AGENDA

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE

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

BOARD OF DIRECTORS

CALL TO ORDER — **DR. CALAMIA**

ADOPTION OF MINUTES
June 11th, 2015

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

METROPLUS HEALTH PLAN — **MR. DIAMOND**

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

ACTION ITEM:

I. **Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to enter into multiple contracts to purchase health information related professional services for the Epic Electronic Medical Record program and Epic related Revenue Cycle modules as needed with 22 vendors (the "Contractors") through requirements contracts for a two year term with three one-year options to renew at the Corporation's exclusive option for an amount not to exceed $119,292,988 million for the initial two year period.** — **MR. GUIDO/ MS. SCHULTZ**

INFORMATION ITEM:

I. **Behavioral Health Update** — **DR. WILSON/ DR. BARRON**

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

MINUTES

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE BOARD OF DIRECTORS

Meeting Date: June 11, 2015

ATTENDEES

COMMITTEE MEMBERS

Vincent Calamia, MD, Committee Chair
Josephine Bolus, RN
Antonio Martin, Executive Vice President and Chief Operation Officer (representing Dr. Ram Raju in voting capacity)
Hillary Kunins, MD (representing Dr. Gary Belkin in a voting capacity)

HHC CENTRAL OFFICE STAFF:

Sharon Abbott, Assistant Director, Corporate Planning
Machelle Allen, MD, Deputy Chief Medical Officer, Office of Health Care Improvement
Maricar Barrameda, Assistant Vice President of EITS
Charles Barron, MD, Director of Psychiatry, Office of Behavioral Health
Janette Baxter, Senior Director, Risk Management
Jennifer Bender, Assistant Director, Communication and Marketing
Donna Benjamin, Restructuring Project Management Officer
Alice Berkowitz, Assistant Director, Corporate Budget
Nicholas Cagliuso, Sr., PhD, MPH, Assistant Vice President, Emergency Management
Deborah Cates, Chief of Staff, Board Affairs
Tammy Carlisle, Associate Executive Director, Corporate Planning
Nelson Conde, Senior Director, Affiliations and Professional Services
Paul Contino, Chief Technology Officer, EITS
Alfred Garofalo, Senior Director, EITS
Imah Jones, Senior Director, Research
Susan Kansagra, Assistant Vice President, Population Health
Mei Kong, Assistant Vice President, Patient Safety
Randall Mark, Chief of Staff, President Office
Marisa Salamone Gleason, Assistant Vice President, EITS
Kenra Ford, Assistant Vice President Clinical Lab Operations/M&PA
Sal Guido, Acting Chief Information Officer, EITS
Ian Michaels, Director, Communication and Marketing
Christina Jenkins, MD Senior Assistant Vice President, Quality & Performance Innovation
Lauren Johnston, Senior Assistant Vice President, Office of Patient Centered Care
John Jurenko, Senior Assistant Vice President, Intergovernmental Relations
Barbara Keller, Deputy Counsel, Legal Affairs
Susan Kansagra, Assistant Vice President, Population Health
Patricia Lockhart, Secretary to the Corporation
Ana Marengo, Senior Vice President, Communications & Marketing
Randall Mark, Chief of Staff, President Office
Ian Michaels, Media Director, Communication and Marketing
Jeff Morrow, Consultant, Enterprise Information Technology Systems
Darren Ng, Systems Analyst, Corporate Budget
Charlotte Nuehaus, Senior Management Consultant, Corporate Planning Services
Joseph Quinones, Senior Vice President, Operation
Salvatore Russo, Senior Vice President & General Counsel, Legal Affairs
Lynnette Sainbert, Assistant Director, Board Affairs

Jared Sender, Senior Director, Population Health EITS
David Shi, Senior Director, Medical and Professional Affairs
Eli Tarlow, EITS
Jay Weinman, Chief Finance Officer, Bellevue Hospital Center
Tony Williams, Director, Enterprise Information Technology System
Ross Wilson, Corporate Chief Medical Officer

FACILITY STAFF:
Steve Alexander, Executive Director, Bellevue Hospital Center
William Bateman, MD, Chief Medical Officer, Gouverneur
Chris Constantino, Senior Vice President, Queens Health Network
Lillian Diaz, Chief Nurse Executive, Metropolitan Hospital Center
Robert Hughes, Executive Director, Coler-Goldwater Specialty Hospital & Nursing Facility
Jasmin Moshirpur, Chief Medical Officer, Elmhurst Hospital Center
Nate Link, MD, Chief Medical Officer, Bellevue Hospital Center
Floyd Long, Chief Operating Officer, Coler-Goldwater specialty Hospital & Nursing Facility
John Maese, MD, Medical Director, Coney Island Hospital
Andreea Mera, Special Assistant to the President, MetroPlus Health Plan, Inc.
Anna Moran, Chief Financial Officer, Finance, Elmhurst Hospital Center
John T. Pellicone, Chief Medical Officer, Metropolitan Hospital Center
Arnold Saperstein, Executive Director, MetroPlus Health Plan, Inc.
Brian Stacey, Chief Financial Officer, Queens Hospital Center
Denise Soares, Senior Vice President, Generation + Network
Arthur Wagner, Senior Vice President, Southern Brooklyn/Staten Island Network

OTHERS PRESENT:
Scott Hill, Account Executive/Quadramed
James Cassidy, OMB
Kent Cherny, OMB
Morin Dolan, Senior Assistant Director, DC37
Denise Dudley, Director, Affiliation Administrator, NYU
Larry Garvey, Cerner
Scott Hill, Account Executive Quadramed
David N. Hoffman, Chief Compliance Officer, PAGNY
Seth Marine, Assistant Director/BHC Affiliation
Richard McIntyre, Cerner
Anthony Mirdita, Chief Financial Officer, PAGNY
Kristyn Raffaele, Analyst, OMB

MEDICAL AND PROFESSIONAL AFFAIRS/
INFORMATION TECHNOLOGY COMMITTEE
Thursday, June 11, 2015

Dr. Vincent Calamia, Chair of the Committee, called the meeting to order at 9:00 AM. The minutes of the May 14, 2015 Medical & Professional Affairs/IT Committee meeting were adopted.

CHIEF MEDICAL OFFICER REPORT

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

HHC's Accountable Care Organization (ACO)

In order to provide a more comprehensive picture of our patients and those providing care, our ACO is now disseminating daily care transitions reports built around real-time ADT data, linked to information such as # of prior hospital encounters, costs, chronic conditions, and programs in which the patient is engaged (e.g., Health Home, Collaborative Care), The broad goal of this report is to facilitate communication and coordination during transitions for ACO patients, as a means of learning more about how to define roles and manage handoffs among ED, inpatient, post-acute, community, and ambulatory care based services for all HHC patients.

After identifying an error by CMS in ACO population attribution, and after advocacy to regulatory leadership by Dr. Raju, the ACO received its 2015 Q1 attribution list with its full patient population properly restored. This correction restores thousands of our engaged patients to the ACO roster and reflects the growth of the ACO Medicare population through active patient engagement.

Now in the final year of its initial 3-year contract period, the HHC ACO has submitted a Notice of Intent to CMS to renew for 2016-2018, under the Medicare Shared Savings Program.

CMS Site Visit

HHC hosted a site visit from CMS for our CMMI grant to evaluate care management in the Emergency Departments of Elmhurst, Queens, Jacobi, Lincoln, Bellevue and Kings. We await the report of the survey, but our teams did well in demonstrating how they have operationalized the grant. Currently the project has on track for patient enrollment.

HHC Health Home

The HHC Health Home has seen tremendous growth since the beginning of FY2015. During the first 10 months of the year), the number of enrolled patients increased by 117% - from 1786 patients in July to 3883 patients in April. During that same time, the number of patients in outreach increased from 182 in July to 13,158 in April.

Much of the increase in outreach and enrollment numbers can be attributed to the growth of the HHC Health Home network. At the beginning of the fiscal year, Health Home services were only provided by Health Home teams based at HHC's 12 hospital facilities. Since then, contracts have been secured with 18 community based organizations to become downstream providers and perform Health Home services as part of the HHC Health Home. In addition, the HHC Health Home has also contracted with all 12 of the HHC ACT teams, who are providing Health Home services to their patients, in addition to ACT services. There are three additional community-based organizations who will be contracting with the HHC Health

Home once the transition to the new EHR is complete and it is expected that others will also join once that transition occurs.

DSRIP Update

Last week, NYS DOH announced 5-year valuations for Performing Provider Systems (PPSs) who will participate in the DSRIP program. OneCity Health, the HHC-led PPS, received a valuation of $1.2 billion to carry out eleven projects focused on improving the health and well-being of both Medicaid and uninsured populations. It is important to note that the payments are not guaranteed; the valuation represents a maximum potential payment in the case that OneCity Health successfully achieves all performance targets over program life.

DSRIP implementation planning has commenced at the borough hub-level and will continue through the summer months. In early meetings, partners are reintroduced to their community needs as detailed in assessments carried out in late 2014, and oriented to the patient's journey along the care continuum. Our engagements will become increasingly detailed over time and will culminate in a granular understanding of each partner's contribution to program efforts. We expect to use this information alongside a detailed assessment survey in order to enter partner contracting in 3Q, 2015.

CTSI- Clinical & Translational Science Institute

The 5-year HHC-NYU clinical translational science grant comes to a close on June 30th. HHC has reapplied with NYU for another 5-year grant. Six researchers that were awarded pilot funding this past year presented their project results in May. Thus far the 6 pilot projects have collectively generated 9 abstracts, presentations, publications and more are expected. A number of the interventions, including a text messaging program and patient empowerment program, are being assessed for scalability.

Emergency Management

We've received confirmation of the award of 3 of our 5 Ebola and special pathogen-related emergency management Federal grants. The first provides more than $6.5MM to HHC / Bellevue over five years for its role as a designated treatment center. Under the grant, HHC / Bellevue will purchase PPE for use in training; continue annual staff training focusing on healthcare worker safety when caring for an Ebola patient; plan and conduct an annual tabletop exercise for its isolation unit; and maintain and calibrate its point of care lab equipment. The second grant provides more than $67,000 to HHC / Bellevue in a single payment to begin the preparatory work for the installation of an autoclave unit that will provide cost savings for waste management throughout the facility. The third grant provides $820,000 to HHC Emergency Management over five years to bolster the Corporation-wide Ebola and special pathogen treatment and preparedness through the development of a Concept of Operations; purchase of lab equipment and PPE; development, implementation and maintenance of a Corporation-wide training and education initiative to ensure healthcare worker PPE competency; and developing and conducting annual HHC-wide Ebola and special pathogen exercises with frontline facilities and external partners such as NYC DOHMH, NYCEM, and FDNY*EMS.

As part of our HHC-wide coastal storm preparedness, we convened and hosted the first meeting of the Special Medical Needs Shelter (SMNS) workgroup that included participants from across HHC, city, state and federal partners to canvas the practical issues related to our operations of New York City's 8 SMNS during activations of the citywide Coastal Storm Plan. We're collaborating closely with NYCEM, DOE, and CUNY to schedule walkthroughs of each of the facilities and we'll convene our first internal SMNS Council meeting of this season on June 30th. The most pressing issue during SMNS activations remains the potential for Adult Care Facilities and Long Term Care Facilities to inappropriately evacuate their

patients to these facilities, thereby overwhelming them. We are in discussions with NYS DOH, as regulator, to take preventive actions, such as enforcing ACFs and LTCFs to develop and implement functional evacuation plans for their facilities to minimize the chances of this from occurring.

METROPLUS HEALTH PLAN, INC.

Arnold Saperstein, MD Executive Director, MetroPlus Health Plan Inc. Presented to the Committee. Dr. Saperstein informed the Committee that the total plan enrollment as of May 1, 2015 was 473,124. Breakdown of plan enrollment by line of business is as follows:

Medicaid	414,927
Child Health Plus	12,978
MetroPlus Gold	3,511
Partnership in Care (HIV/SNP)	4,759
Medicare	8,459
MLTC	872
QHP	26,919
SHOP	61
FIDA	98

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.

We have recently submitted the 2016 Qualified Health Plan (QHP) premium rates to New York State Department of Financial Services (DFS). We continually review the amounts we charge to manage our members' healthcare needs. We have taken significant cost-saving measures which resulted in decreased premiums for the majority of our products and minimized the increase for two of our SHOP plans in 2016. In 2015 MetroPlus offered some of the most affordable rates across many of the health insurance options available on the NY State of Health Marketplace.

The rate changes vary based on product (SHOP and Individual) and across the various metal levels. The proposed decreases range from -2% to -9% for Individual plans and from -1% to -5% for SHOP plans. The two SHOP plans with proposed increases range from 0.2% to 1%. While we try to provide members with the most accurate information possible, final rates may differ based on the benefit plan design and other features members choose on renewal. Also, the final, approved rate may differ as DFS may change the proposed rate. For members who enrolled through the NY State of Health and qualified for financial assistance, called an Advanced Premium Tax Credit (APTC), their current premium is less than the amount shown in the letter they received from us notifying them of a rate change. Their 2016 premium will also be less than shown in the letter they received if they qualify for the APTC again next year. NY State of Health will calculate their eligibility for financial assistance each year. Currently, approximately 84% of MetroPlus Marketplace members qualify for an APTC.

In addition, as a result of the ACA legislation and market pressures, we are realigning our Medicare offerings for 2016. We are consolidating two Medicare Dual-eligible SNPs (Select into Advantage). The members will see no change in the services they are provided. The plan will benefit from some operational efficiencies as well as see a reduction in overall cost (shifting some cost from the Plan to New York State Fee-for-Service). We are also closing our PIC (Partnership-in-Care) product. With rising premiums, PIC enrollment has fallen to approximately 50 enrollees. These enrollees are being encouraged to enroll in either our Advantage or Platinum products depending on their Medicaid status. The HIV+ members will

see a decrease in their monthly premiums while getting the same services and physician network. We have also restructured our pharmacy network to reduce plan costs, something many competitors have already done.

Going forward, we have put together a workgroup to improve the Plan's overall Medicare Star ratings. Increasing our ratings from the current 3.5 to 4.0 would mean an increase in revenue by 5%, allowing us much more flexibility in providing competitive benefits.

MetroPlus is preparing for the Contract Management Team Operations (CMTO) FIDA Plan Onsite Review on June 4th where a team comprised of both NYSDOH and CMS representatives will be looking for MetroPlus to present on operational items such as Call Center systems review, Network Management, Care Management onboarding process, and Marketing.

The HARP On-Site Review date is scheduled for June 22nd and June 23rd. We will be the first Plan to be reviewed.

Chief Information Officer Report

Sal Guido, Acting Corporate Chief Information Officer, Enterprise Information Technology Services provide the committee members with several key updates: the Epic Electronic Medical Record (EMR) Strategy Session that took place on May 15th and 16th, a status on Meaningful Use (MU) and Eligible Professionals (EP) and an update on HHC's migration to the Exchange email system.

Epic Electronic Medical Record (EMR) Strategy Session – Friday May 15th and Saturday May 16th:

On Friday and Saturday, May 15th and 16th, an Epic EMR Strategy Session was held with members from HHC EITS Leadership, the Clinovations Implementation team, HHC President Dr. Ram Raju, COO and Executive Vice President Antonio Martin, Chief Medical Officer Dr. Ross Wilson and Chief Financial Officer and Senior Vice President Marlene Zurack, representatives from the Mayor's Office and four (4) CIOs from New York University Medical Center, Mount Sinai Health System, University of California at Los Angeles (UCLA) and Massachusetts General, all whom have completed large Epic installations. The goal of this two (2) day strategy session was to share HHC's Epic EMR journey from procurement to design and implementation planning as well as to hear first-hand about the work, approaches and best practices from the four (4) Medical Center CIOs who have already gone live with Epic.

The entire group was very much engaged over the two (2) days with individuals providing relevant feedback and sharing experiences with an Epic go-live event. Program risks such as Enterprise Master Patient Index (EMPI), lab, procurements, the Soarian integration as well as other third party integrations were reviewed and discussed by the entire team. Areas of concern, consideration and opportunity were noted and recorded for further work. Ideas were also shared on how to approach certain upcoming project millstones as well as how to create strategies to sustain the Epic product.

The following day these areas of concern and opportunity were consolidated and prioritized. A brainstorming session followed with all parties providing input to planning, risk mitigation and strategic approaches to enable programs that Epic will be dependent on. Certain potential roadblocks were highlighted and noted to be tracked. All agreed that the time spent was mutually beneficial and that these seasons should continue periodically. Further sessions will be scheduled in the future.

I will continue to have on-going dialogues with all four (4) CIOs who participated and engage them for their advice on strategies and best practices as we approach our Epic implementation. I will also keep the

M&PA/IT Committee as well as Leadership and the IT Executive Governance committee members informed and updated as we continue our progress.

Meaningful Use (MU) and Eligible Professional (EP) Update:

QCPR v6.1 Upgrade:

On May 27th, Harlem Hospital successfully completed its upgrade to QCPR v6.1. In less than five hours downtime, the Generations+ QCPR team led by Sima Bruk took the system down, performed the upgrade and brought the system back up making it available for all users. This upgrade also included Meaningful Use Eligible Professionals and ICD10 database enhancements.

New Meaningful Use (MU) Proposed Rule:

On April 10, 2015, CMS released a proposed rule to align Meaningful Use (MU) Stages 1 and 2 objectives with the long term goals proposed for Stage 3 Eligible Hospitals (EH) and Professionals (EP). If passed, new providers demonstrating meaningful use for the first time would immediately attest to Stage 2 objectives in 2015. In addition, the proposed rule would shorten the reporting measurement period to any ninety (90) consecutive days in 2015. This rule would also remove objectives that were topped off, duplicative or redundant.

HHC will remain in Stage 2 for the EH EMR incentive program for its 4th and 5th year in 2015 and 2016 respectively. Changing the measurement period to calendar year, HHC would benefit from the extended deadline of December 31st.The reduction in the overall number of objectives from 19 to 9 offers no significant benefit as HHC facilities have already exceeded the CMS thresholds by far except for Measure C6 – Patient Portal. This measure is retained under the proposed rule and will continue to be challenging for HHC.

For Eligible Professionals (EP) in its 1st year, HHC providers will attest directly to Modified Stage 2, skipping Stage 1 altogether. However, starting on January 1, 2016, HHC will attest to its full year of Stage 2 with additional required objectives, such as, secured messaging technology as a form of communication between providers and their patients. The technology is not available to HHC at this time. This measure will transform HHC's workflow, both clinically and operationally. Other MU objectives, to mention a few, which will be required in 2016 include public health reporting, registries, medication reconciliation and transition of care.

There are approximately 3043 eligible providers identified by Finance based on CMS eligibility criteria. Ongoing pre-validation of eligibility with the State Department of Health continues so to avoid future audits. So far, 641 HHC providers have been identified and HHC anticipates receiving its first payment of $21,250 for each in 2015 for a total of over $13.6M. Overall, the estimated return of Eligible Professionals EHR incentive program over five (5) years is $180M. These EPs must be "meaningful users" to avoid a Medicare reduction payment of up to 5%. The New York State Department of Health has also extended the enrollment deadline by another 15 days to Monday, June 15th.
Our EITS/QCPR Team remains fully committed to work collaboratively with the business in meeting these regulatory requirements. We will continue to provide ongoing reports to this committee on our progress.

HHC's Exchange Email System Migration:

The Enterprise Infrastructure team has been working over the past year on planning the migration of the HHC workforce from the current Novell GroupWise email system to Microsoft's Exchange system, establishing one single email system for the entire Corporation.

This migration will allow for HHC to have a more advanced and feature rich email system which will be able to easily integrate with other applications allowing our users to interact in new ways including instant messaging, mobile applications, integrated, and video conferencing. A new email archive system will also be available to users, allowing them to more seamlessly archive email and view both active and archived emails side by side all within the same application. Users will no longer require the use of separate folders, outside applications or cumbersome steps to reference or search for historical emails.

Final pilots are underway with select small groups of EITS staff to test how the new email system works. The plan is to move approximately 1500 users per week beginning with Central Office staff in May, followed by the North Bronx and Queens Networks in June, North, Central and South Brooklyn networks in July and Lincoln/Harlem and South Manhattan completing their migration in August.

Both on-site and on-line training is planned for all staff. Roadshows for each of the networks and facilities are being finalized as well as are a series of on-going communications to continuously alert and update staff as to our progress.

ACTION ITEMS:

Ross Wilson, MD, Senior Vice President/Corporate Chief Medical Officer, Antonio Martin, Executive Vice President and Chief Operation Officer, and Marlene Zurack, Senior Vice President/Chief Finance Officer presented to committee on the following resolutions.

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and execute a Physician Services Agreement with New York University School of Medicine ("NYUSOM") for the provision of General Care and Behavioral Health Services at Bellevue Hospital Center ("Bellevue"), Gouverneur Healthcare Services ("Gouverneur"), Coler Rehabilitation and Nursing Care Center ("Coler"), Henry J. Carter Specialty Hospital and Nursing Facility ("Carter"), Woodhull Medical and Mental Health Center ("Woodhull"), and Cumberland Diagnostic and Treatment Center ("Cumberland") for a period of five years, commencing July 1, 2015 and terminating on June 30, 2020, for an amount not to exceed $1,688,679,033; 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, calculated on an annual basis, in any fiscal year to NYUSOM that exceed twenty-five percent (25%) of the not to exceed amount specified in this resolution.

Resolution was approved by the board.

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and execute a Physician Services Agreement with the Icahn School of Medicine at Mount Sinai ('Sinai") for the provision of General Care and Behavioral Health Services at Elmhurst Hospital Center ("Elmhurst") and Queens Hospital Center ("Queens") for a period of five years, commencing July 1, 2015 and terminating on June 30, 2020, for an amount not to exceed $1,150,620,692; 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, calculated on an annual basis, in any fiscal year to Sinai that exceed twenty-five percent (25%) of the not to exceed amount specified in this resolution.

Resolution was approved by the board.

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and execute a Physician Services Agreement with the Physician Affiliate Group of New York, P.C. ("PAGNY") for the provision of General Care and Behavioral Health Services at Lincoln Medical and Mental Health Center ("Lincoln"), Morrisania Diagnostic and Treatment Center ("Morrisania"), Segundo Ruiz Belvis Diagnostic and Treatment Center ("Belvis"), Jacobi Medical Center ("JMC"), North Central Bronx Hospital ("NCB"), Harlem Hospital Center ("Harlem"), Renaissance Health Care Network Diagnostic and Treatment Center ("Renaissance"), Metropolitan Hospital Center ("Metropolitan"), Coney Island Hospital ("CIH"), and Kings County Hospital Center ("KCHC") for a period of five years, commencing July 1, 2015 and terminating on June 30, 2020, for an amount not to exceed $2,562,175,665; 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, calculated on an annual basis, in any fiscal year to PAGNY that exceed twenty-five percent (25%) of the not to exceed amount specified in this resolution.

Resolution was approved by the board.

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

MetroPlus Health Plan, Inc.
Report to the
HHC Medical and Professional Affairs Committee
July 9, 2015

Total plan enrollment as of June 1, 2015 was 473,905. Breakdown of plan enrollment by line of business is as follows:

Medicaid	415,887
Child Health Plus	13,309
MetroPlus Gold	3,526
Partnership in Care (HIV/SNP)	4,738
Medicare	8,446
MLTC	893
QHP	26,403
SHOP	601
FIDA	102

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.

NYS Department of Financial Services is continuing to review the 2016 Qualified Health Plan Rates we submitted in May. An answer is expected to be released in the first week of July.

New York Health Plan Alliance released a summary of the most common reasons for discrepancies between issuers (insurers), eMedNY (State enrollment database) and NYSoH (which contribute to member dissatisfaction and therefore potential disenrollment). MetroPlus is facing the same issues as the other participants, namely late renewals, the State's failure to process 834s, renewal date not available to plans, duplicate accounts, or the State's failure to submit effectuations.

The MetroPlus Quality Management department is working diligently to collect and submit the 2014 Medicare Star rating data. We predict our score to be the same as the past two years (3.5 stars).

In a previous report to this Committee I mentioned that our growth strategy includes expansion of our network into Staten Island. We have had discussions with the two hospitals in Staten Island – Staten Island University Hospital (SIUH) and Richmond University Medical Center (RUMC). We expect to finalize rates with RUMC this week. SIUH is more challenging due to its being part of the overall North Shore LIJ network. We are primarily targeting PCPs and high volume specialties. In addition, after mailing over 1,000 letters to Staten Island providers, we have almost 150 in the credentialing/contracting pipeline. SIUH Physicians and RUMC physician group (Amboy Medical PC) will both be contracted at the same time as the hospital agreements. This will provide over 500 physicians for the network. We also have a relationship with Advantage Care physicians through the Preferred Health Partners group in Brooklyn. They offer two sites in Staten Island with approximately 120 providers who are willing to contract. Pharmacy, Dental and Behavioral Health/Substance Abuse providers are all being addressed through our delegated vendors. We already meet network requirements for Staten Island in these areas.

As of the date of this report, we are undergoing the Onsite BH/HARP Readiness Review. The components of the onsite review are Program Operations (clinical program structure, clinical interviews with Utilization Management and Case Management staff, members services structure and protocols), Information Systems (claims, data warehouse, clinical and telephonic systems), and Document Review (sample of executed provider

contracts and corresponding credentialing files, as well as resumes of plan staff participating in interviews). I will provide information about the outcome at the next meeting.

Since I have mentioned the HARP Readiness Review, I will inform you that MetroPlus is also scheduled to undergo the Article 44 Audit at the end of September 2015.

In looking at state-wide data on the Fully-Integrated Dual Advantage (FIDA) program, total enrollment in NYS as of June 2, 2015 was 4,407. There were 47,702 opt-outs. The passive enrollment schedule will enroll 3,908 individuals in July (effectuated June 1, 2015), and 5,584 in August (effectuated July 1, 2015) across the State. In addition, I would like to bring to this committee's attention that the three-way contract requires plans to move the provider payment agreements from fee-for-service to alternative payment arrangements. We are required to submit proposals for DOH review and approval by August 15, 2015.

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

June-2015

		Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Total Members	Prior Month	468,175	471,370	462,248	464,151	468,678	470,300	474,232
	New Member	19,430	26,663	17,483	23,079	18,711	19,222	18,151
	Voluntary Disenroll	1,695	1,984	1,871	1,609	1,509	1,392	1,539
	Involuntary Disenroll	14,540	33,801	13,709	16,943	15,580	13,898	16,939
	Adjusted	143	169	146	-307	441	1,424	0
	Net Change	3,195	-9,122	1,903	4,527	1,622	3,932	-327
	Current Month	471,370	462,248	464,151	468,678	470,300	474,232	473,905
Medicaid	Prior Month	396,612	403,854	409,131	410,095	411,938	413,066	416,328
	New Member	17,477	20,635	14,292	17,627	16,119	17,017	16,348
	Voluntary Disenroll	1,409	1,101	1,312	1,153	1,173	1,111	1,295
	Involuntary Disenroll	8,826	14,257	12,016	14,631	13,818	12,644	15,494
	Adjusted	137	161	135	-325	421	1,350	0
	Net Change	7,242	5,277	964	1,843	1,128	3,262	-441
	Current Month	403,854	409,131	410,095	411,938	413,066	416,328	415,887
Child Health Plus	Prior Month	12,198	12,303	12,166	12,156	12,376	12,641	12,998
	New Member	710	849	557	854	650	678	641
	Voluntary Disenroll	99	525	154	249	59	13	22
	Involuntary Disenroll	506	461	413	385	326	308	308
	Adjusted	5	1	2	7	11	20	0
	Net Change	105	-137	-10	220	265	357	311
	Current Month	12,303	12,166	12,156	12,376	12,641	12,998	13,309
Family Health Plus	Prior Month	5,892	3,533	0	0	0	0	0
	New Member	12	0	0	0	0	0	0
	Voluntary Disenroll	25	16	0	0	0	0	0
	Involuntary Disenroll	2,346	3,517	0	0	0	0	0
	Adjusted	-4	0	0	0	0	0	0
	Net Change	-2,359	-3,533	0	0	0	0	0
	Current Month	3,533	0	0	0	0	0	0

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

June-2015

		Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
HHC	Prior Month	3,461	3,474	3,631	3,464	3,512	3,556	3,548
	New Member	60	197	27	63	59	31	1
	Voluntary Disenroll	0	0	170	0	0	0	0
	Involuntary Disenroll	47	40	24	15	15	39	23
	Adjusted	6	6	6	7	12	41	0
	Net Change	13	157	-167	48	44	-8	-22
	Current Month	3,474	3,631	3,464	3,512	3,556	3,548	3,526
SNP	Prior Month	4,955	4,935	4,890	4,832	4,791	4,770	4,769
	New Member	61	42	57	39	52	66	47
	Voluntary Disenroll	29	29	47	26	32	16	31
	Involuntary Disenroll	52	58	68	54	41	51	47
	Adjusted	-1	-1	-1	-1	-2	10	0
	Net Change	-20	-45	-58	-41	-21	-1	-31
	Current Month	4,935	4,890	4,832	4,791	4,770	4,769	4,738
Medicare	Prior Month	8,466	8,537	8,560	8,591	8,601	8,493	8,459
	New Member	291	443	296	281	316	316	284
	Voluntary Disenroll	133	313	187	180	229	242	191
	Involuntary Disenroll	87	107	78	91	195	108	106
	Adjusted	1	2	2	2	3	0	0
	Net Change	71	23	31	10	-108	-34	-13
	Current Month	8,537	8,560	8,591	8,601	8,493	8,459	8,446
Managed Long Term Care	Prior Month	775	806	806	820	882	866	879
	New Member	55	37	41	81	50	61	66
	Voluntary Disenroll	0	0	0	0	16	10	0
	Involuntary Disenroll	24	37	27	19	50	38	52
	Adjusted	0	0	0	1	-3	7	0
	Net Change	31	0	14	62	-16	13	14
	Current Month	806	806	820	882	866	879	893

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

June-2015

		Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
QHP	Prior Month	35,093	33,177	22,365	23,552	25,952	26,244	26,553
	New Member	719	4,422	2,185	4,108	1,400	1,003	746
	Voluntary Disenroll	0	0	0	0	0	0	0
	Involuntary Disenroll	2,635	15,234	998	1,708	1,108	694	896
	Adjusted	0	-1	-1	-1	-3	-4	0
	Net Change	-1,916	-10,812	1,187	2,400	292	309	-150
	Current Month	33,177	22,365	23,552	25,952	26,244	26,553	26,403
SHOP	Prior Month	723	751	695	628	610	607	604
	New Member	45	34	19	21	24	12	6
	Voluntary Disenroll	0	0	1	0	0	0	0
	Involuntary Disenroll	17	90	85	39	27	15	9
	Adjusted	-1	1	3	3	3	3	0
	Net Change	28	-56	-67	-18	-3	-3	-3
	Current Month	751	695	628	610	607	604	601
FIDA	Prior Month	0	0	4	13	16	57	94
	New Member	0	4	9	5	41	38	12
	Voluntary Disenroll	0	0	0	1	0	0	0
	Involuntary Disenroll	0	0	0	1	0	1	4
	Adjusted	0	0	0	0	-1	-3	0
	Net Change	0	4	9	3	41	37	8
	Current Month	0	4	13	16	57	94	102

Management Indicator Report # 1

For Enrollment Month 201506

Indicator #1A for Enrollment Month: June 2015

Disenrollments To Other Plans

		Enrollment Mont			Twelve Months Period		
		FHP	MCAD	Total	FHP	MCAD	Total
	INVOLUNTARY		30	30	16	425	441
	VOLUNTARY		46	46	23	546	569
Affinity Health Plan	**TOTAL**		**76**	**76**	**39**	**971**	**1010**
	INVOLUNTARY		62	62	20	796	816
	VOLUNTARY		82	82	13	932	945
Amerigroup/Health Plus/CarePlus	**TOTAL**		**144**	**144**	**33**	**1728**	**1761**
	INVOLUNTARY		205	205	42	2249	2291
	VOLUNTARY		337	337	74	3257	3331
Fidelis Care	**TOTAL**		**542**	**542**	**116**	**5506**	**5622**
	INVOLUNTARY		298	298	56	3667	3723
	VOLUNTARY		583	583	87	6071	6158
Health First	**TOTAL**		**881**	**881**	**143**	**9738**	**9881**
	INVOLUNTARY		40	40	1	353	354
	VOLUNTARY		36	36	8	352	360
HIP/NYC	**TOTAL**		**76**	**76**	**9**	**705**	**714**
	INVOLUNTARY		57	57	19	703	722
	VOLUNTARY		61	61	6	488	494
United Healthcare of NY	**TOTAL**		**118**	**118**	**25**	**1191**	**1216**
	INVOLUNTARY		36	36	14	452	466
	VOLUNTARY		23	23	9	191	200
Wellcare of NY	**TOTAL**		**59**	**59**	**23**	**643**	**666**
	INVOLUNTARY		827	827	191	9286	9477
	VOLUNTARY		1176	1176	235	11954	12189
Disenrolled Plan Transfers	**TOTAL**		**2003**	**2003**	**426**	**21240**	**21666**
	INVOLUNTARY		41	41	22	712	734
	VOLUNTARY		69	69	3	634	637
Disenrolled Unknown Plan Transfers:	**TOTAL**		**110**	**110**	**25**	**1346**	**1371**
	INVOLUNTARY		14530	14530	5859	138176	144035
	UNKNOWN		7	7	113	388	501
	VOLUNTARY		28	28	13	1386	1399
Non-Transfer Disenroll Total:	**TOTAL**		**14565**	**14565**	**5985**	**139950**	**145935**
	INVOLUNTARY		15398	15398	6072	148174	154246
	UNKNOWN		7	7	140	396	536
	VOLUNTARY		1273	1273	251	13974	14225
Total MetroPlus Disenrollment:	**TOTAL**		**16678**	**16678**	**6463**	**162544**	**169007**

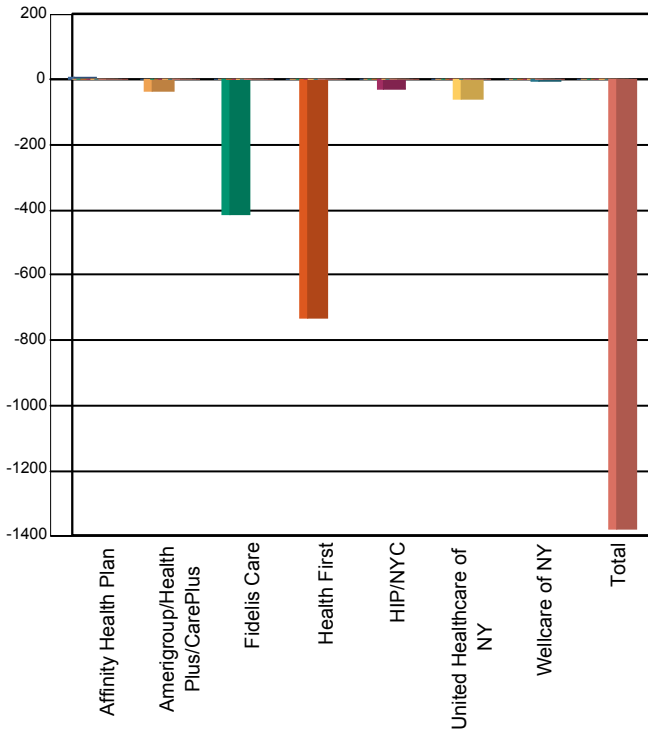
New MetroPlus Members Disenrolled From Other Plans

	FHP	MCAD	Total	Y FHP	Y MCAD	Y Total
Affinity Health Plan		82	82	14	1,021	1,035
Amerigroup/Health Plus/CarePlus		106	106	16	1,359	1,375
Fidelis Care		129	129	23	1,358	1,381
Health First		148	148	17	1,632	1,649
HIP/NYC		44	44	2	539	541
United Healthcare of NY		56	56		653	653
Wellcare of NY		56	56	8	608	616
Total		621	621	80	7,170	7,250
Unknown/Other (not in total)		3,372	3,372	54	51,915	51,969

Net Difference

	Enrollment Month			Twelve Months Period		
	FHP	MCAD	Total	FHP	MCAD	Total
Affinity Health Plan		6	6	-25	50	25
Amerigroup/Health Plus/CarePlus		-38	-38	-17	-369	-386
Fidelis Care		-413	-413	-93	-4,148	-4,241
Health First		-733	-733	-126	-8,106	-8,232
HIP/NYC		-32	-32	-7	-166	-173
United Healthcare of NY		-62	-62		-538	-563
Wellcare of NY		-3	-3	-15	-35	-50
Total		-1,382	-1,382	-346	-14,070	-14,416

Enroll Month Net Transfers (Known)



Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 06/14/2015

Other Plan Name	Category	2014_07		2014_08		2014_09		2014_10		2014_11		2014_12		2015_01		2015_0	2015_0	2015_0	2015_0	2015_0	TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	MCAD	MCAD	MCAD	MCAD	MCAD	
AETNA	INVOLUNTARY	1	6	0	7	0	8	1	4	0	5	0	7	1	7	10	5	8	10	19	99
	VOLUNTARY	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
	TOTAL	1	6	0	7	0	8	1	4	0	5	0	7	1	7	10	5	8	10	20	100
Affinity Health Plan	INVOLUNTARY	5	91	3	20	1	23	3	24	0	37	2	23	2	36	35	44	25	37	30	441
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	3
	VOLUNTARY	0	0	7	52	6	94	6	53	3	62	0	43	1	45	36	49	35	31	46	569
	TOTAL	5	91	10	72	7	117	9	77	3	99	2	66	6	81	71	93	60	68	76	1,013
Amerigroup/ Health Plus/CarePlus	INVOLUNTARY	6	129	0	45	0	54	1	54	5	55	4	57	4	73	51	60	56	100	62	816
	UNKNOWN	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	3
	VOLUNTARY	0	1	5	80	2	115	0	67	1	97	3	94	2	65	79	72	100	80	82	945
	TOTAL	6	131	5	125	2	169	1	121	6	152	7	151	7	138	130	132	156	181	144	1,764
BC/BS OF MNE	INVOLUNTARY	1	9	1	12	0	21	1	10	3	18	3	13	1	28	17	68	26	30	41	303
	VOLUNTARY	0	0	0	0	0	0	0	0	0	1	0	2	0	4	0	1	2	0	0	10
	TOTAL	1	9	1	12	0	21	1	10	3	19	3	15	1	32	17	69	28	30	41	313
CIGNA	INVOLUNTARY	0	1	1	4	0	0	0	0	0	5	0	0	0	3	4	5	1	2	12	38
	VOLUNTARY	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	TOTAL	0	1	1	4	0	1	0	0	0	5	0	0	0	3	4	5	1	2	12	39
Fidelis Care	INVOLUNTARY	20	395	5	134	3	150	4	160	1	172	2	137	7	229	129	182	178	178	205	2,291
	UNKNOWN	0	0	0	0	0	0	0	0	2	0	1	0	1	0	0	1	0	0	0	5
	VOLUNTARY	0	0	10	315	22	404	16	298	11	335	7	341	8	279	202	258	242	246	337	3,331

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 06/14/2015

		2014_07		2014_08		2014_09		2014_10		2014_11		2014_12		2015_01		2015_0	2015_0	2015_0	2015_0	2015_0	TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	MCAD	MCAD	MCAD	MCAD	MCAD	
Fidelis Care	TOTAL	20	395	15	449	25	554	20	458	14	507	10	478	16	508	331	441	420	424	542	5,627
GROUP HEALTH INC.	INVOLUNTARY	0	7	0	3	1	5	0	3	0	6	0	4	0	6	8	3	10	2	6	64
	VOLUNTARY	0	0	0	0	0	2	0	0	0	0	0	0	0	0	1	2	1	0	0	6
	TOTAL	0	7	0	3	1	7	0	3	0	6	0	4	0	6	9	5	11	2	6	70
Health First	INVOLUNTARY	26	657	1	178	5	195	6	240	5	274	7	218	6	366	297	323	282	339	298	3,723
	UNKNOWN	0	0	1	0	0	1	2	1	2	1	1	0	0	0	0	0	2	0	0	11
	VOLUNTARY	0	0	25	521	18	732	18	523	12	560	10	647	4	511	362	549	529	554	583	6,158
	TOTAL	26	657	27	699	23	928	26	764	19	835	18	865	10	877	659	872	813	893	881	9,892
HEALTH INS PLAN OF GREATER NY	INVOLUNTARY	0	3	0	3	0	1	0	4	1	7	0	2	0	4	2	7	2	3	4	43
	VOLUNTARY	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	2
	TOTAL	0	3	0	3	0	1	0	5	1	7	0	2	0	4	2	7	2	3	5	45
HIP/NYC	INVOLUNTARY	1	71	0	18	0	20	0	28	0	26	0	24	0	39	21	20	20	26	40	354
	UNKNOWN	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	VOLUNTARY	0	0	1	33	2	37	2	38	1	33	1	28	1	35	24	33	20	35	36	360
	TOTAL	1	71	1	51	3	57	2	66	1	59	1	52	1	74	45	53	40	61	76	715
OXFORD INSURANCE CO.	INVOLUNTARY	1	1	1	3	0	7	0	3	1	5	0	2	0	3	3	6	2	7	11	56
	VOLUNTARY	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	2
	TOTAL	1	1	1	3	0	7	0	3	1	5	0	2	0	4	4	6	2	7	11	58
UNION LOC. 1199	INVOLUNTARY	1	8	0	4	1	1	0	3	2	4	0	2	0	5	5	3	9	7	6	61
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 06/14/2015

		2014_07		2014_08		2014_09		2014_10		2014_11		2014_12		2015_01		2015_0	2015_0	2015_0	2015_0	2015_0	TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	MCAD	MCAD	MCAD	MCAD	MCAD	
UNION LOC. 1199	VOLUNTARY	0	0	1	14	8	23	5	7	1	9	0	5	0	14	3	1	7	6	6	110
	TOTAL	1	8	1	18	9	24	5	10	3	13	0	7	1	19	8	4	16	13	12	172
United Healthcare of NY	INVOLUNTARY	6	70	0	40	1	47	0	61	4	50	2	57	6	81	53	67	56	64	57	722
	UNKNOWN	0	0	1	0	0	0	1	0	1	0	3	0	0	0	0	0	0	0	0	6
	VOLUNTARY	0	0	2	39	1	63	3	38	0	32	0	60	0	45	27	41	37	45	61	494
	TOTAL	6	70	3	79	2	110	4	99	5	82	5	117	6	126	80	108	93	109	118	1,222
Wellcare of NY	INVOLUNTARY	9	42	1	10	0	28	1	36	0	56	2	33	1	38	25	35	51	62	36	466
	UNKNOWN	2	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	4
	VOLUNTARY	0	0	0	26	3	21	5	14	1	13	0	14	0	12	15	20	17	16	23	200
	TOTAL	11	42	1	36	3	49	6	50	1	69	3	47	2	50	40	55	68	78	59	670
Disenrolled Plan Transfers	INVOLUNTARY	77	1,490	13	481	12	560	17	630	22	720	22	579	28	918	660	828	726	867	827	9,477
	UNKNOWN	2	1	2	0	1	1	3	1	5	1	6	0	7	0	0	1	2	1	0	34
	VOLUNTARY	0	1	51	1,080	62	1,492	55	1,039	30	1,142	21	1,234	16	1,011	750	1,026	990	1,013	1,176	12,189
	TOTAL	79	1,492	66	1,561	75	2,053	75	1,670	57	1,863	49	1,813	51	1,929	1,410	1,855	1,718	1,881	2,003	21,700
Disenrolled Unknown Plan Transfers	INVOLUNTARY	5	134	1	35	1	60	4	40	6	67	3	45	2	51	64	75	48	52	41	734
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
	VOLUNTARY	0	19	1	42	0	51	2	78	0	67	0	48	0	39	39	61	67	54	69	637
	TOTAL	5	153	2	77	1	111	6	118	6	134	4	93	2	90	103	136	115	106	110	1,372
Non-Transfer Disenroll	INVOLUNTARY	850	10,494	799	10,900	778	9,864	1,061	10,869	1,286	10,311	365	8,162	720	13,253	11,238	13,698	13,043	11,814	14,530	144,035
	UNKNOWN	29	22	34	45	10	47	1	55	19	41	7	40	13	30	40	29	24	8	7	501

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 06/14/2015

		2014_07		2014_08		2014_09		2014_10		2014_11		2014_12		2015_01		2015_0	2015_0	2015_0	2015_0	2015_0	TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	MCAD	MCAD	MCAD	MCAD	MCAD	
Non-Transfer Disenroll Total	VOLUNTARY	0	107	1	90	3	78	1	81	4	76	4	126	0	51	523	66	116	44	28	1,399
	TOTAL	879	10,623	834	11,035	791	9,989	1,063	11,005	1,309	10,428	376	8,328	733	13,334	11,801	13,793	13,183	11,866	14,565	145,935
Total MetroPlus Disenrollment	INVOLUNTARY	932	12,118	813	11,416	791	10,484	1,082	11,539	1,314	11,098	390	8,786	750	14,222	11,962	14,601	13,817	12,733	15,398	154,246
	UNKNOWN	31	23	36	45	11	48	4	56	24	42	14	40	20	30	40	30	26	9	7	536
	VOLUNTARY	0	127	53	1,212	65	1,621	58	1,198	34	1,285	25	1,408	16	1,101	1,312	1,153	1,173	1,111	1,273	14,225
	TOTAL	963	12,268	902	12,673	867	12,153	1,144	12,793	1,372	12,425	429	10,234	786	15,353	13,314	15,784	15,016	13,853	16,678	169,007

MetroPlus Health Plan

New Member Transfer From Other Plans

	2014_07		2014_08		2014_09		2014_10		2014_11		2014_12		2015	2015	2015	2015	2015	2015	TOTAL
	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	MCAD	MCAD	MCAD	MCAD	MCAD	MCAD	
AETNA	0	3	0	8	0	6	0	7	1	9	0	8	7	1	1	11	5	7	74
Affinity Health Plan	1	88	3	95	5	101	2	86	1	87	2	118	63	68	76	63	94	82	1,035
Amerigroup/Health Plus/CarePlus	5	119	3	115	5	135	3	96	0	93	0	142	91	147	89	118	108	106	1,375
BC/BS OF MNE	0	7	0	19	0	30	0	25	0	49	0	44	28	18	12	14	10	14	270
CIGNA	0	6	0	0	0	1	0	4	0	1	0	1	1	0	1	2	2	2	21
Fidelis Care	9	146	6	115	6	137	2	116	0	97	0	113	113	123	90	87	92	129	1,381
GROUP HEALTH INC.	0	2	0	5	0	13	0	9	0	4	0	8	8	3	5	5	4	9	75
Health First	7	146	4	133	2	182	1	128	3	131	0	196	116	134	103	98	117	148	1,649
HEALTH INS PLAN OF GREATER N	0	3	0	8	0	8	1	3	0	10	0	15	10	2	6	5	1	2	74
HIP/NYC	2	43	0	36	0	53	0	55	0	50	0	52	36	46	30	52	42	44	541
OXFORD INSURANCE CO.	0	5	1	2	0	7	0	0	0	4	0	5	2	3	1	2	5	4	41
UNION LOC. 1199	3	8	2	12	1	17	0	17	2	3	0	6	14	2	0	4	3	8	102
United Healthcare of NY	0	54	0	43	0	56	0	55	0	63	0	54	44	56	57	48	67	56	653
Unknown Plan	14	4,724	9	4,365	5	5,223	14	4,811	4	5,171	8	5,908	6,009	3,517	2,942	3,008	2,865	3,372	51,969
Wellcare of NY	1	52	3	52	2	57	1	48	0	37	1	53	64	62	46	48	33	56	616
TOTAL	42	5,406	31	5,008	26	6,026	24	5,460	11	5,809	11	6,723	6,606	4,182	3,459	3,565	3,448	4,039	59,876

Report ID: MHP1268C
Report Run Date: 6/15/2015

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to enter into multiple contracts to purchase health information related professional services for the Epic Electronic Medical Record program and Epic related Revenue Cycle modules as needed with 22 vendors (the "Contractors") through requirements contracts for a two year term with three one-year options to renew at the Corporation's exclusive option for an amount not to exceed $119,292,988 million for the *initial* two year period.

WHEREAS, the capacity of the Corporation's current employees is not sufficient to implement and deploy all required features for the Epic Electronic Medical Record; and

WHEREAS, the proposed contracts will allow the Corporation to secure the necessary expertise to complete required milestones and deliverable for the Epic EMR deployment; and

WHEREAS, the Corporation has selected EPIC, a single enterprise-wide EMR to meet the needs of HHC's expansive size, improve patient care, control costs, and overcome gaps in care transitions; and

WHEREAS, the Corporation issued a Health Information Related Services Request for Proposals to which the Contractors responded; and

WHEREAS, the utilization of these contracts will provide the Corporation with health information related professional services on an as-needed basis for implementation, advisory, support and/or training services for a wide array of technology staffing needs for the EMR program; and

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

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 enter into multiple contracts to purchase health information related professional services for the Epic Electronic Medical Record program and Epic related Revenue Cycle modules as needed with 22 vendors (the "Contractors") through requirements contracts for a two year term with three one-year options to renew at the Corporation's exclusive option for an amount not to exceed $119,292,988 million for the *initial* two year period.

Executive Summary
EITS Professional Services Contracts

The purpose of these requirement contracts is to establish a pool of 22 vendors for HHC to obtain as-needed information technology (IT) consultants with the necessary skillsets at the required times for the Epic Electronic Medical Record (EMR) program. The contract term will be two years with three one-year options to renew. The spending authority under the Resolution will not exceed a total of $119,292,988 million over the *initial* two-year period which includes both projected clinical EMR and revenue cycle spending. The projected spending amount for the clinical EMR is included in the $764 million six-year implementation budget for the Epic EMR program. The Revenue Cycle spending amount is included in a separate budget for Epic –related Revenue Cycle modules.

Currently, the Corporation utilizes consulting contracts which will be expiring in December 2015. While the abilities of current employees are being utilized, additional temporary staff are required in order to meet project deadlines.

This set of contracts will allow the Corporation to hire those short-term consultants for the necessary tasks in a timely and efficient manner. The requirement contracts will enable the Corporation to secure a wide array of Epic certified resources necessary to support the structure and processes in place throughout the EMR project life-cycle including implementation, deployment, Go-Live support and trainers.

A Request for Proposals (RFP) was issued and advertised in the City Record and HHC received 58 responses. Respondents were evaluated and scored by a selection committee. The intention of the RFP was to award to a sufficient number of contracts as necessary to meet the IT services needs of our large organization. Based on the evaluation scoring matrix, the 22 highest ranked responsive and responsible proposers with satisfactory or above scores which demonstrated the experience and organizational capacity necessary to provide the services were selected and their proposed pricing was consistent with industry rates for similar personnel. In addition, based on experience with the expiring panel of requirements contracts, it was determined that 22 contracts is a sufficient number of contracts to meet the significant staffing needs for IT services across HHC.

The actual services performed under the contracts will be governed by a written work order identifying the specific project, scope of work, hourly rate, period of performance and the not-to-exceed amount. Each work order for new consultant services will be issued on an as needed basis through a competitive process. Each request for new IT consultant services will be issued to the contractors, HHC will evaluate the responses based on technical qualifications and price and will select the response that offers the Corporation the most favorable combination of quality and price.

Payment is based on actual services performed pursuant to a work order issued by HHC, the contracts do not guarantee a minimum payment to the Contractors.

Contract Title: Information Technology Consulting Services

Project Title & Number: Epic EMR Implementation

Project Location: Enterprise wide

Requesting Dept.: Enterprise IT Services (EITS)

Successful Respondent: **22 Vendors to be awarded (See attachment)**

Contract Amount: $119,292,988 for the initial two year period

Contract Term:

2 Years with 3 one-year options to renew

Number of Respondents: 58
(If Sole Source, explain in Background section)

Range of Proposals: $ 50.00/hour to $ 870.00/hour

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

Funding Source: General Care X Capital

Grant: explain

X Other: explain Operating funds

Method of Payment: X Time and Rate

Other: explain

EEO Analysis: Pending.

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

Vendex Clearance Yes No N/A 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):*

HHC's implementation of the Epic EMR system requires considerable human resource effort and skill. While the Corporation is drawing upon the diverse talents of existing staff for a large portion of the work, certain phases of the program plan require a significant number of additional staff.

Currently, the Corporation utilizes a set of HHC consulting requirements contracts as well as Third Party Contract vendors. The HHC consulting contracts will be expiring in December 2015. While the abilities of current employees will be fully utilized, additional temporary staff are required in order to meet project deadlines.

This set of contracts will allow the Corporation to hire those short-term consultants for the necessary tasks in a timely and efficient manner. The requirement contracts will enable the Corporation to secure a wide array of Epic certified resources necessary to support the structure and processes in place throughout the EMR project life-cycle including implementation, deployment, Go-Live support and trainers.

These contracts will also provide IT consultants with the necessary skillsets at the required times to support other projects and systems on an as-needed basis for a wide array of potential technological staffing needs to perform implementation, IT support and/or training for non-EMR related clinical and business applications, infrastructure, and to supplement IT staff throughout HHC and its facilities. The spending authority for these non-EMR consultant needs will be presented to the Board at a separate, later scheduled meeting.

The spending authority includes both projected clinical EMR and Revenue Cycle spending. The projected spending amount for the clinical EMR is included in the $764 million six-year implementation budget for the Epic EMR program. The Revenue Cycle spending amount is included in a separate budget for Epic-related Revenue Cycle modules.

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

Yes. June 29, 2015.

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

No.

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):*

All 58 respondents were considered and were scored by the evaluation committee in accordance with the following evaluation criteria specified in the RFP:

a. Experience, Resources, Past Performance 45%

b. Organizational Capability 20%

c. Fee Schedule/Proposed Cost 35%

Responses were evaluated against three main criteria: organizational capability, past experience, and the proposed fees. Organizational capability factored in the expertise of the staff, the company's performance record, and their managerial and performance capability. Past experience was based on professional competence, educational background, prior experience of assigned personnel, and experience in similar work. Costs were compared against other respondents as well as prior market knowledge.

The intention of the RFP was to award to a sufficient number of contracts as necessary to meet the IT services needs of our large organization. Based on the evaluation scoring matrix, the 22 highest ranked responsive and responsible proposers with satisfactory or above scores which demonstrated the experience and organizational capacity necessary to provide the services were selected, subject to Vendex clearance and compliance with HHC's EEO and other contracting policies, and their proposed pricing was consistent with industry rates for similar personnel. In addition, based on experience with the expiring panel of requirements contracts, it was determined that 22 contracts is a sufficient number of contracts to meet the significant staffing needs for IT services across HHC. Attached is the list of selected vendors.

Scope of work and timetable:

This panel of firms will provide expertise in the area of Healthcare Information Systems and other related information technology services and allow the Corporation to secure resources on an as needed basis to support major software implementation, infrastructure, clinical and business applications, training, and maintenance activities. This will include assisting with the implementation of industry recognized electronic health record and associated ancillary and support applications. They will provide specialized and trained expertise for a large number of implementation teams working throughout HHC's eleven hospitals, five long-term care sites, six diagnostic & treatment centers, and 80 plus clinics.

Written work orders identifying the specific project, scope of work, hourly rate, period of performance and the not-to-exceed amount will be issued to the Contractors on an as needed basis for new consultant services through a competitive process. Each request for new IT consultant services will be issued to the appropriate contractors, HHC will evaluate the responses based on technical qualifications and price and will select the response that offers the most favorable combination of quality and price to the Corporation. The hourly rates in the work orders can be less then, but cannot exceed, the hourly rates in the contract.

Payment is based on actual services performed pursuant to a work order issued by HHC, the contracts do not guarantee a minimum payment to the Contractors.

Contract Review Committee Process

CRC Meeting Date……. June 29, 2015

Board of Directors Approval Process

M&PA/IT Board Date…….…….. July 16, 2015
Board of Directors Date…… July 30, 2015

Contract Execution……..…… October 2015
Contract Start……... January 2015

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

Different models of staffing were considered for the EPIC EMR project. It was determined that the more economical and practical solution was for the Corporation to pursue a combination of consultants and FTE staff. This staffing model allows for rapid staffing of needed skills in the first phase of the project and an efficient workforce recruitment effort when the needs of the project call for a surge in support for go lives to ensure successful adoption of the Epic EMR.

As noted above, the spending authority for non-EMR consultant needs will be presented to the Board at a separate, later scheduled meeting. For the services not related to the EMR project, Health Information-Related Services will be utilized on an as-needed basis, to obtain expertise, experience or knowledge that is either not available in the Corporation or is not required on a long term basis sufficient to hire a full time employee; to satisfy an immediate need that cannot be filled by current staff; to fill a gap during the recruitment of full time employees, or any other circumstances where staff augmentation is determined to be required.

These contracts will help the Corporation achieve the flexibility and agility necessary to quickly align with changing technologies and respond to new business demands in a cost effective manner.

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

EMR Clinical Consultants:

Fiscal Year	Total Spend
FY13	$1 M
FY14	$12.3 M
FY15	$20.3 M

Revenue Cycle

Fiscal Year	Total Spend
FY13	N/A
FY14	N/A
FY15	$1.5 M

CONTRACT FACT SHEET (**continued**)

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

Current staff will be involved throughout the implementation process, but certain phases of development and rollout require more manpower than current employees can provide.

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?

These contracts are not expected to produce any type of intellectual property. If they do, HHC will retain ownership.

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

Sal Guido
Interim Chief Information Officer
55 Water Street, 24th Floor
New York, NY 10041

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):*

PENDING

Received By E.E.O. _____
Date

Analysis Completed By E.E.O._____
Date

_____
Name

ATTACHMENT A

SELECTED VENDORS
CTG Health Care Solutions
Emergis (Telus)
Mediant
Kforce Inc.
Experis (Manpower)
Tekmark
Teksystems
314e Corporation
HCI Group
CSI Healthcare
Cumberland Consulting Group
NTT Data
Dyntek Services
Soliant Health
Lucca Consulting Group
Intellect Resources
KPMG *
Momentum
Physician Tech Partners
Culbert Healthcare Solutions
Innovative Consulting Group
ISS

***Note: KPMG submitted a proposal and recently acquired another proposer – Beacon Partners. Award is subject to approval by the Audit Committee.**

EITS Requirements Contracts for IT Consultant Services

Medical & Professional Affairs/ IT Committee

July 16, 2015

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

nyc.gov/hhc

The Request

Award 22 Requirement Contracts

(To provide IT consultants on an as-needed basis for implementation, support/maintenance, and training)

- Contract Term 2 years + 3 one-year renewals
- The contracts will replace and expand upon the existing requirement contracts established in 2010 that are expiring December 2015
- Today's request is for spending authority related to the Epic EMR project and Revenue Cycle modules
- A subsequent request will be submitted for non-Epic EMR-related projects.

Spending Authority up to $119,292,988 million for initial 2 year term

- Estimate based on historical spending and EMR deployment schedule
  - Go-live Support, Trainers, Ramp Up Consultants
- EPIC EMR estimated spending was projected and budgeted for in the EMR budget
- No guarantee to vendors of a minimum payment
- Payment is based on actual services performed pursuant to a work order signed by HHC and vendor

Business Justification

Requirement Contracts allow HHC to achieve flexibility to quickly align with changing technologies and respond to new business needs in a cost effective manner.

Benefits Associated with the Epic EMR Implementation Program

- Selected vendors have expertise in Healthcare Information Systems and/or enable the Corporation to secure Epic certified resources
- Selected vendors will work jointly with HHC to ensure that a support structure and process is in place for the effective deployment of the EMR
- Provide specialized and trained expertise
- Ability to scale staffing needs to meet changing demands throughout the project life cycle
- Ability to roll off consultants as needed

Procurement Process

Request for Proposals

Solicitation

- Publicly Advertised in City Record
- Over 200 Vendors Downloaded RFP

Evaluation

- 58 proposals were evaluated by evaluation committee

Evaluation Criteria

- Organizational Capability – 20%
- Experience/Resources/Past Performance – 45%
- Fee Schedule – 35%

Contract Selection & Award

Snapshot of Selected Vendors

- 22 contractors
- 16 new vendors/ 6 existing incumbent vendors

6 Year Epic Implementation Budget

EMR Project - Six Year Implementation Budget [Expenditures include Invoices Paid or In-Process]					
	Item	Description	Total Implementation Dollars (in millions)		
			Total Budget	Expenditures [Paid or in Process] as of 05/31/2015	Balance
1	Epic Contract	Includes Software and Implementation and Training Services.	$144	$66	$78
2	Third Party & Other Software	Includes Endoscopy, Fetal Monitoring Systems, ePrescribing, Patient Education.	$30	$2	$28
3	Hardware	Includes Servers, Storage, Server Licensing, Network Switches.	$84	$26	$58
4	Interfaces	Includes Interface Software/Biomed Middleware.	$39	$4	$35
5	Implementation Support	Third party vendor staff augmentation, go-live support and training (Includes costs associated with backfilling non-IT staff and temps).	$355	$35	$320
6	Application Support Team	New HHC FTE staff to be used through the implementation period including fringe benefits. These costs will become on-going after implementation period.	$113	$27	$86
	Clinicals-Only Total	[Without QuadraMed Transition/Existing Application/Existing Staff Costs]	$764	$160	$604

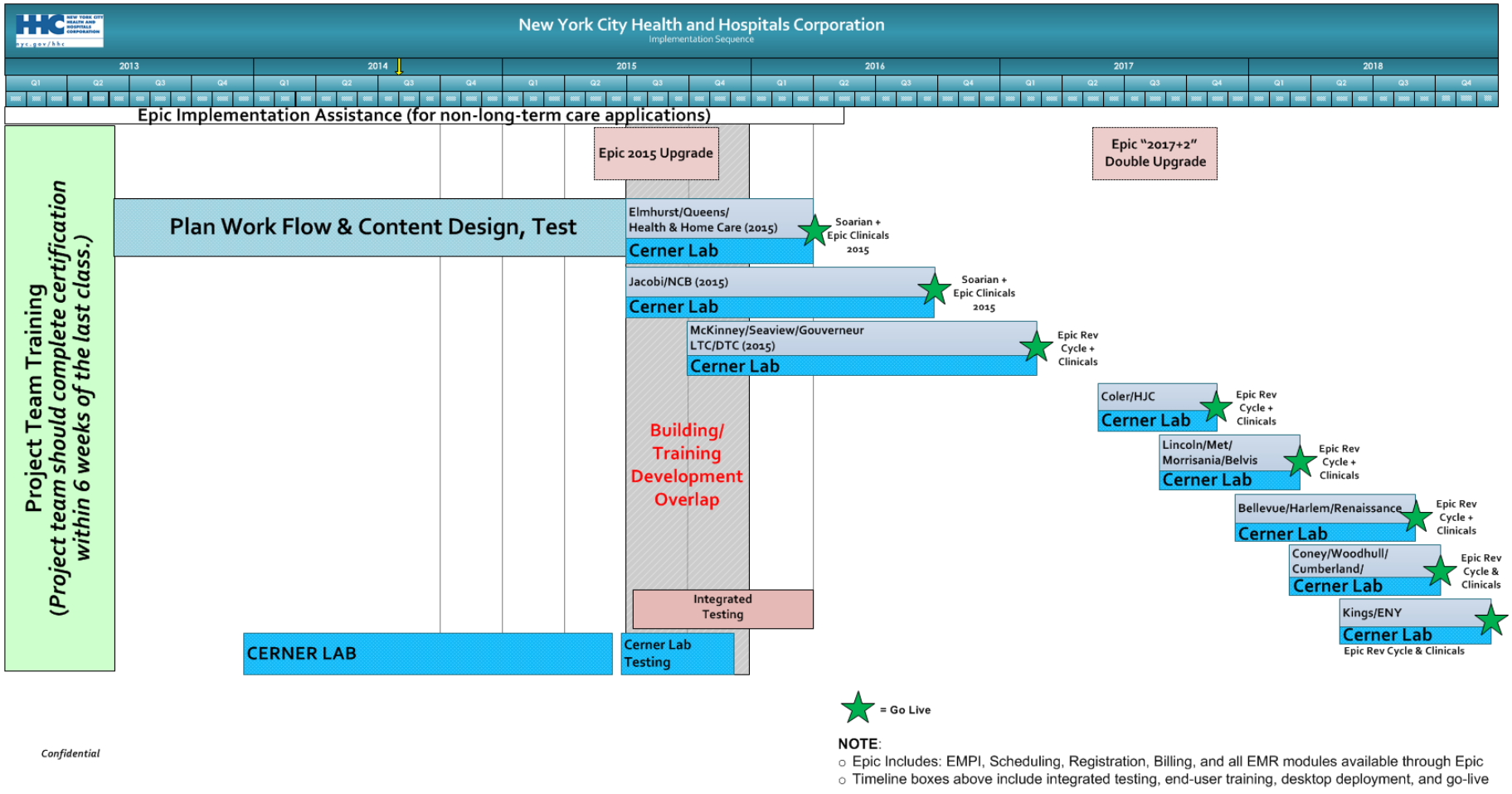
The Clinical EMR budget included these Clinical EMR IT Consultant Costs

The Epic Revenue Cycle budget included these Revenue Consultant Costs

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

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

Program Timeline



Confidential

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

Work Order Assignment Process

- Each assignment will be governed by a written work order identifying the specific project, scope of work, hourly rate, period of performance and the total not-to-exceed amount
- Request for a Statement of Work for new consultant resources will be sent to appropriate Contractors, describing the project, required services, staffing necessary to complete the statement of work, a schedule and completion date for the services
- Contractors will respond to the request with resumes of the staff consultants, a proposed approach, if applicable and an hourly rate
- The proposed hourly rate can be less than the contract rates/cannot exceed contract rates
- Evaluate the responses and select the Contractor whose response provides the combination of quality and price most favorable to the Corporation.

Questions?

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

BOARD OF DIRECTORS

MEDICAL & PROFESSIONAL AFFAIRS COMMITTEE

BEHAVIORAL HEALTH UPDATE

JULY 16, 2015

Office of Behavioral Health

Behavioral Health Transformation - Current state

- **NY State is transitioning to Medicaid managed care** with fully integrated behavioral/physical health and specialized Health and Recovery Plans **(HARPs)** for the seriously ill, between 2015-17 – **ending fee-for-service (FFS) reimbursement** for carved-out services
  - Impending **changes to BH Medicaid funding could significantly impact HHC**
- **DSRIP** has major implications for BH

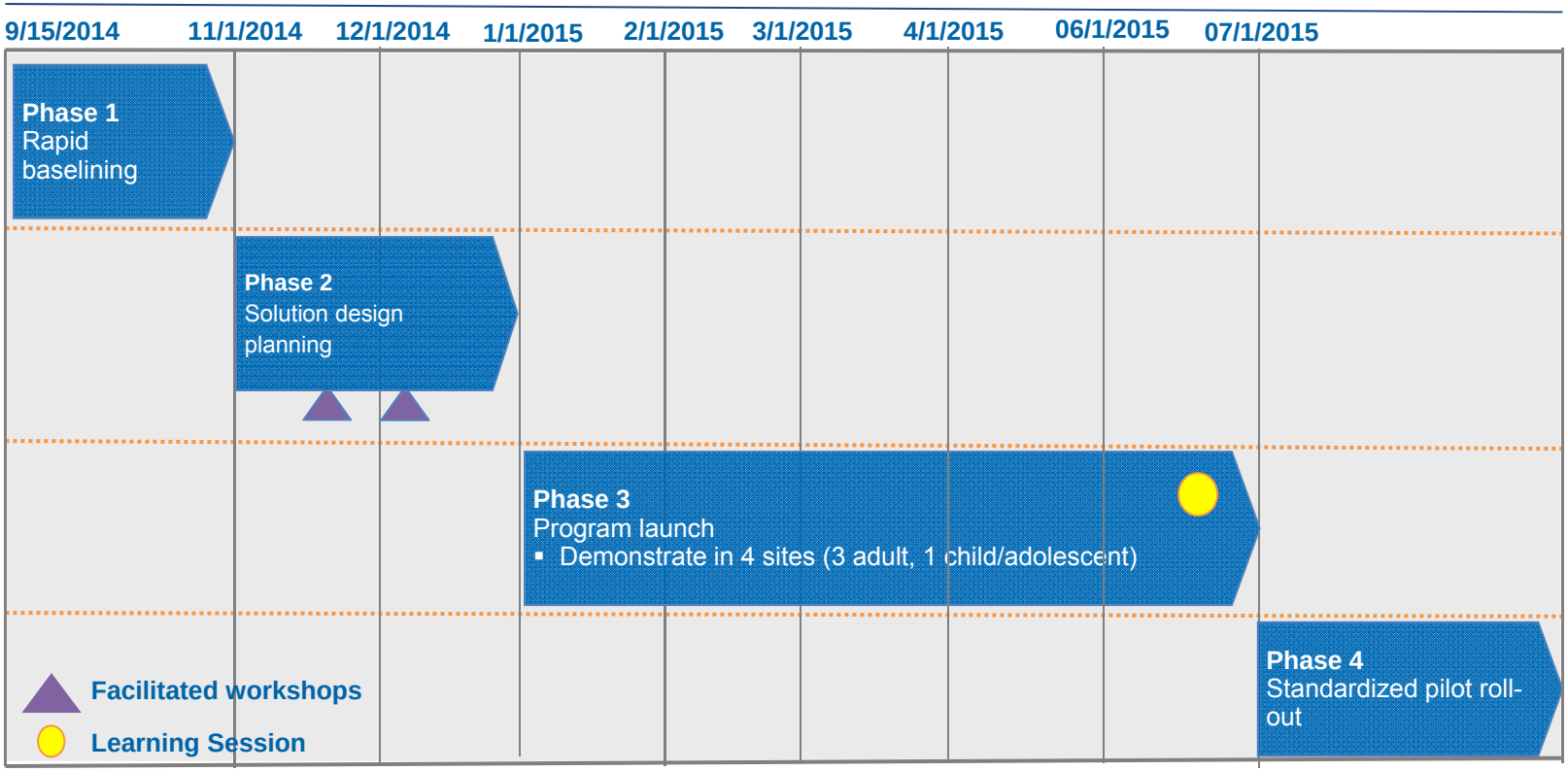
- Given its **large BH service,** high proportion of **Medicaid patients,** significant **value at risk and strong mission** for serving the neediest, our efforts here need strong support
  - **Largest BH service in NYC** (e.g., >40% of total IP discharges)
  - Medicaid FFS accounts for ~52% IP/~40% OP by volume with **$250M revenue at risk**

- HHC has taken significant strides recently **to improve its BH service ...**
  - **Improved outpatient wait times** by 15% as part of ambulatory care access project
  - **Reduced length of stay (LOS)** for inpatient psych by >20% since 2012

SOURCE: McKinsey analysis - HHC Finance, DataGPS, SPARCS

Managed Care Transformation Timeline

Overall project phases & timeline

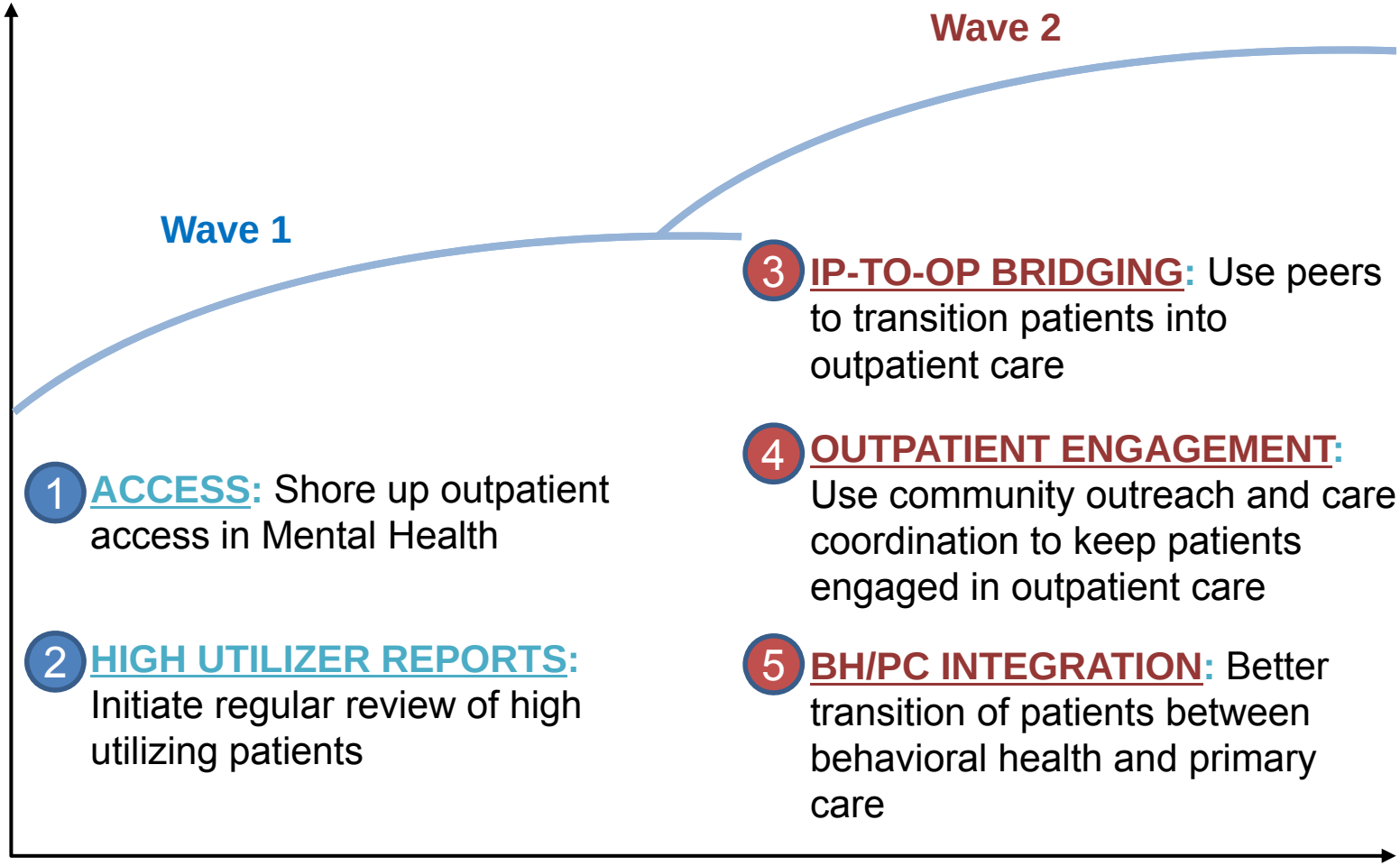


Phases 2 & 3: Solution Design & Program Launch

"Pillars" of Transformation		4 Early Adopter Sites
1 **Increase use of peers**	Services driven by needs and hopes of individuals/families seeking help and incorporate peer recovery support	▪ Adult population: — Elmhurst — Kings County — Gouverneur Health ▪ Child/Adolescent population: — Bellevue
2 **Strengthen care management**	Services provide easy access, early intervention, flexible flow, and care coordination	
3 **Make care co-occurring capable**	Every program and person delivers matched, integrated services to individuals/families with co-occurring MH/SUD needs	
4 **Primary care integration**	All health and behavioral health services provide integrated PH/BH services	
5 **Complete OP and crisis continuum**	Continuum of crisis and routine outpatient services for each defined population	
6 **Develop community partnerships**	Each facility is key partner in community service collaborative	

MH: mental health; SUD: substance use disorder; PH: physical health; BH: behavioral health

Standardized Transformation Activities



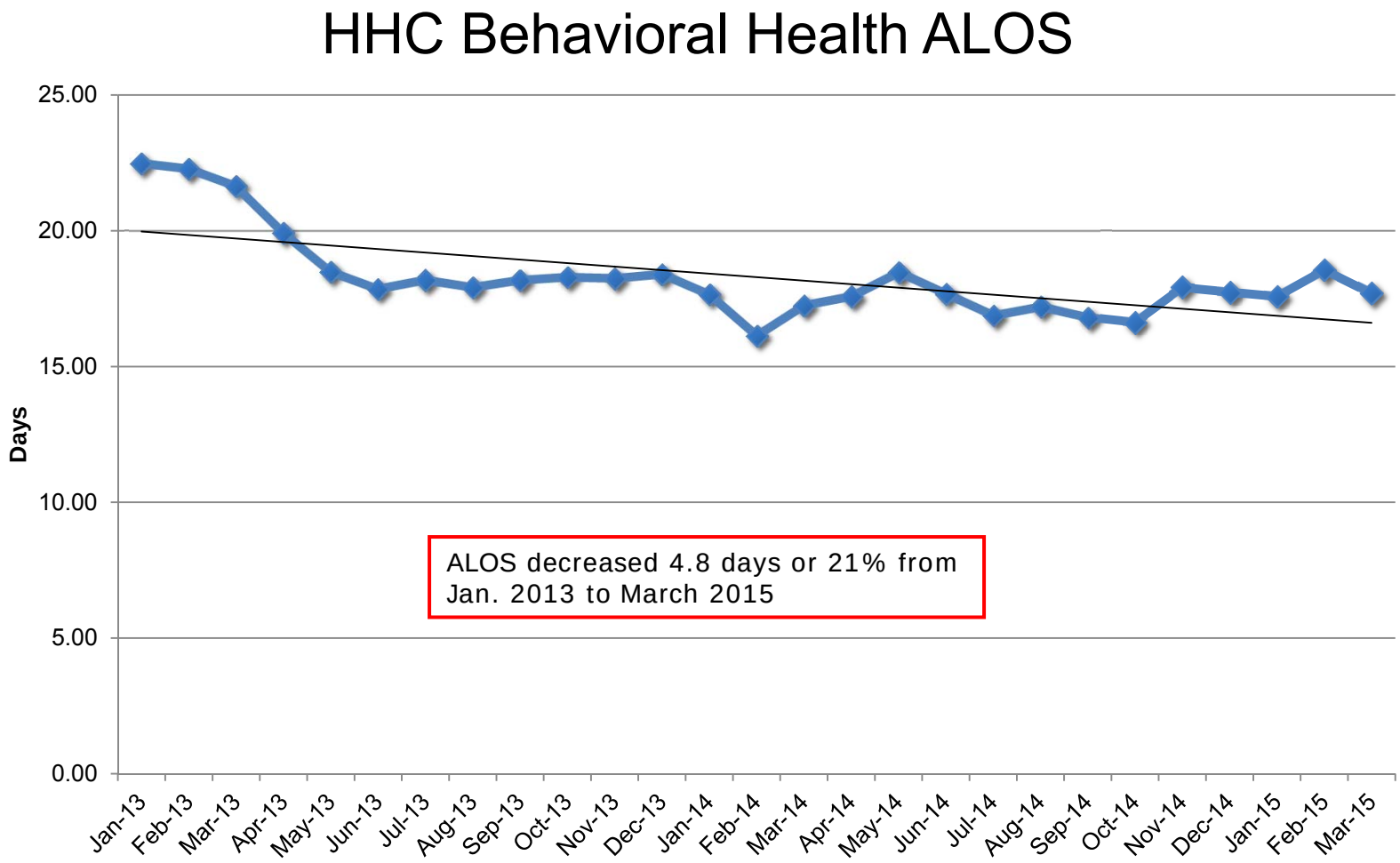
Pilots and Lessons Learned

Early Adopter Pilots

- **Kings**:
  - Reduction of CPEP High utilizers;
  - engagement in outpatient
- **Elmhurst**:
  - Expand Access Project
  - Increase co-occurring screening and treatment
- **Gouverneur**:
  - Increase co-occurring capability
  - High utilizers with medical conditions
- **Bellevue (Child)**
  - Expansion of care continuum
  - Family oriented services

Lessons Leaned

- Importance of facility steering committee
  - Inclusion of Finance, Managed Care, DSRIP
- Importance of a site transformation coordinator.
- Importance of regular weekly team performance meetings
- Importance of regular monthly steering committee meetings.
- Need for Behavioral Health coach for teams.
- Need to standardize future pilots across all facilities simultaneously.


HHC Behavioral Health ALOS
25.00
20.00
15.00
10.00
5.00
0.00
Days
ALOS decreased 4.8 days or 21% from Jan. 2013 to March 2015
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
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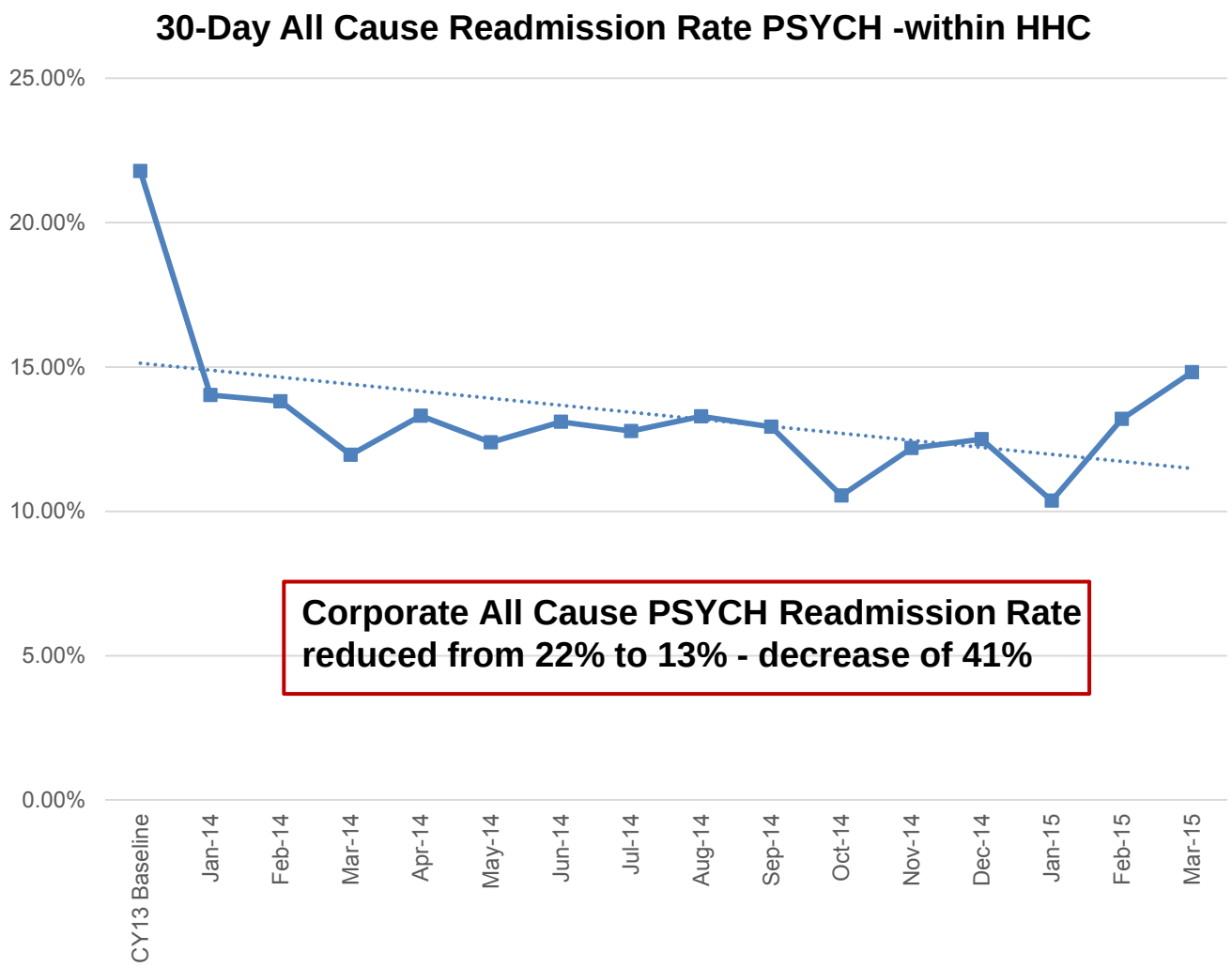
Jan-15
Feb-15
Mar-15

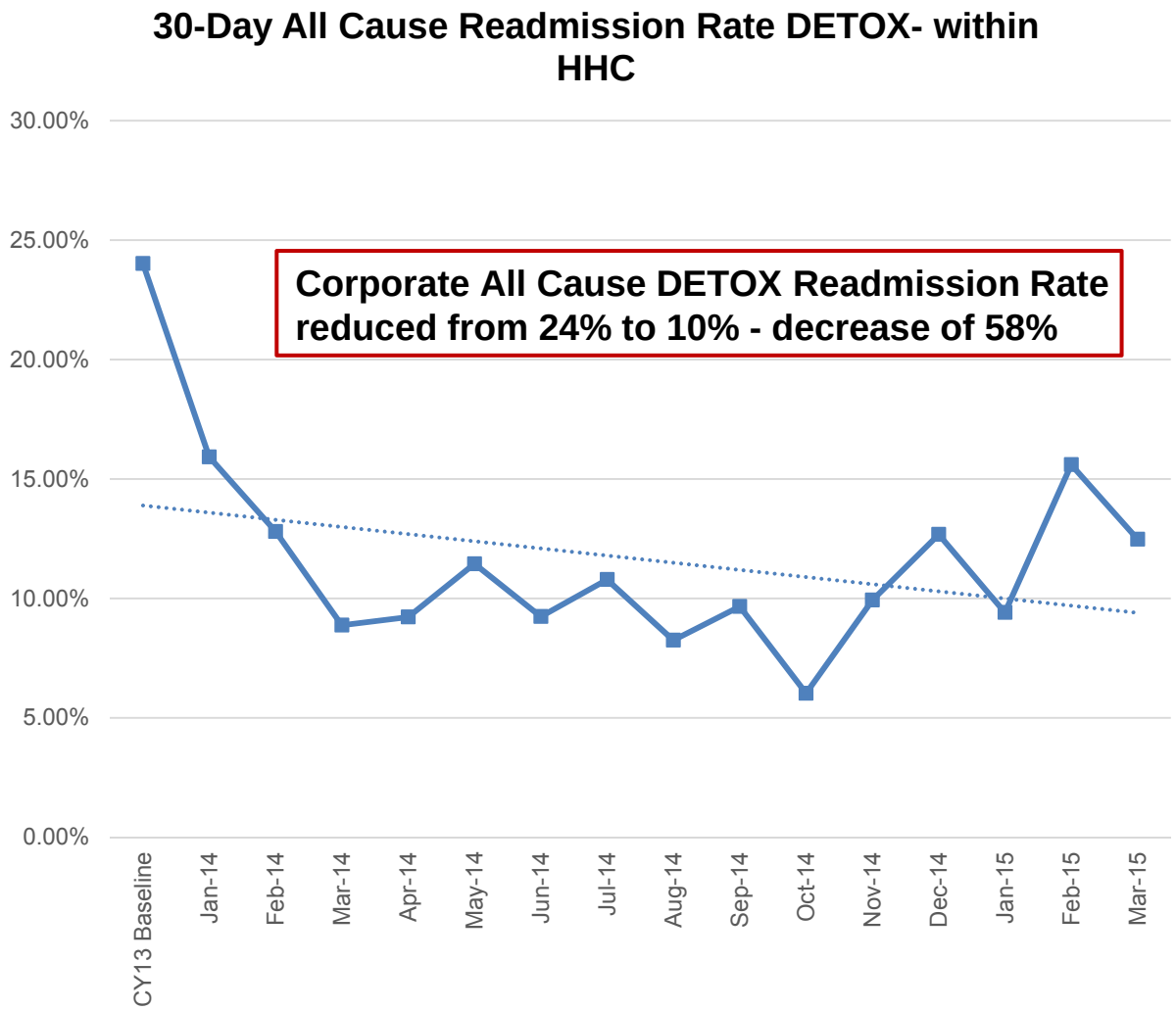
30-Day All Cause Readmission Rate PSYCH - within HHC



Facility	CY13	CY14*
BHC	23%	13%
CI	23%	8%
EHC	20%	15%
HAR	30%	12%
JMC	19%	11%
KCHC	19%	11%
LIN	23%	14%
MET	28%	19%
NCB	17%	9%
QHC	20%	12%
WMC	18%	11%
CORP	22%	13%

Facility performance compares CY13 to CY 14.

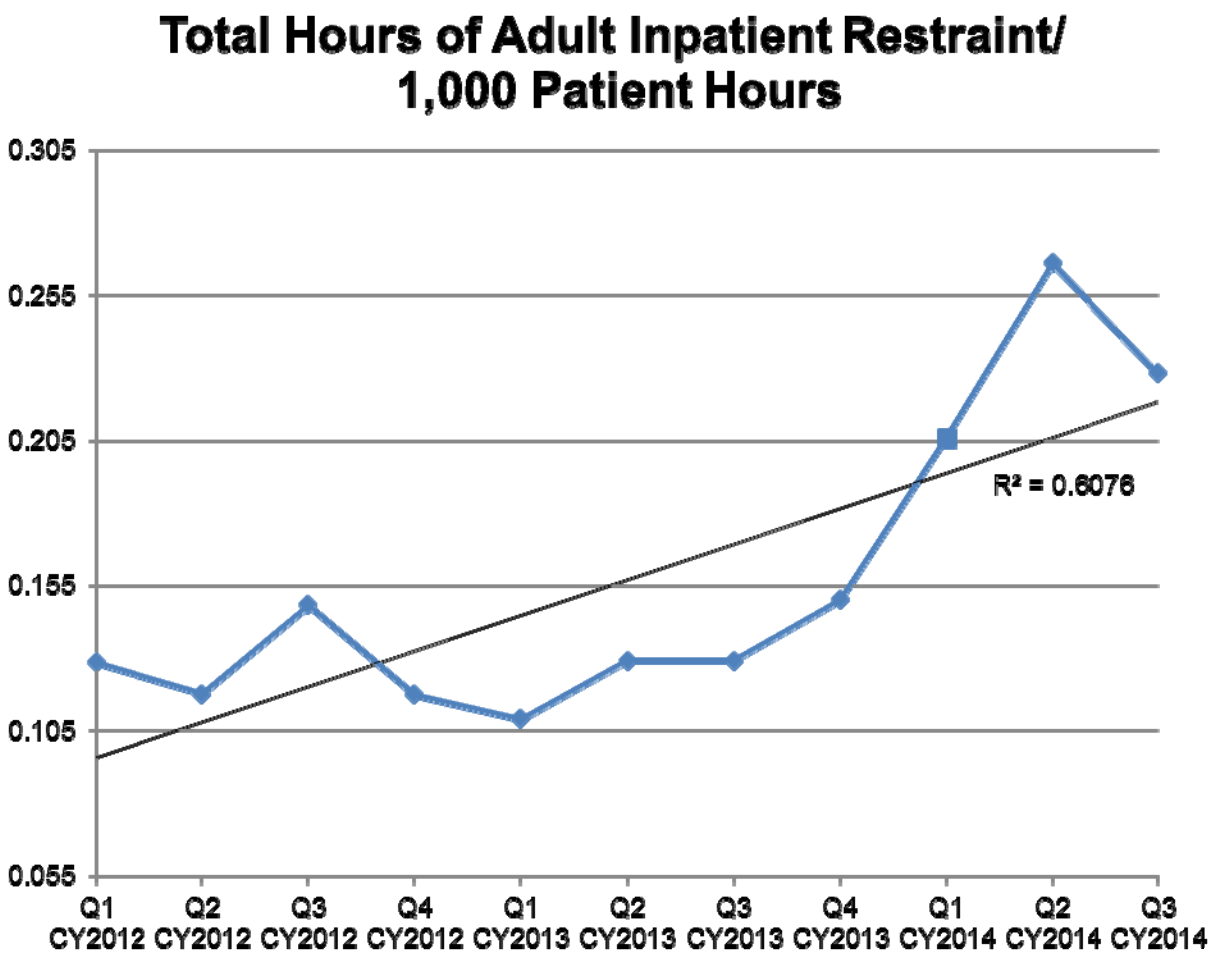
30-Day All Cause Readmission Rate DETOX - within HHC



Facility	CY13	CY14*
BHC	23%	12%
CI	N/A	4%
EHC	N/A	N/A
HAR	28%	14%
JMC	19%	10%
KCHC	28%	12%
LIN	N/A	N/A
MET	30%	11%
NCB	N/A	N/A
QHC	13%	N/A
WMC	19%	9%
CORP	24%	10%

Facility performance compares CY13 to CY 14.

Use of Physical Restraint

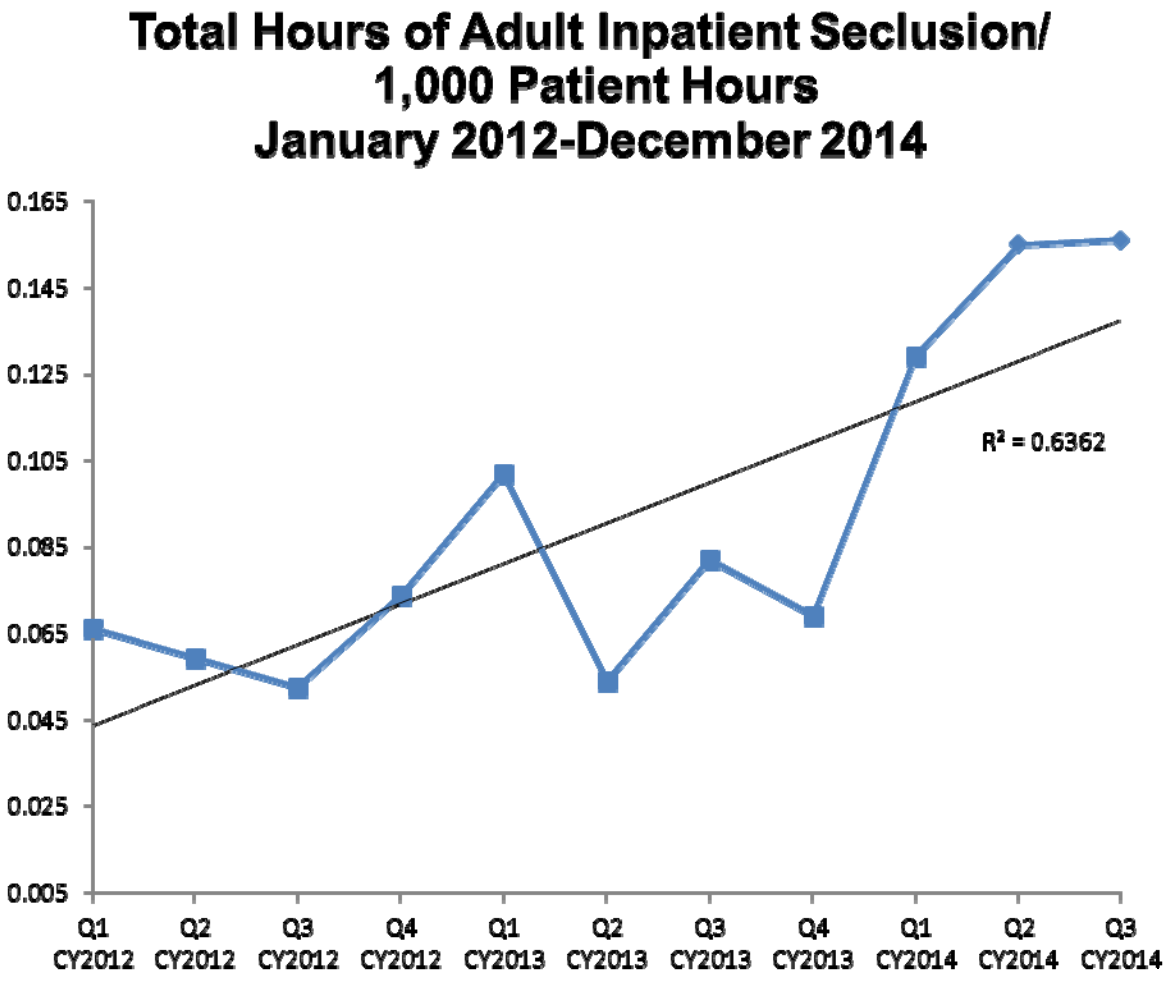


*Excludes Q4 of CY2014
**Q1 of CY'13 includes closures from Hurricane Sandy

Facility	CY12	CY13	CY14*
BHC	0.087	0.089	0.316
CI	0.041	0.074	0.033
EHC	0.180	0.186	0.363
HAR	0.209	0.148	0.346
JMC	0.131	0.031	0.064
KCHC	0.163	0.151	0.226
LIN	0.000	.0.046	0.018
MET	0.055	0.062	0.077
NCB	0.016	0.012	0.010
QHC	0.059	0.103	0.028
WMC	0.266	0.323	0.352
CORP	0.129	0.130	0.233

*** Facility performance compares CY12 to CY14.**

Use of Seclusion



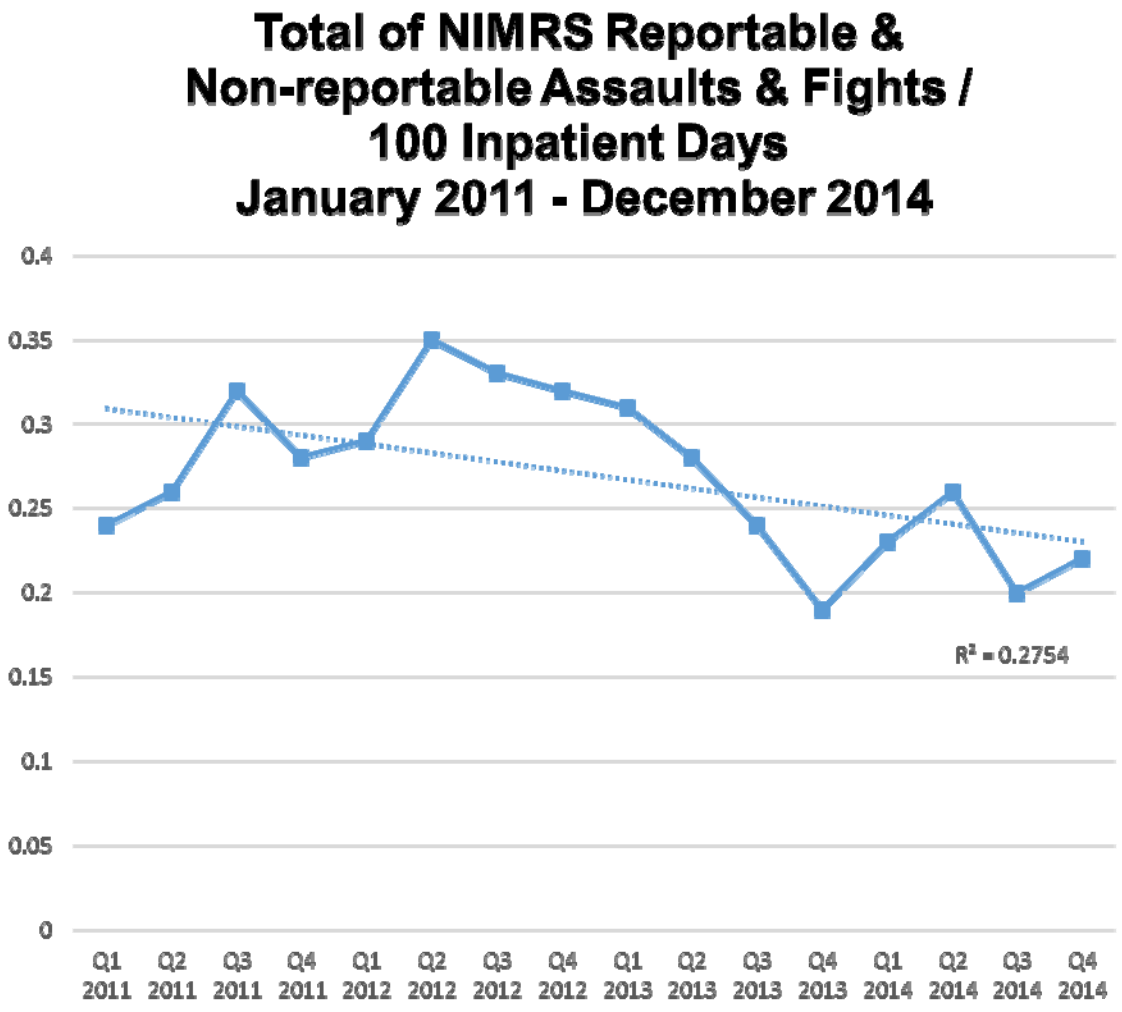
*Excludes Q4 of CY2014
**Q1 of CY'13 includes closures from Hurricane Sandy

EHC, HAR, KCHC - by policy have eliminated the use of seclusion = NA

Facility	CY12	CY13	CY14*
BHC	0.099	0.091	0.261
CI	0.009	0.000	0.000
EHC	N/A	N/A	N/A
HAR	N/A	N/A	N/A
JMC	0.136	0.172	0.304
KCHC	N/A	N/A	N/A
LIN	0.069	0.397	0.494
MET	0.117	0.048	0.111
NCB	0.046	0.088	0.233
QHC	0.022	0.200	0.065
WMC	0.107	0.064	0.120
CORP	0.062	0.076	0.147

*** Facility performance compares CY12 to CY14.**

Assaults and Fights



Facility	CY11	CY12	CY13	CY14*
BHC	0.15	0.23	0.21	0.25
CI	0.08	0.08	0.05	0.17
EHC	0.39	0.33	0.28	0.3
HAR	0.44	0.43	0.32	0.27
JMC	0.14	0.11	0.17	0.16
KCHC	0.34	0.62	0.4	0.37
LIN	0.3	0.3	0.24	0.06
MET	0.22	0.18	0.2	0.23
NCB	0.35	0.42	0.23	0.22
QHC	0.18	0.23	0.26	0.18
WMC	0.19	0.19	0.12	0.09
CORP	0.24	0.29	0.23	0.23

*** Facility performance compares CY11 to CY 14.**

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

Next Steps

- To develop new, efficient ambulatory and crisis services including rehabilitation and recovery services as part of the 1915(i) waiver (HCBS – Home and Community Based Services)
- Accelerate efforts for prepare for Managed behavioral health and HARP
- Coordinate above efforts with the DSRIP initiatives - especially integration of primary and BH. These require:
  - changes to both clinical practice and operations
  - strengthened relations with finance, centrally and at facility levels
  - a stronger culture of continuous quality improvement along with standardization of increased data collection and analysis