number of Respondents: TEN (10)
(If Sole Source, explain in Background section))

Range of Proposals: $ 16.1 million to $ 17.6 million
(Proposal costs were based on 500,000 patients)

Successful Respondent: Microsoft Corporation Health Solutions Group

Contract Amount: $ 16.1 million

Contract Term: 5 Years with 2, 1-year options to renew

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

Funding Source: __General Care __ Capital
__ Grant: explain _____
X Other: Central Budget/ENT IT General Operating Fund

Method of Payment: __ Lump Sum __ Per Diem __ Time and Rate__
Other: The awarded contract vendor would receive monthly payment for invoiced work.

EEO Analysis: Microsoft Corporation is a non-Minority/Women's Business Enterprise. However, it has received an approved status.

Compliance with HHC's McBride Principles? X Yes _ No

Vendex Clearance _ Yes _ No X Pending

(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):*

NCQA PCMH Recognition and Health Home Programs require utilization of interoperable care plans to improve care outcomes of Medical Home patients including Medicaid enrollees with multiple and complex needs that drive high volume and high cost utilization of services. Currently, HHC does not have any technology within its infrastructure to address this requirement.

The care plan information system is a dynamic web-based tool, used by the patient, their involved family members, primary care providers, members of the extended care team (e.g., psychiatrists and other behavioral health providers, emergency physicians, physical therapists, home care nurses) Community Based Organizations, and ancillary staff. It aids both patients and their extended care teams to manage and coordinate the medical and non-medical services and resources the patient may require to be successful in reaching their goals.

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

The proposed contract will be presented at the May 23, 2012 CRC meeting.

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

No, there have been no changes to the proposed contract's scope of work, timetable, budget, contract deliverables or the accountable person since presentation to the CRC.

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:*

Selection Committee Members and responding firms' lists are attached hereto.
All RFP responses were reviewed in three rounds.

- **First round**: Vendors must have met two minimum, pass/fail requirements:
  i. Vendors must have previous experience in health information technology;
  ii. Vendors must be in agreement to comply with Attachment C, "Vendor Contract Agreement: e-collaborative SHIN-NY
- **Second round**: Vendors having met both minimum pass/fail requirements must *also* have an existing care plan information system product.
- **Third round**: Vendors having met both first *and* second round requirements moved on to the third round i.e., the "short list". Vendors on the short list were:
  i. CareTeam Connect, Inc.
  ii. GSI Health
  iii. Harris Corporation
  iv. IBM
  v. Microsoft, Health Solutions Group

Third round vendors were invited to conduct onsite demonstrations of their products before the entire evaluation committee.

- In preparation for the demonstrations, all responding vendors were sent simultaneously the same use case scenario to use during their presentations. The patient in the use case scenario, "Patient AM" is a patient with multiple conditions representative of the patients HHC typically serves.
- In addition, the evaluation committee debriefed after each vendor's demonstration to discuss the vendor's product capabilities to support our care plan information system needs.
- A scoring tool was developed was developed to evaluate submissions. The tool consisted of all the questions asked in the RFP. An orientation session was held on April 10, 2012 to educate selection committee members on how to use the evaluation tool.

- Finalists' scores were tabulated. On April 26, 2012 the selection committee identified the highest ranking vendor: Microsoft Health Solutions Group.

Scope of work and timetable first year of contract:

SCOPE OF WORK	DUE
Planning and initial design	**2 months**
Functional priorities to be implemented: • Implement a care plan information system with data element fields as identified in Attachment B of the RFP. • Implement capability to assign patients to care teams • Roster Management: Implement the capability to enroll patients and track their information as outlined in the NYS Tracking Sheet • Assessment capabilities - Capture patient assessment (baseline and subsequent) data, including a free text format for care coordination notes. • Encounter activity types – tracking capability for care coordination, billing, and reporting purposes • Encounter alerts - capability to alert care coordination and outreach teams	**3-6 months**
Defining integration with EMR	**6-8 months**
(Alerts) Defining clinical decision support for patients and providers	
Population Health Management/Quality Improvement tools	
Patient portal with EHR integration	**8+ months**

Costs Analysis

Fixed Patient Population

	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	TOTAL
Enrollment Assumptions	50,000	50,000	50,000	50,000	50,000	
Software Licensing	$2,140,000					$2,140,000
Support & Maintenance (base)		$428,000	$428,000	$428,000	$428,000	$1,712,000
Implementation	$1,043,000					$1,043,000
Language support	$125,000					$125,000
Training	$42,800	$21,400	$21,400	$21,400	$21,400	$128,400
Professional Services	$150,000	$50,000				$200,000
Server/Storage/Infrastructure	$100,000				$100,000	$200,000
Total	$3,600,800	$499,400	$449,400	$449,400	$549,400	$5,548,400

Expanded Patient Population

	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	TOTAL
Enrollment Assumptions	50,000	100,000	250,000	350,000	500,000	
Software Licensing	$2,140,000	$1,550,000				$3,690,000
Tiered Pricing						
next 50,000		$200,000	$200,000	$200,000	$200,000	$800,000
next 150,000		$-	$600,000	$600,000	$600,000	$1,800,000
next 100,000		$-	$-	$300,000	$300,000	$600,000
next 250,000					$450,000	$450,000
next 500,000						
Support & Maintenance (base)		$428,000	$428,000	$428,000	$428,000	$1,712,000
20% of license fees			$160,000	$220,000	$310,000	$690,000
Implementation	$1,043,000					$1,043,000
Language support	$125,000					$125,000
Training	$42,800	$21,400	$21,400	$21,400	$21,400	$128,400
Professional Services	$150,000	$50,000				$200,000
Server/Storage/Infrastructure	$100,000				$100,000	$200,000
Total	$3,600,800	$2,249,400	$1,409,400	$1,769,400	$2,409,400	$11,438,400

Option Years

	YEAR 6	YEAR 7
Enrollment Assumptions	500,000	500,000
Software Licensing		
Tiered Pricing		
next 50,000	$200,000	$200,000
next 150,000	$600,000	$600,000
next 100,000	$300,000	$300,000
next 250,000	$450,000	$450,000
next 500,000		
Support & Maintenance (base)	$428,000	$428,000
20% of license fees	$310,000	$310,000
Implementation		
Language support		
Training	$21,400	$21,400
Professional Services		
Server/Storage/Infrastructure		
Total	$2,309,400	$2,309,400

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

Not applicable

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

HHC does not have existing technology needed to meet requirements for operating Health Home and Patient Centered Medical Home Programs.

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?

It is not anticipated that the contract will produce artistic/creative/intellectual property.

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

- Ross Wilson, MD, Corporate Chief Medical Officer, SVP of Quality
- Bert Robles, SVP, Chief Information Officer
- Irene Kaufmann, Senior Assistant Vice President
- Paul Contino, Chief Technology Officer
- Inger Dobson Slade, Associate Director

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):*

Microsoft Health Solutions Group submitted its Supply and Service Employment Report on May 1, 2012. As part of its submission, Microsoft attached a copy of its approval received from New York City on June 10, 2010 along with Part I of the Employment Report, a copy of its EEO statements, and a staffing plan including the signed and notarized Employment Report signature page. Its current submission has been approved as well.

Received By E.E.O. May 2, 2012
Date

Analysis Completed By E.E.O. May 3, 2012
Date

Manasses C. Williams, AVP
Name

ATTACHMENT A

CARE PLAN INFORMATION SYSTEM RFP, DCN 1995

Evaluation Committee Members:

1. Oladipo Alao, MD, MetroPlus Health Plan
2. Gary Belkin, MD, Behavioral Health
3. Paul Contino, Information Services
4. Louis Capponi, MD, Clinical Information Services
5. Mary-Ann Etiebet, MD, Office of Ambulatory Care Transformation
6. Terry Hamilton, HIV Services
7. Irene Kaufmann, Office of Ambulatory Care Transformation, Chair
8. Walid Michelen, MD, Generations Plus/Northern Manhattan Network
9. Peter Peacock, MD, Kings County Hospital Center

LIST OF FIRMS RESPONDING:

1. AllScripts, Inc.
2. CareTeam Connect, Inc.
3. Consilience Software
4. Epic
5. GSI Health
6. Harris Corporation
7. IBM
8. Microsoft, Health Solutions Group
9. QuadraMed
10. Tailwinds Associates.

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
125 Worth Street, Suite 401, New York, NY 10013 Tel: 212-788-3380 Fax: 212-788-3689
nyc.gov/hhc

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

TO: Inger Dobson Slade, Associate Director
Office of Ambulatory Care Transformation

FROM: Manasses C. Williams

DATE: May 3, 2012

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor/consultant, **Microsoft Corporation**, has submitted to the Affirmative Action Office a completed Contract Compliance Questionnaire and the appropriate EEO documents. This company is a:

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

Project Location(s): Corporate-wide

Contract Number: _____ Project: Software and Installation Services

Submitted by: Office of Ambulatory Care Transformation

EEO STATUS:

1. [X] Approved
2. [ ] Approved with follow-up review and monitoring
3. [ ] Not approved
4. [ ] Subject to EEO Committee Review

COMMENTS:

MCW:srf

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

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

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

TO: Inger Dobson Slade, Associate Director
Office of Ambulatory Care Transformation

FROM: Manasses C. Williams

DATE: May 3, 2012

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor/consultant, **iNetXperts Corp., dba Get Real Consulting**, has submitted to the Affirmative Action Office a completed Contract Compliance Questionnaire and the appropriate EEO documents. This company is a:

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

Project Location(s): Corporate-wide

Contract Number: _____ Project: Software and Installation Services

Submitted by: Office of Ambulatory Care Transformation

EEO STATUS:

1. [X] Approved

2. [ ] Approved with follow-up review and monitoring

3. [ ] Not approved

4. [ ] Subject to EEO Committee Review

COMMENTS:

MCW:srf

Care Plan Information System

Ross Wilson MD, SVP & Chief Medical Officer,
Bert Robles, SVP & Chief Information Officer

HHC Board

May 24, 2012

Overview

- Regulatory requirement and clinical need
  - a person-centered web-based inter-operable care plan
  - supports care coordination services for HHC's Patient Centered Medical Home (PCMH) and Health Home (HH) patient populations
  - Is accessible to all members of the care team
  - documents, integrates, and tracks progress of patients' clinical and non-clinical health-care related needs, goals, and services (ranging from current medications and appointments to housing or entitlement needs)
- Electronic notification to assigned care teams that allows providers to render *timely and effective* care, through alerts and other communication tools
- Data reporting capability to ensure end to end tracking and billing for outreach and HH services
- Can work effectively with a Personal Health Record and existing EHRs

Process

- RFP process through a selection committee
- Applications scored against:
  - ✓ Assessment Capability
  - ✓ Care Plan Capability
  - ✓ Alert Notification/Messaging Capability
  - ✓ Encounter Management
  - ✓ Enrollment Capability
  - ✓ Reporting
  - ✓ Technical System Architecture
  - ✓ Integration and Interface Capability
  - ✓ Understanding of Work; Soundness of Approach
  - ✓ Firm's Experience
  - ✓ Cost Proposal

Process II

- 50% of the submitted proposals that met the minimum criteria were invited to demonstrate their systems
- Short list of vendors:
  - CareTeam Connect, Inc.
  - GSI Health
  - Harris Corporation
  - IBM
  - Microsoft, Health Solutions Group
- Invited vendors were asked to demonstrate system for Care Coordination services for a diabetic patient with behavioral health conditions

Outcome

- Two vendors scored significantly higher, with Microsoft clearly highest
- The 7-year cost analysis for scaling up to 500,000 patients was similar for the two finalists
  - GSI: $17.6 million
  - Microsoft: $16.1 million
- Final selection was based on the system's functionality, implementation plan, embedded PHR solution, cost and fit with HHC's future EMR system
- Microsoft was the selected vendor

Timeline and Cost

- Estimated time to commence implementation:
  - planning and initial design: 2 months
  - care plan implementation: 3-9 months
- Estimated time to scale up to 500,000 patients: 5 years
- Total contract expenditure over 5 years: $11.4 Million
- Expenditure in the first year would be:
  - $3.6 Million Microsoft contract
  - $300K HHC FTEs
- Two, one-year extensions would be available at the conclusion of 5 years at $2.3 Million

Readmissions

MPA/IT Committee

May 24, 2012

Acute Inpatient PPS

- Wage Index Reform
- Wage Index
- Outlier Payments
- Disproportionate Share Hospital (DSH)
- Direct Graduate Medical Education (DGME)
- Indirect Medical Education (IME)
- New Medical Services and New Technologies
- Wage Index Files
- Three Day Payment Window
- **Readmissions Reduction Program**
- Medicare PPS Excluded Cancer Hospitals
- Acute Inpatient - Files for Download
- Historical Impact Files for FY 1994 through Present
- IPPS Regulations and Notices
- Acute Inpatient PPS Transmittals

Readmissions Reduction Program

Background

Section 3025 of the Affordable Care Act added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. The proposed regulations that would implement this provision are in proposed subpart I of 42 CFR part 412 (proposed §412.150 through §412.154).

Readmissions Measures

In the FY 2012 IPPS final rule, CMS finalized the readmission measures for Acute Myocardial Infarction, (AMI) Heart Failure (HF) and Pneumonia (PN) and the calculation of the excess readmission ratio, which will then be used, in part, to calculate the readmission payment adjustment under the Hospital Readmissions Reduction Program. CMS defined readmission as an admission to a subsection(d) hospital within 30 days of a discharge from the same or another subsection(d) hospital. CMS finalized the calculation of a hospital's excess readmission ratio for AMI, HF and PN, which is a measure of a hospital's readmission performance compared to the national average for the hospital's set of patients with that applicable condition. CMS established a policy of using the risk adjustment methodology endorsed by the National Quality Forum (NQF) for the readmissions measures for AMI, HF and PN to calculate the excess readmission ratios. The excess readmission ratio includes adjustment for factors that are clinically relevant including patient demographic characteristics, comorbidities, and patient frailty. Finally, CMS established a policy of using three years of discharge data and a minimum of 25 cases to calculate a hospital's excess readmission ratio of each applicable condition. For FY 2013, the excess readmission ratio will be based on a discharges occurring during the 3-year period of July 1, 2008 to June 30, 2011. For more information on the readmissions measures, please refer to the FY 2012 IPPS Final Rule in the Downloads section below.

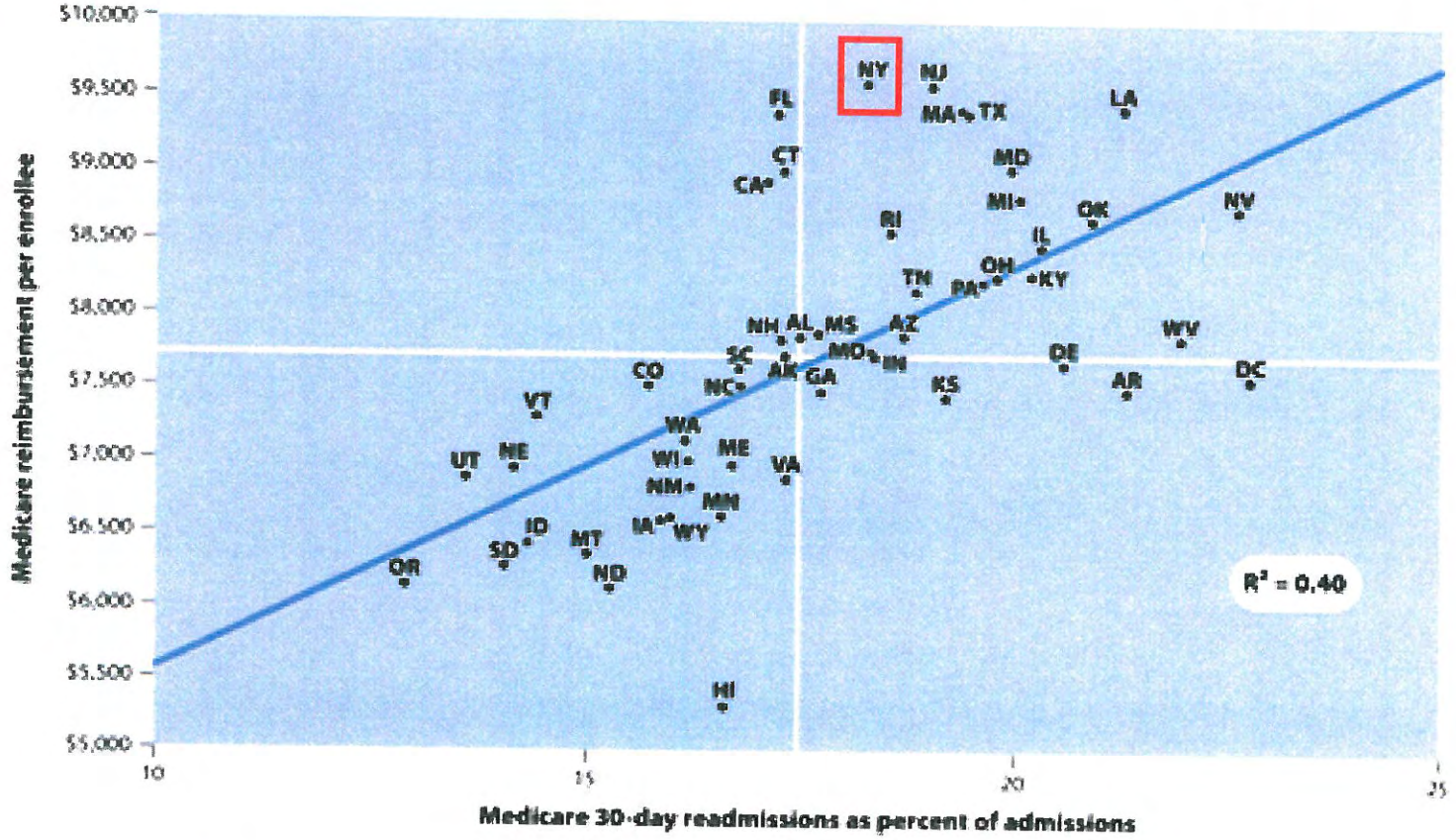
Payment Adjustment

CMS plans to continue implementation of this program in its FY 2013 IPPS rulemaking cycle. In the FY 2013 IPPS proposed rule, CMS proposed which hospitals will be subject to the Hospital Readmissions Reduction Program, the methodology to calculate the hospital readmission adjustment factor, what portion of the IPPS payment will be used

Known

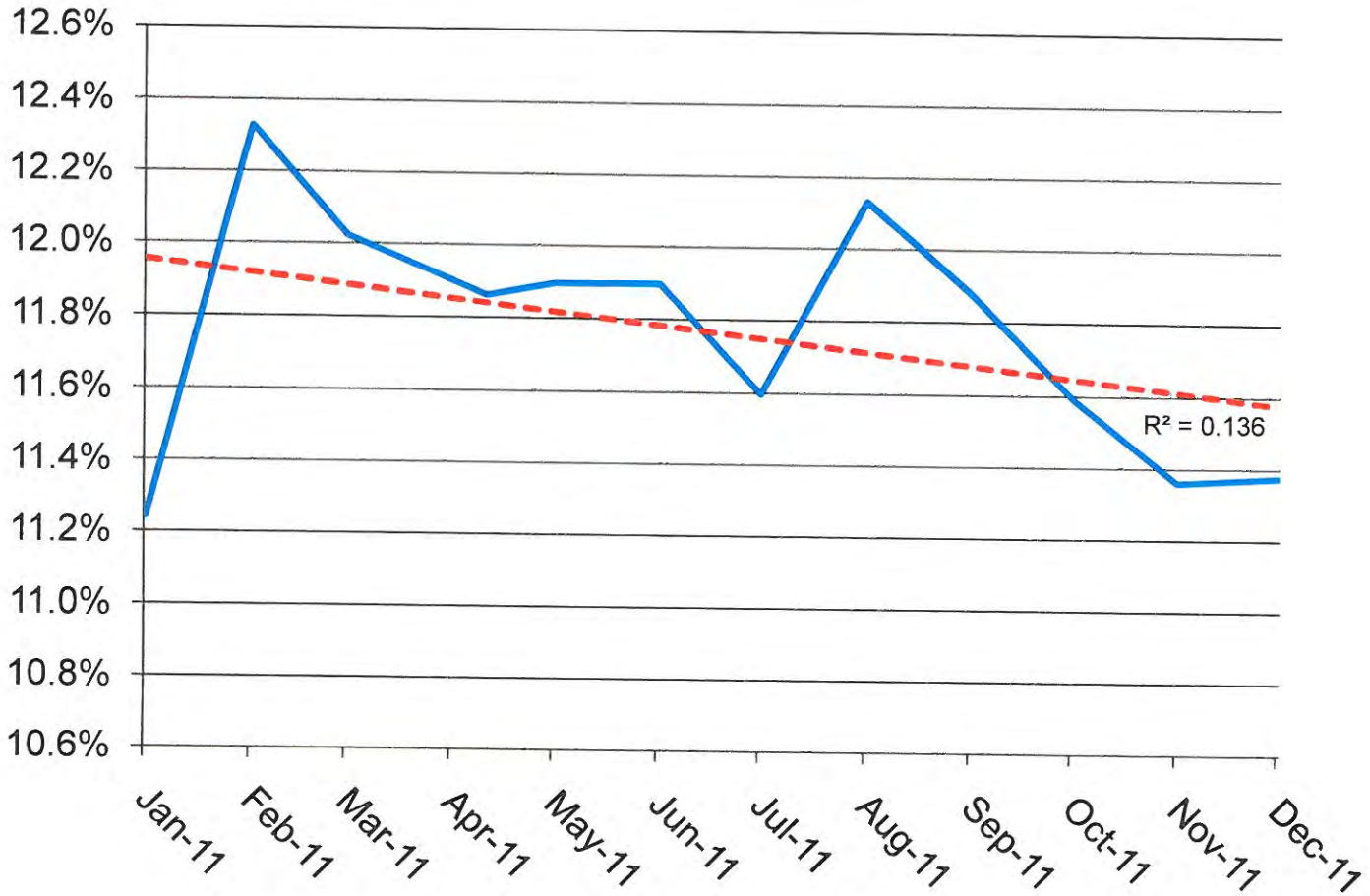
Price and Reimbursement

Medicare Cost Per Beneficiary and 30-Day Readmissions by State



DATA: Medicare readmissions — 2006–07 Medicare 5% SAF Data; Medicare reimbursement — 2006 Dartmouth Atlas of Health Care
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2009

Total Percentage Readmissions HHC cy 2011



~ 2000 readmissions/month

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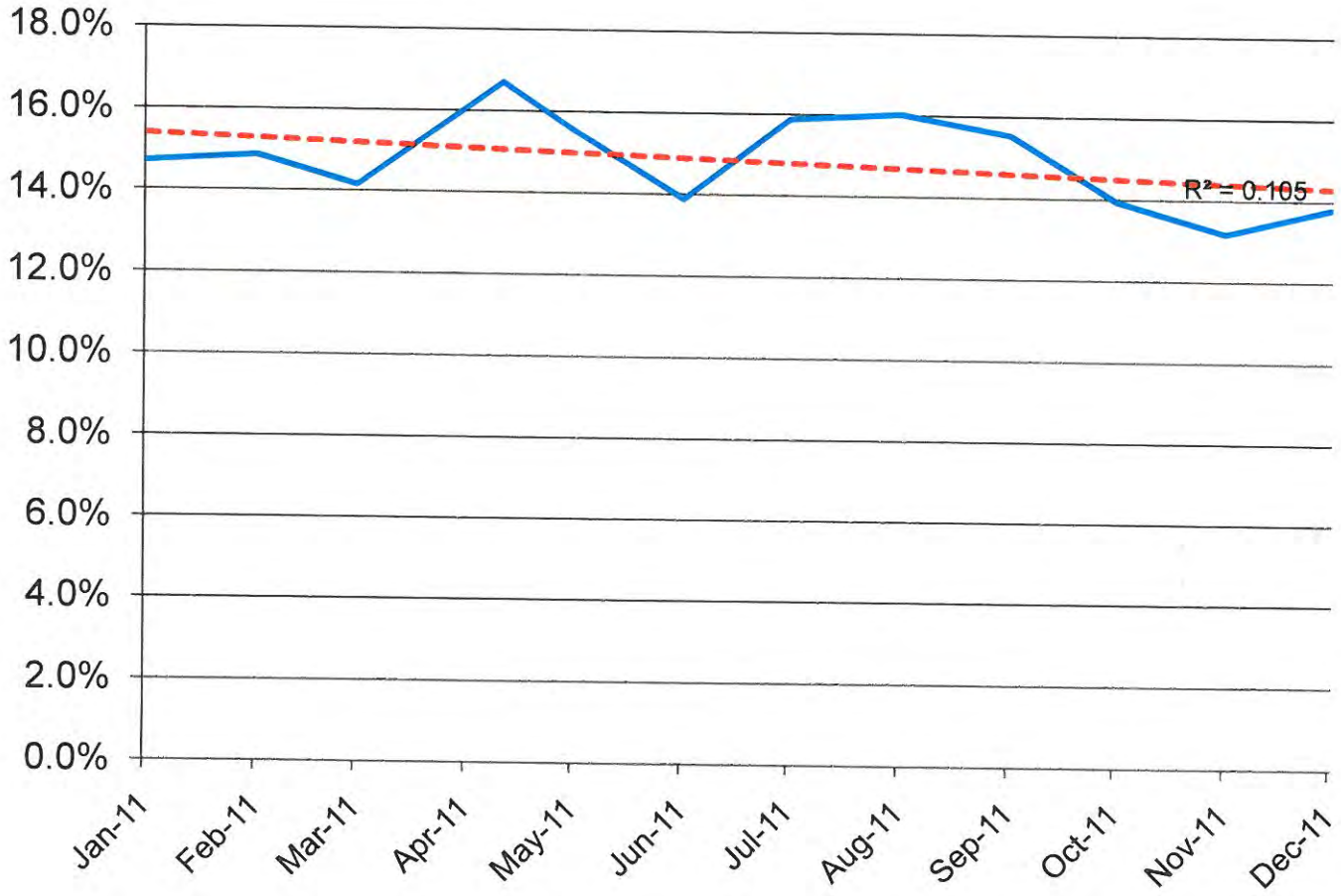
Total HHC Psych Readmissions 2011



~ 1400 readmissions/month

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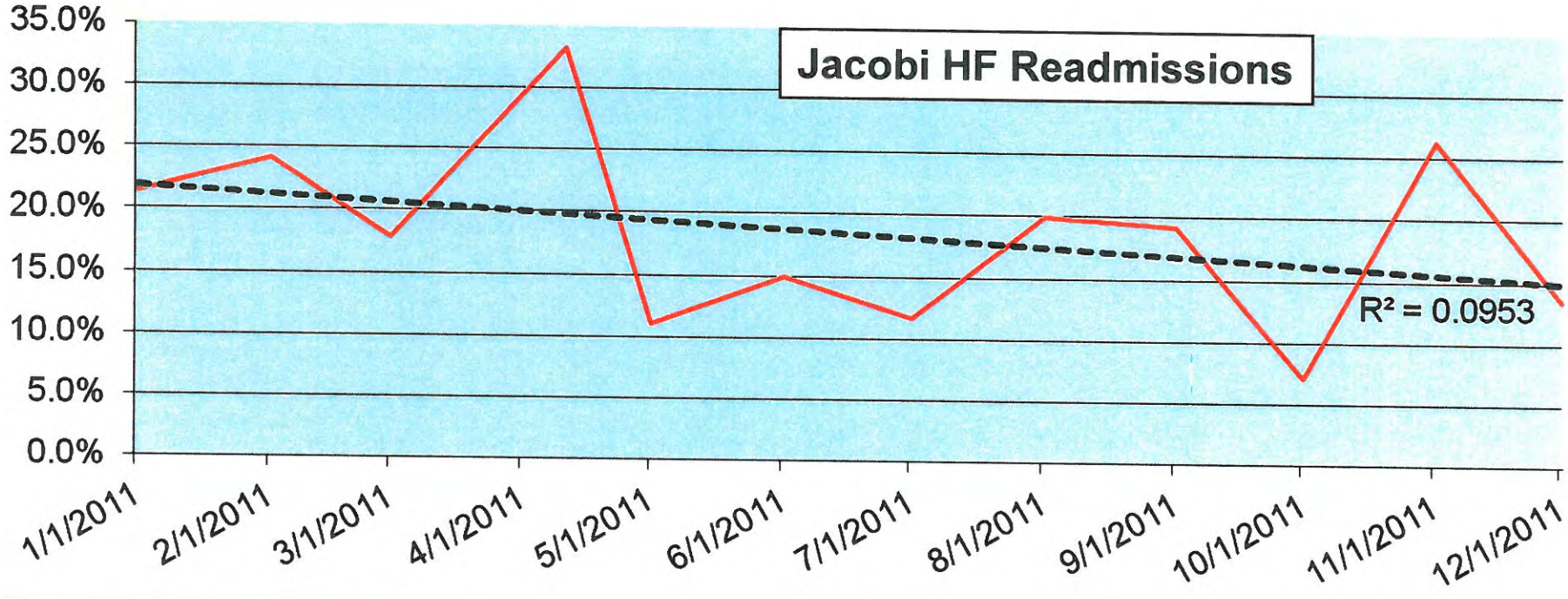
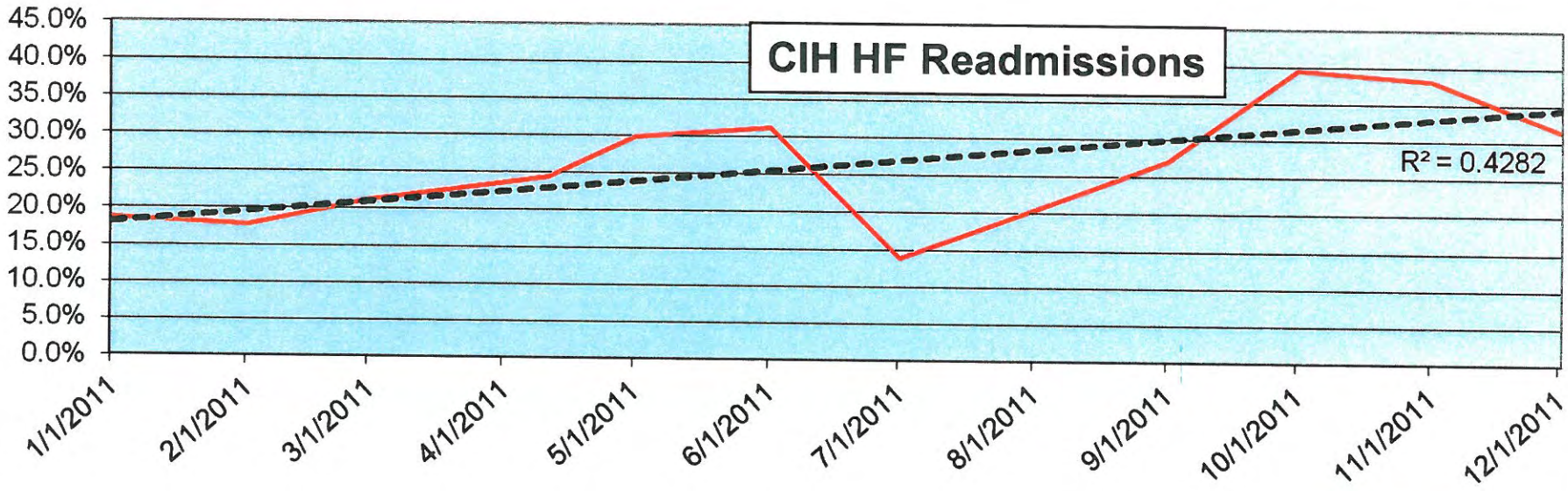
Heart Failure	Facility (Discharges, Re-admits, Re-admission Rate)											
	BELLEVUE		CONEY ISLAND		ELMHURST		HARLEM		JACOBI		KINGS COUNTY	
Discharge Month	Discharges	Re-admits / %	Discharge	Re-admits / %	Discharge	Re-admits / %	Discharges	Re-admits / %	Discharges	Re-admits / %	Discharges	Re-admits / %
Jan-11	61	10 16.4%	69	13 18.8%	36	5 13.9%	24	8 33.3%	28	6 21.4%	42	14 33.3%
Feb-11	29	10 34.5%	56	10 17.9%	33	5 15.2%	17	6 35.3%	29	7 24.1%	47	12 25.5%
Mar-11	56	10 17.9%	47	10 21.3%	25	7 28.0%	16	1 6.3%	28	5 17.9%	43	13 30.2%
Apr-11	42	6 14.3%	45	11 24.4%	32	7 21.9%	23	6 26.1%	24	8 33.3%	50	9 18.0%
May-11	76	18 23.7%	50	15 30.0%	26	8 30.8%	19	8 42.1%	27	3 11.1%	52	10 19.2%
Jun-11	44	15 34.1%	48	15 31.3%	23	5 21.7%	15	5 33.3%	20	3 15.0%	46	12 26.1%
Jul-11	38	12 31.6%	43	6 14.0%	35	7 20.0%	11	3 27.3%	17	2 11.8%	42	10 23.8%
Aug-11	36	4 11.1%	39	8 20.5%	26	4 15.4%	19	6 31.6%	25	5 20.0%	39	11 28.2%
Sep-11	43	9 20.9%	33	9 27.3%	34	10 29.4%	29	8 27.6%	26	5 19.2%	30	6 20.0%
Oct-11	40	7 17.5%	58	23 39.7%	35	10 28.6%	22	8 36.4%	14	1 7.1%	45	6 13.3%
Nov-11	34	4 11.8%	47	18 38.3%	16	4 25.0%	18	4 22.2%	19	5 26.3%	57	15 26.3%
Dec-11	52	10 19.2%	60	19 31.7%	28	6 21.4%	6	2 33.3%	37	5 13.5%	54	12 22.2%
Total	551	115 20.9%	595	157 26.4%	349	78 22.3%	219	65 29.7%	294	55 18.7%	547	130 23.8%

Heart Failure	Facility (Discharges, Re-admits, Re-admission Rate)											
	LINCOLN		METROPOLITAN		NCB		QUEENS		WOODHULL		Total	
Discharge Month	Discharges	Re-admits / %	Discharge	Re-admits / %	Discharge	Re-admits / %	Discharges	Re-admits / %	Discharges	Re-admits / %	Discharges	Re-admits / %
Jan-11	28	10 35.7%	14	4 28.6%	12	1 8.3%	30	4 13.3%	24	4 16.7%	368	79 21.5%
Feb-11	21	5 23.8%	12	2 16.7%	8	3 37.5%	39	10 25.6%	33	12 36.4%	324	82 25.3%
Mar-11	29	10 34.5%	7	2 28.6%	17	4 23.5%	33	5 15.2%	30	7 23.3%	331	74 22.4%
Apr-11	32	6 18.8%	10	2 20.0%	15	4 26.7%	41	10 24.4%	36	11 30.6%	350	80 22.9%
May-11	29	12 41.4%	14	3 21.4%	11	3 27.3%	33	8 24.2%	34	10 29.4%	371	98 26.4%
Jun-11	35	11 31.4%	11	4 36.4%	11	1 9.1%	27	5 18.5%	25	5 20.0%	305	81 26.6%
Jul-11	16	5 31.3%	14	5 35.7%	7	2 28.6%	31	7 22.6%	16	3 18.8%	270	62 23.0%
Aug-11	27	10 37.0%	11	2 18.2%	11	2 18.2%	21	5 23.8%	19	6 31.6%	273	63 23.1%
Sep-11	26	8 30.8%	9	2 22.2%	10	1 10.0%	28	8 28.6%	20	3 15.0%	288	69 24.0%
Oct-11	21	8 38.1%	24	12 50.0%	8	3 37.5%	27	4 14.8%	27	4 14.8%	321	86 26.8%
Nov-11	30	5 16.7%	10	3 30.0%	14	2 14.3%	24	4 16.7%	22	6 27.3%	291	70 24.1%
Dec-11	39	12 30.8%	10	2 20.0%	11	0 0.0%	24	0 0.0%	20	5 25.0%	341	73 21.4%
Total	333	102 30.6%	146	43 29.5%	135	26 19.3%	358	70 19.6%	306	76 24.8%	3833	917 23.9%





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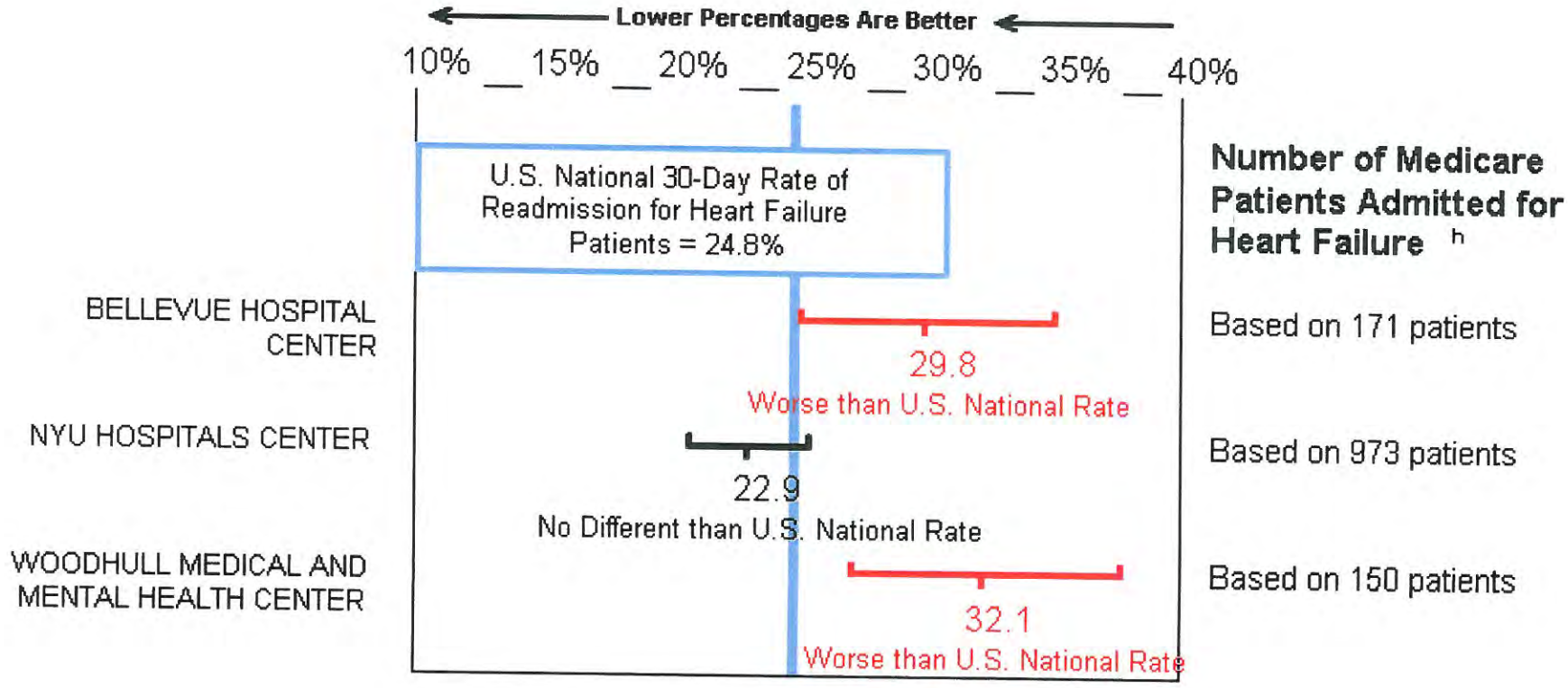
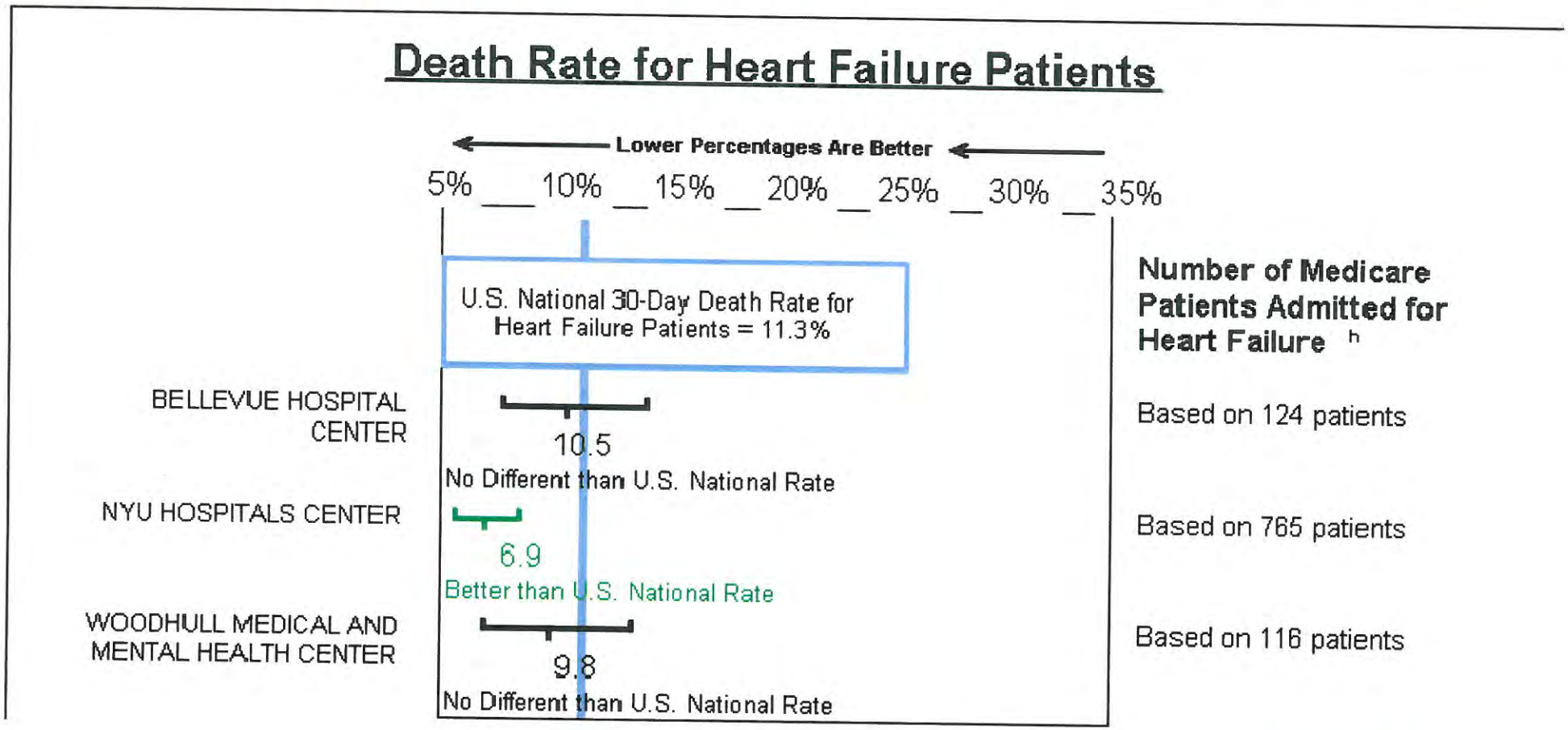
'hese percentages were calculated from Medicare data on patients discharged between July 01,2007 and June 30, 2010. They don't include people in ledicare Advantage Plans (like an HMO or PPO) or people who don't have Medicare.

Rate of Readmission for Heart Failure Patients



These percentages were calculated from Medicare data on patients discharged between July 01,2007 and June 30, 2010. They don't include people in Medicare Advantage Plans (like an HMO or PPO) or people who don't have Medicare.

Death Rate for Heart Failure Patients



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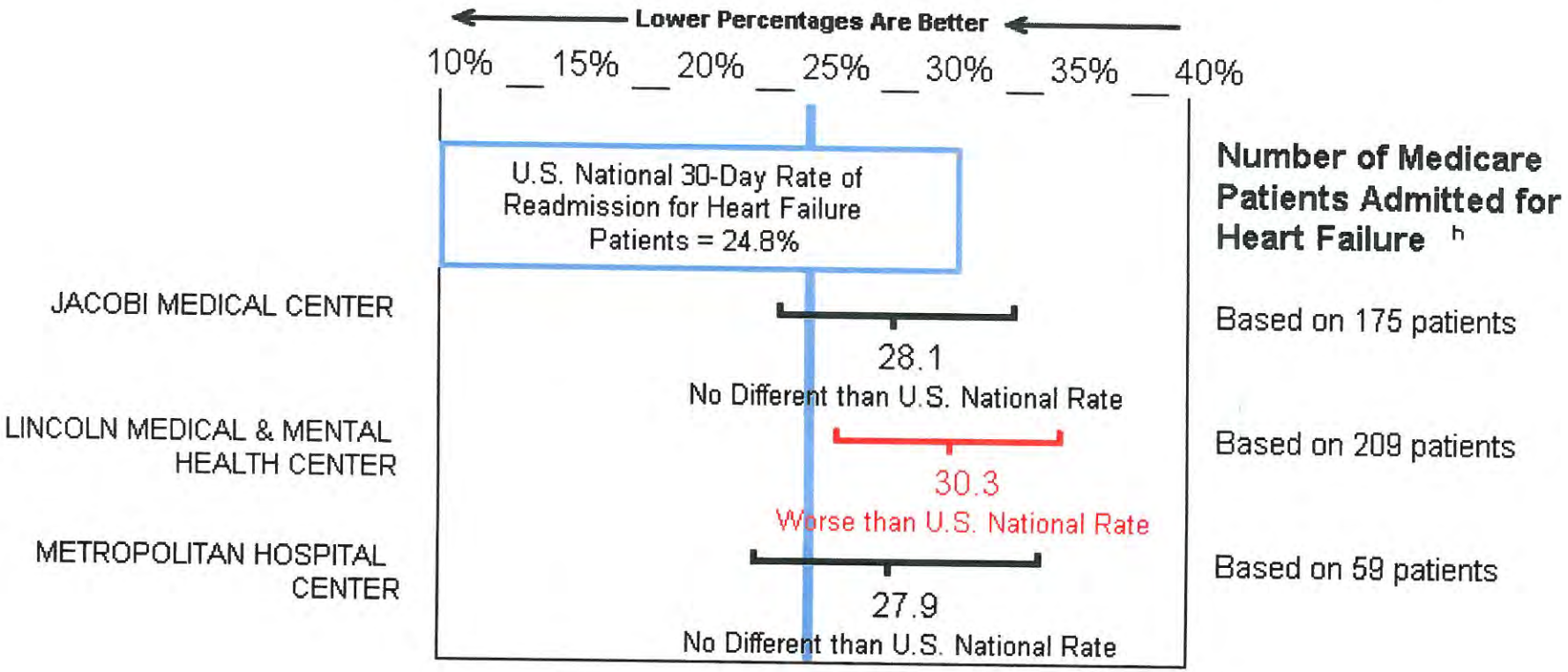
Rate of Readmission for Heart Failure Patients



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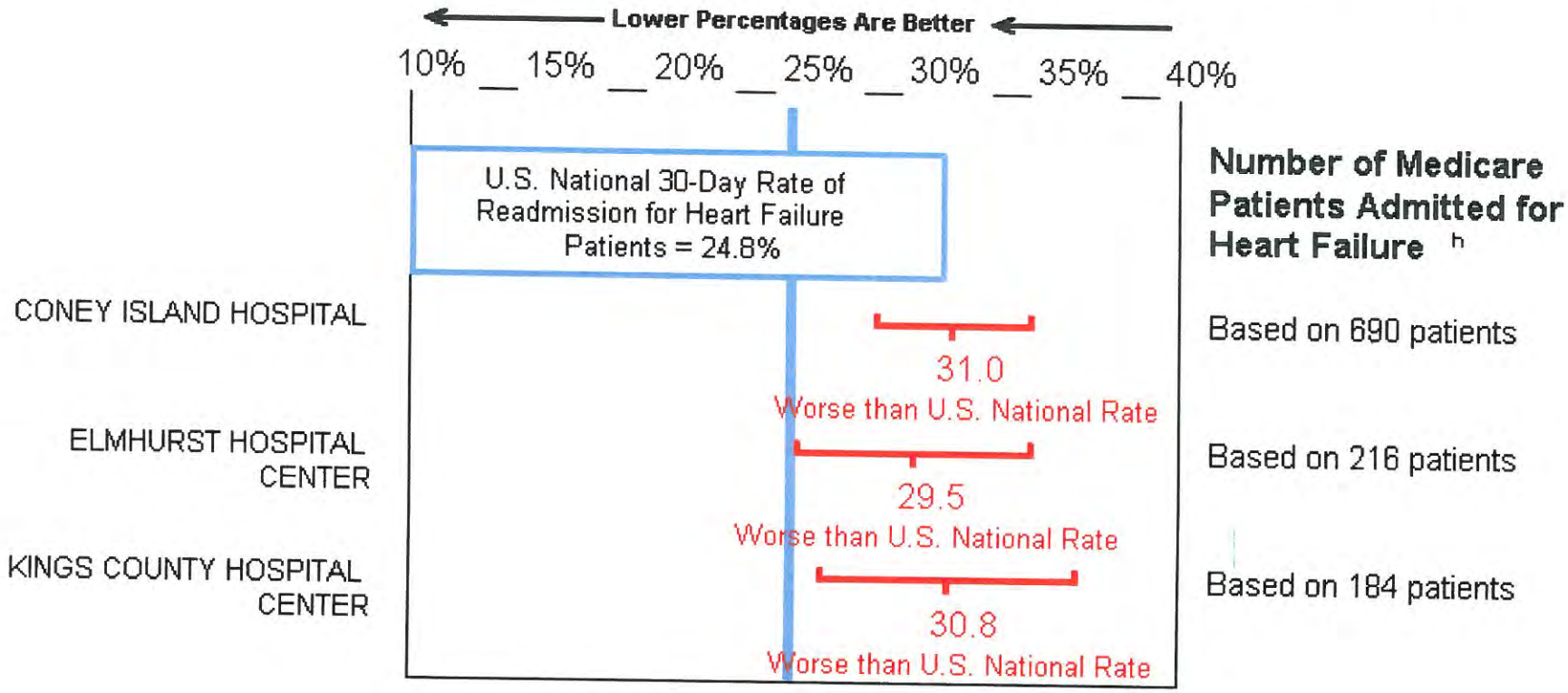
Rate of Readmission for Heart Failure Patients



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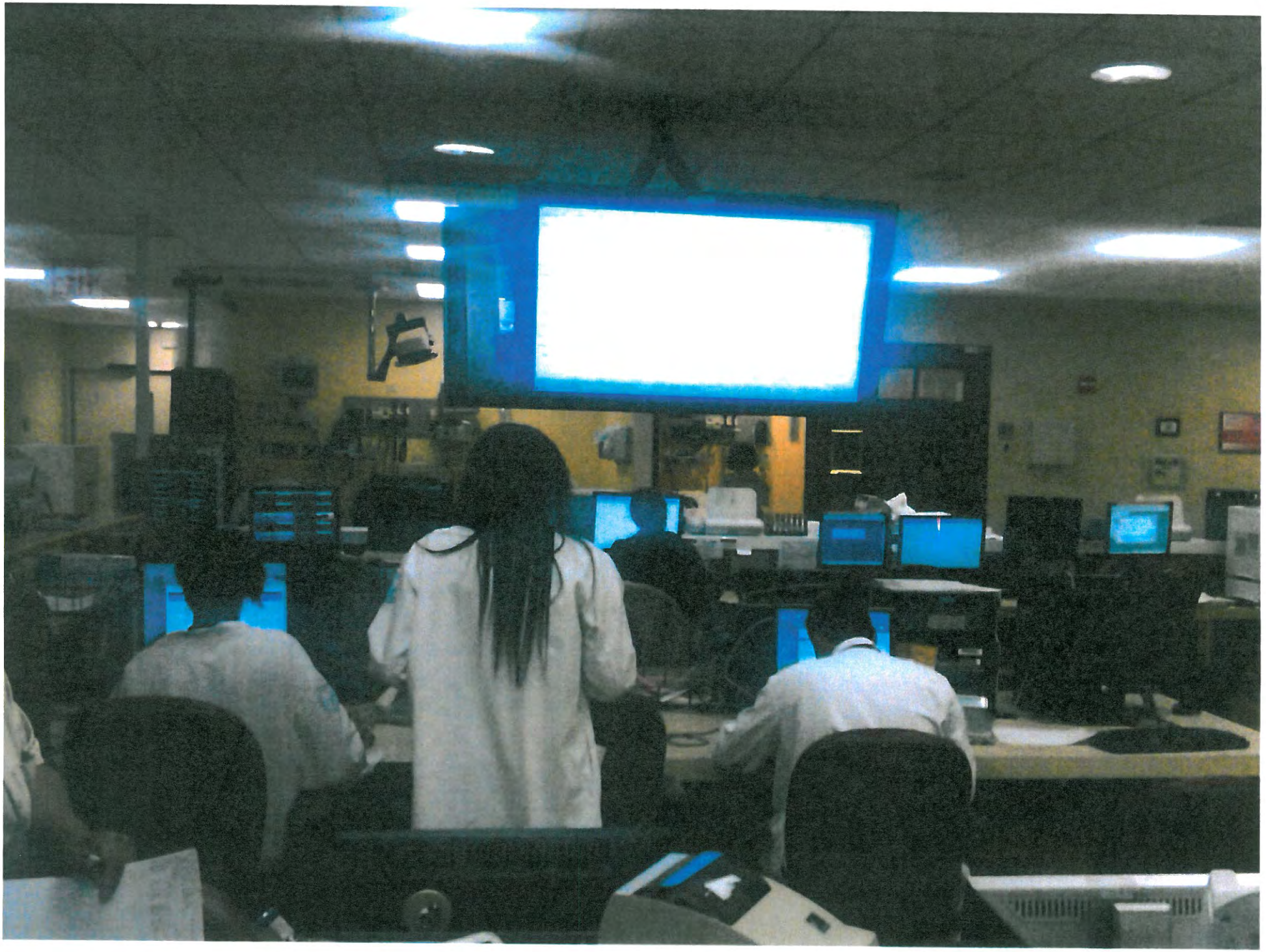
MPA IT Meeting:
Emergency Department Dashboards Update

May 24, 2012

by HHC Clinical Information Systems



DRAFT

A more Integrated Clinical Information System was required for electronic documentation across HHC's Emergency Departments

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- The Clinical Information Systems division led the design, build and implementation of documentation screens and whiteboard functionality in the Emergency Departments (EDs) of ten acute care hospitals across HHC as part of pre-ICIS work and to help resolve disparate use of data in the EDs.

- The Clinical Information Systems team engaged numerous stakeholders within central office and within each acute care hospital across HHC in 2011 to complete the ICIS: ED project.

- The project transformed hospitals that relied on a patient flow driven by paper charts to one where patients can be electronically tracked via real-time updates triggered by electronic clinical documentation.

DRAFT

Reporting dashboards were implemented for 10 Emergency Departments across the Corporation

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Clinical Information Systems

There are currently three ED Dashboards that are live in 10 acute care hospitals and one dashboard that is not yet live with all users:

i) Volume and Throughput Metrics Dashboard: displays monthly volume & throughput performance

ii) Operational Dashboard: displays overall status of the ED in near-real time

iii) ED Trends Dashboard: displays historical trending information on the volume and throughput metrics

iv) Corporate Overview Dashboard: displays a snapshot of all HHC hospitals specific to wait times

Benefits

Value to Patients: Patients can be tracked electronically via real-time updates to electronic clinical documentation to ensure the appropriate level of care is provided at the appropriate time.

Value to Clinicians: Clinicians can assess the patient care demands placed on care teams in near-real time and assign new patients to the most available team.

Value to Administration: Hospital administrators are able to use concrete data to identify bottlenecks in patient flow and base decisions such as modifying staffing levels to reduce long wait-times.

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The Volume and Throughput Metrics (By Facility) Dashboard summarizes monthly performance

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Clinical Information Systems

1 of 1 100% Find | Next

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Queens Volume and Throughput Metrics Dashboard

Last Dashboard Update: 5/8/2012 1

Volume and Throughput Metrics Dashboard

Volume Metrics							
# of Patients Arrived to ED	8,403	8,320	8,108	8,381	8,291	8,829	8
# of Patients Left Before Triage	231	278	259	319	177	178	
% of Patients Left Before Triage	2.7 %	3.3 %	3.2 %	3.8 %	2.1 %	2.0 %	1
# of Patients Triaged	8,172	8,042	7,849	8,062	8,114	8,651	8
# of Patients Claimed by a Provider	7,743	7,602	7,410	7,596	7,708	8,172	8
# of Patients with a Disposition of LWBS	97	101	128	134	141	138	
# of Patients Left After Triage	332	339	311	332	265	341	
% of Patients Left After Triage	4.1 %	4.2 %	4.0 %	4.1 %	3.3 %	3.9 %	4
# of Patients Left Without Being Seen	563	617	570	651	442	519	
% of Patients Left Without Being Seen	6.7 %	7.4 %	7.0 %	7.8 %	5.3 %	5.9 %	5
# of Patients with a Disposition not LWBS	7,640	7,500	7,256	7,490	7,589	8,040	7
# of Patients Left Against Medical Advice	69	79	83	84	73	75	
# of Patients Walked Out During Evaluation / Eloped	45	49	47	41	40	33	
# of Patients Seen & Discharged	6,797	6,642	6,458	6,733	6,893	7,373	7
# of Patients Transferred to Another Hospital	66	86	90	95	102	101	
# of ED Patients Who Were Admitted	720	718	654	620	577	544	
% of ED Patients Who Were Admitted	9.4 %	9.6 %	9.0 %	8.3 %	7.6 %	6.8 %	8
Throughput Metrics - In Median Times (hh:mm)							
Arrival to Triage	0:09	0:09	0:09	0:08	0:11	0:12	
Triage to First Provider	0:18	0:18	0:17	0:19	0:18	0:20	
Arrival to First Provider	0:33	0:32	0:31	0:33	0:33	0:37	
Arrival to First Provider - Discharged Patients	0:36	0:35	0:33	0:36	0:36	0:39	
First Provider to Exit for Discharged Patients	1:54	2:03	2:00	1:56	1:48	1:49	
Triage to Exit for Discharged Patients	2:33	2:45	2:46	2:41	2:35	2:42	
First Provider to Disposition for Admitted Patients	4:06	4:06	4:12	4:08	4:08	4:01	
Dwell for Admitted Patients	1:34	1:33	1:25	1:15	1:11	1:12	
First Provider to Exit for Admitted Patients	6:05	6:12	6:00	5:36	5:32	5:27	
Triage to Exit for Admitted Patients	6:16	6:28	6:17	5:55	5:42	5:43	
ED LOS for Discharged Patients	2:50	3:00	3:02	2:55	2:52	3:01	
ED LOS for Admitted Patients	6:27	6:38	6:25	6:04	5:54	5:51	
Triage to Provider Time by Triage Categories							
# of Visits							

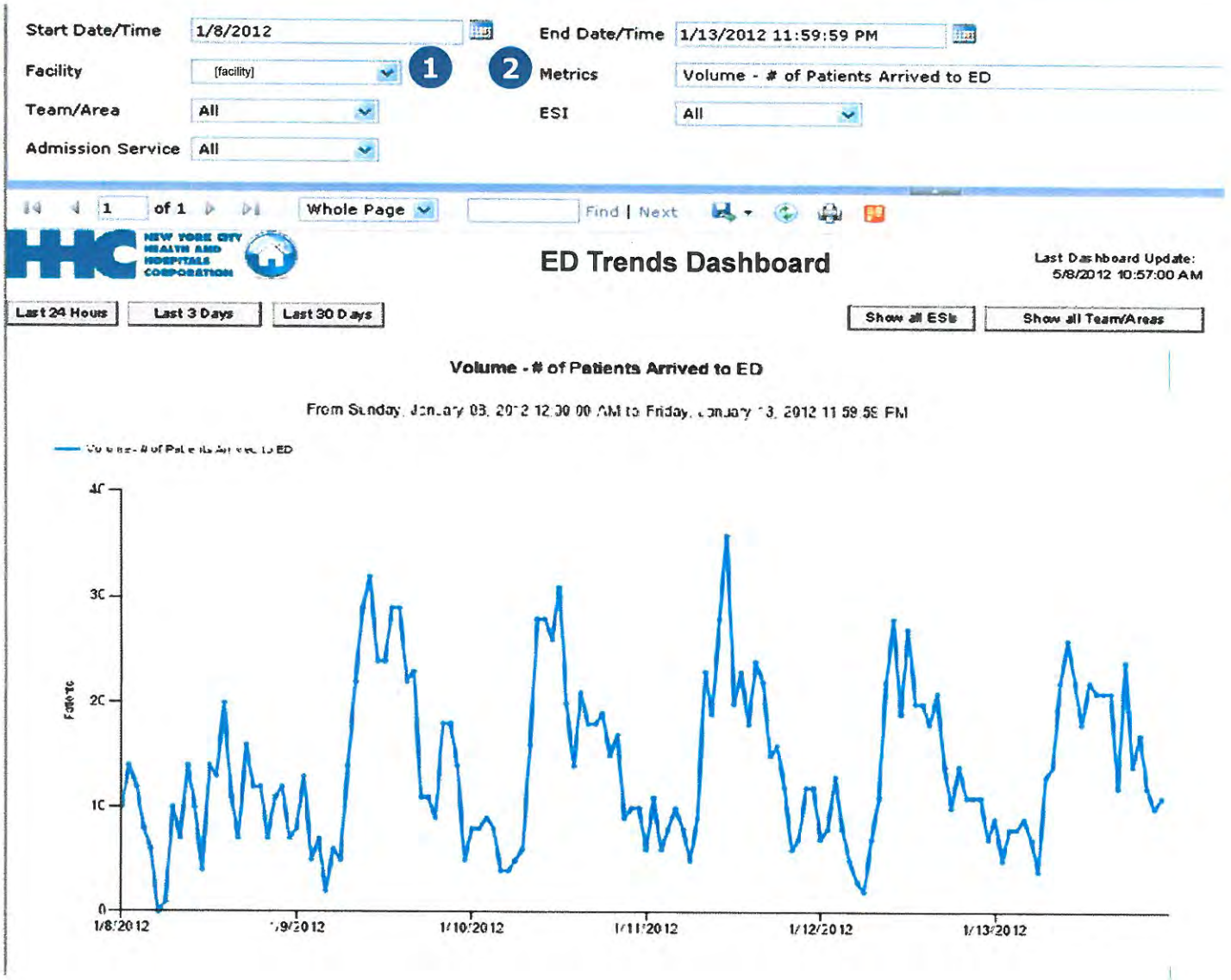
Done

The Volume and Throughput Metrics (By Facility) Dashboard displays one facility's monthly volume and throughput performance. Data is updated at midnight daily and a running total is calculated for the current month.

DRAFT

The ED Trends Dashboard displays historical trending data for the volume & throughput metrics

Clinical Information Systems



1. Users can select a wide range of volume and throughputs metrics to view trend data

2. Users have the ability to filter by facility, team/area, patient acuity (ESI), admission service and date/time range

Volume and Throughput Metrics (By Facility) Dashboard – Throughput Calculations

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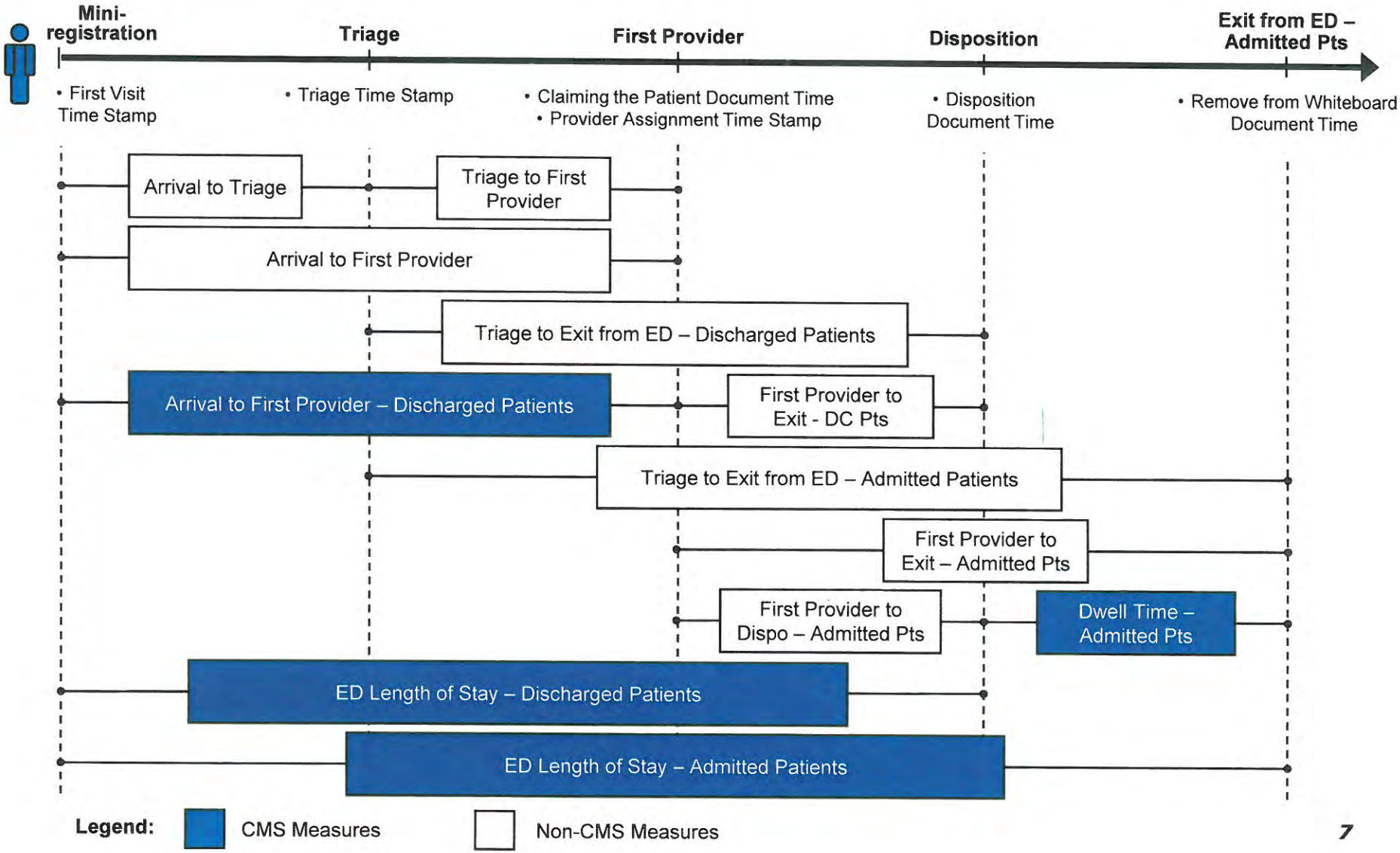
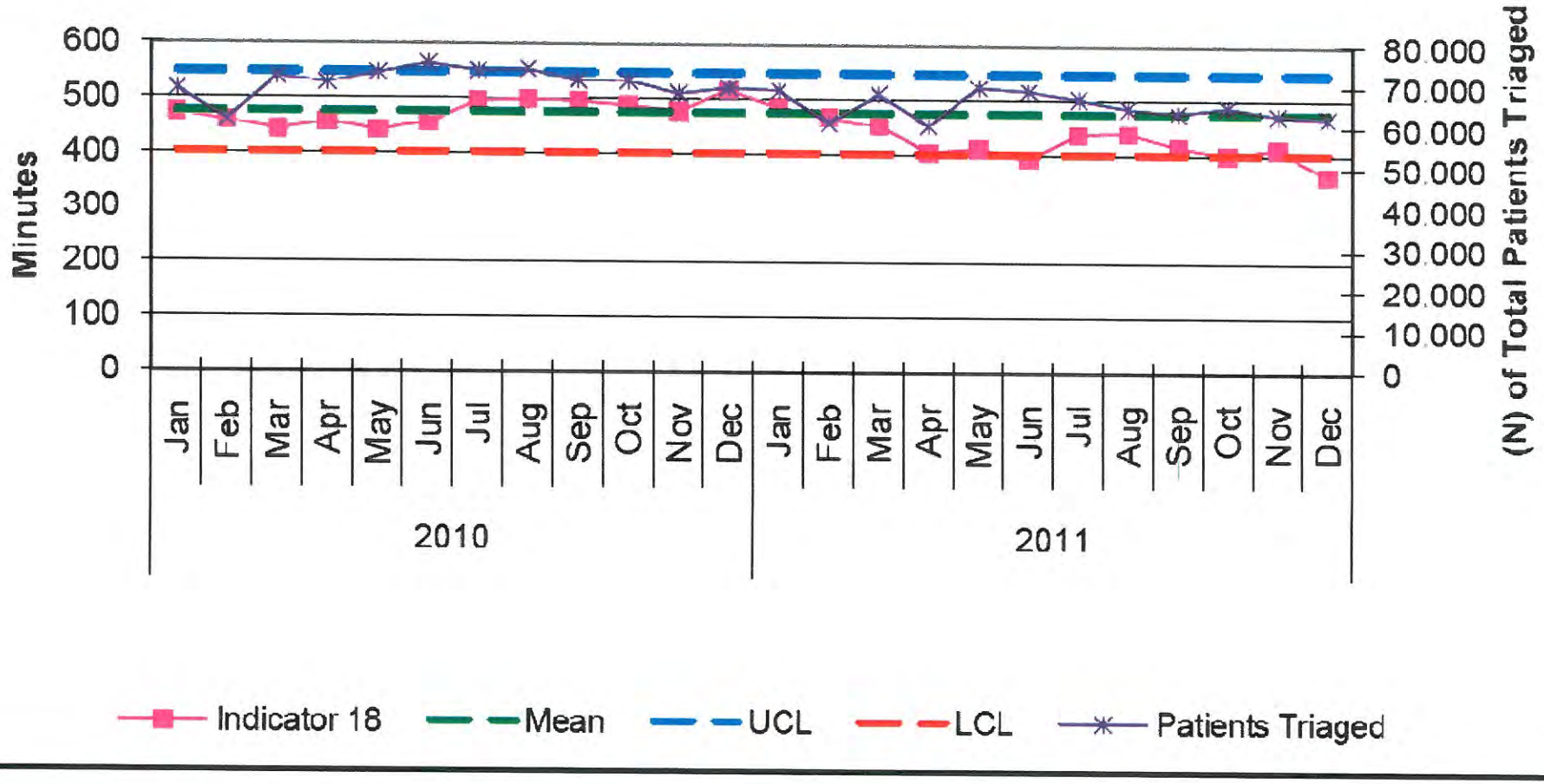
Clinical Information Systems



ED Indicator-Level Reports

Indicator 18: Median time from triage to exit from ED - admitted patients (min)

Jan 2010 to Dec 2011



NEW YORK CITY HEALTH AND HOSPITALS

ED Indicator-Level Reports

Indicator 17: Median time from triage to exit from ED - discharged patients (min)

Jan 2010 to Dec 2011