AGENDA

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE

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

BOARD OF DIRECTORS

CALL TO ORDER — **DR. STOCKER**

ADOPTION OF MINUTES
-July 18, 2013

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

METROPLUS HEALTH PLAN — **DR. SAPERSTEIN**

ACTION ITEM:

1. Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate and execute a contract with The Nash Group ("Nash") for enterprise–wide nursing optimization. The contract shall be for a period of three years with one, three-year option to renew exercisable solely by the Corporation, in an amount not to exceed $7 million for the entire term of the contract, including the initial and optional renewal terms. — **DR. WILSON/ MS. JOHNSTON**

INFORMATION ITEMS:

1. **Windows 7 and Office 2010 Deployment Update** — **MR. GUIDO**
2. **ICIS Electronic Health Record Implementation Update** — **DR. CAPPONI**
3. **Meaningful Use Update** — **DR. CAPPONI**

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

MINUTES

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE BOARD OF DIRECTORS

Meeting Date: July 18, 2013

ATTENDEES

COMMITTEE MEMBERS:

Michael A. Stocker, MD, Chairman
Antonio Martin (representing Alan Aviles, President, in a voting capacity)
Josephine Bolus, RN
Amanda Parsons, MD (representing Health Commissioner, Thomas Farley, MD in a voting capacity)

HHC CENTRAL OFFICE STAFF:

Louis Capponi, MD, Chief Medical Informatics Officer
Deborah Cates, Chief of Staff, Board Affairs
Duane Chandler, Assistant Director, Office of Special Projects
Paul Contino, Chief Technology Officer
Barbara DeIorio, Senior Director, Internal Communication Group
Juliet Gaengan, Senior Director, Office of Clinical Affairs
Marisa Salamone-Greason, Assistant Vice President, EITS
Terry Hamilton, Director, Corporate Planning & HIV Services
Caroline Jacobs, Senior Vice President, Safety and Human Development
Christina Jenkins, MD, Assistant Vice President, Primary Care Services
Lauren Johnston, Senior Assistant Vice President/Chief Nursing Officer, Patient Centered Care
Irene Kaufmann, Senior Assistant Vice President, Ambulatory Care Redesign
Patricia Lockhart, Secretary to the Corporation
Ronald Low, MD, Senior Director
Tamiru Mammo, Chief of Staff, Office of the President
Ana Marengo, Senior Vice President, Communications & Marketing
Antonio D. Martin, Executive Vice President/Corporate Chief Operating Officer
Susan Meehan, Assistant Vice President, HHC Office of Emergency Management
Deidre Newton, Senior Counsel, Office of Legal Affairs
Jean Perrine, First Deputy Inspector General
Bert Robles, Senior Vice President, Chief Information Officer
Salvatore Russo, Senior Vice President & General Counsel, Legal Affairs
David Stevens, MD, Senior Director, Office of Healthcare Improvement
Steven Van Schultz, Director, IT Audits
Joyce Wale, Senior Assistant Vice President, Office of Behavioral Health
Jaye Weisman, Ph.D. Assistant Vice President/COO, Accountable Care Organization
Manasses Williams, Assistant Vice President, Office of Affirmative Action/EEO
Ross Wilson, MD, Senior Vice President/Corporate Chief Medical Officer

FACILITY STAFF:

Lynda D. Curtis, Senior Vice President, South Manhattan Network
Van H. Dunn, MD, Medical Director, MetroPlus Health Plan
Elizabeth Gerdts, Chief Nursing Officer, North Central Bronx Hospital
George Proctor, Senior Vice President, North & Central Brooklyn Network
Denise Soares, Senior Vice President, Generations +/Northern Manhattan Network
Arthur Wagner, Senior Vice President, South Brooklyn/SI Health Network
William Walsh, Senior Vice President, North Bronx Healthcare Network

OTHERS PRESENT:

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Scott Hill, Account Executive, QuadraMed
Richard McIntyre, Key Account Executive, Siemens
Kristyn Raffaele, Analyst, Office of Management and Budget
Dhruneanne Woodrooffe, Analyst, Office of Management and Budget

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**MEDICAL AND PROFESSIONAL AFFAIRS/
INFORMATION TECHNOLOGY COMMITTEE
Thursday, July 18, 2013**

Michael A. Stocker, MD, Chairman of the Board, called the meeting to order at 10:39 A.M. The minutes of the June 20, 2013 Medical & Professional Affairs/IT Committee meeting were adopted.

CHIEF MEDICAL OFFICER REPORT

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

1. New York State Justice Center

On June 30, 2013, the New York State Justice Center became operational. This new agency was created to safeguard the rights of people served by OMH, OASAS, OFCS and OPWDD licensed providers. The Justice Center is a law enforcement agency with the primary responsibility for tracking, investigating and prosecuting serious abuse and neglect complaints and is authorized to monitor facility and provider agency responses to reportable incidents and will identify patterns and trends relating to abuse and make recommendations to positively impact the safety of service recipients and the employees who are entrusted with their care. The impact on HHC will be the need to complete pre-employment background checks and the signing of a mandatory code of conduct that some staff must sign and update annually, in addition to Incident Investigation, Reporting and Management requirements. The Offices of Behavioral Health, Legal Affairs and Human Resources are working together with regards to the implementation at HHC.

2. Care Plan Management System

Since our last report in June, we have continued the roll-out of the Care Plan Management System to Health Home care coordinators at Coney Island and Bellevue Hospitals. The system currently contains 1,039 consented Health Home patients who are linked to CPMS trained care coordinators. The system is designed to support care plan development and the sharing of care plans and relevant patient information with all members of the patients' care team, regardless of location and agency.

We are scheduled to roll-out the system to Elmhurst and Queens Hospitals at the beginning of August which will complete the deployment of the system as planned. The next steps will be to develop the patient portal of this system to allow patients to access elements of their medical record, consistent with the “Meaningful Use” requirements.

3. Assessment of Physician Compensation and Productivity

As part of our continued efforts to achieve the balance between compensating our physician workforce at a level which is competitive for recruiting purposes, versus having to manage in our current fiscal situation, a new project commences later this month. This will assess compensation and productivity for our nearly 5,000 physicians, against local and national benchmarks. It will provide the basis for the evolution of compensation models that are more consistent with our future needs that are focused on delivering quality and value, and not simply on volume. The effort will be led by Dr. Christina Jenkins, along with consultants McKinsey + Company. Key stakeholders, including affiliate leadership, Doctors Council and senior HHC leadership, are engaged and aware of the project's intent and scope.

4. Emergency Preparedness

In addition to the ongoing work at Bellevue, Coler and Coney Island Hospitals in recovering from Sandy, HHC has been very focused on ensuring that all facilities and central office have implemented changes in responses to issues that we brought to light by Hurricane Sandy, for the new storm season which is upon us. In addition, strengthening all our current efforts for protection against power or air conditioning interruptions during the current summer weather, is a top priority.

5. HHC Accountable Care Organization (ACO)

Considerable effort is going into building the IT and management infrastructure required to effectively operate the HHC ACO's participation in the Medicare Shared Savings Plan. Dr. Jaye Weisman, as the ACO Chief Operating Officer is guiding these vital steps. Hopefully with the building of effective IT infrastructure we will be able to comply with this year's reporting requirements, and have the necessary information to commence directly engaging physicians with the performance data of their patients, in order to identify timely opportunities to improve quality and remove waste.

6. HHC Flu Policy

This week sees the finalization of HHC's policy to implement the new State regulations that mandate that healthcare workers who are not currently immunized against influenza will wear a surgical mask, for the duration of the flu season. We and the State DOH are hoping this will move our employee vaccination rates to close to the 90% level required to achieve "herd immunity" and hence increased community protection, especially for the very young or elderly who are most vulnerable. Discussions with staff and our labor colleagues will commence next week on the details and the policy and plans for its implementation.

7. Primary Care Access

We are six (6) months into a 24-month engagement to achieve demonstrable improvement in access to primary care. Our access team has completed initial work in three (3) pilot facilities: Harlem, Kings, and Gouverneur; and our 17 clinics at those facilities are beginning to show improvement. With continued support of local and central leadership, we believe clinics can embed changes and sustain results within 6 months. We've recently engaged with three (3) new facilities: Lincoln, Metropolitan, and Jacobi; and look forward to a successful process.

CHIEF INFORMATION OFFICER REPORT

Mr. Bert Robles, Senior Vice President/Chief Information Officer reported on the following initiatives:

1. ICIS Electronic Health Record (EHR) Program Update

Since Mr. Robles's last report to the Committee at the May meeting, the following activities have been achieved regarding the Epic implementation: the Infrastructure group completed their Epic Chronicles training, data migration continued with an analysis being done on the scope of the extraction efforts and eLearning modules were made available to a select group of Subject Matter Experts (SMEs) in anticipation of the July 9-11 Workflow Preview Sessions; the Epic Database (Clarity) was installed on June 26-27 with test patient information; and a meeting was held with Finance to review key points of integration between Epic and Soarian.

2. WorkFlow Preview Sessions

Pre-Workflow Preview Session webinars were developed and conducted on July 1-3 for Subject Matter Experts (SMEs) attending the first preview week scheduled for July 9th through July 11th. These webinars were designed to help SMEs understand what the sessions would entail and how their input would be used toward crafting the Electronic Health Record (EHR).

For the first Workforce Preview session which was held from Tuesday, July 9th through Thursday, July 11th, an average of 438 Subject Matter Experts participated in each of these three (3) day sessions. Three were a total of 81 meetings held over the three (3) days, ranging from cardiology to billing. Following these meetings, a survey was developed and sent to all invitees to solicit their feedback. The input we receive will be used going forward to plan for Weeks 2, 3 and 4 of the Workflow Previews. The remaining dates for these sessions are: July 30-August 1, August 20-22 and September 23-25. Mr. Robles will keep the Committee posted on the outcome of this important activity.

3. HHC Operations ICIS EHR Kick-Off Meeting

An Operations ICIS EHR Kick-Off Meeting for HHC Senior Leadership has been rescheduled for October 8th at Harlem Hospital Center. The goal of this event is to explain the program as well as delineate the individual and departmental roles for HHC Leadership within this program. HHC Board Members are also encouraged to attend.

4. ICIS Communications

Within the area of program communications MR. Robles reported the following: *ICIS Update:* a weekly communication about the Program's activities is sent and opened by approximately 10,000 regular readers; *ICIS News:* A full-color monthly newsletter has been developed in conjunction with HHC Internal Communications and is sent out to all HHC employees. It provides the reader with current activities, introduces ICIS team member roles and interviews with HHC staff that will use Epic going forward; and *ICIS Communication SharePoint site:* This site is a repository for all program information. Since its launch, the site has been viewed by over 12,000 unique HHC visitors.

5. Meaningful Use –Stage 2 (MU2) Update

Mr. Robles provided the Committee on the following activities regarding Meaningful Use-Stage 2 (MU2): *Bar Code Medication Administration Project (BCMA)*: One of the MU2 objectives involves the implementation of the BCMA project at Bellevue, Coney Island, Harlem, Metropolitan, Lincoln and Woodhull Hospitals. Preparation at each of these sites included the acquisition of new equipment (scanners and medication carts), database configuration and training. The goal is to go live at all the sites by July 31, 2013. To date, both Harlem and Lincoln have completed their go-lives; and *Beta Software Agreement*: the Beta Software agreement with Jacobi Medical Center and QuadraMed has been fully executed and the QCPR 6.0 Beta Code was loaded as of Friday, June 16, 2013. A kick-off meeting was held to discuss both testing and training.

6. Update on Deployment of the HHC Care Plan Management System (CPMS)

Phase 1 of HHC's Care Plan Management System, which uses Amalga, HealthVault and Get Real Health InstantPHR, has gone live at seven (7) facilities including Kings, Woodhull, Lincoln, Coney, Metropolitan, Cumberland and East New York. The remaining facilities are scheduled and will be completed in the next two months. The next phase of CPMS which will deploy in the fall of 2013 will allow HHC to provide

patients with a Personal Health Record (PHR). The Patient Portal will allow patients to view their Care Plans and interact with their care team.

7. Providing Patients Access to their Health Information in support of Meaningful Use – Stage 2

For Meaningful Use Stage 2 (MU2), HHC is required to provide patients with the ability to view online, download, and transmit information about a hospital admission. Fifty percent (50%) of HHC's patients must have the information available online within thirty-six (36) hours of discharge. Additionally, we must demonstrate that more than 5% of our patients have accessed this information within the MU2 attestation reporting period. There are four, 3 month attestation reporting periods that HHC can target for each facility. The first starts October 1st and the last start July 1, 2014. HHC has approximately 1.4 million admissions a year. Therefore, HHC needs to implement a patient portal supporting at least 110,000 patients with at least 11,000 logging in to use it. Additionally the system must be fully implemented and live before facility's MU2 attestation period can start.

EITS performed a review of several different possible portal solutions to meet the requirement. The solutions considered included QuadraMed's new Patient Access Module (PAM) available in QCPR version 6.0, New York eCollaborative's (NYeC's) new patient portal, and HHC's Care Plan Management System (CPMS). The CPMS system provided the best solution considering time to implement, cost, risk, and quality of the portal experience.

In the next month, EITS will be working with other relevant departments to solidify the scope of the effort as well as defining the project team. Two (2) issues present the biggest challenges for the project at this time. First, the key to making the MU2 requirement involves getting the patients to actually log in and use the system. This will require analyzing and modifying existing admission and discharge processes as well as engaging the clinical staff in how to utilize the system. Second, the solution must be implemented in a very short timeframe. Scope will need to be managed such that non-essential portal design features and functions do not cause delays. A full plan is being developed for review.

METROPLUS HEALTH PLAN, INC.

Van H. Dunn, MD, Medical Director, MetroPlus Health Plan, Inc. presented to the Committee. Dr. Dunn informed the Committee that the total plan enrollment as of June 28th, 2013 was 427,758. Breakdown of plan enrollment by line of business is as follows:

Medicaid	366,017
Child Health Plus	12,668
Family Health Plus	33,394
MetroPlus Gold	3,236
Partnership in Care(HIV/SNP)	5,446
Medicare	6,799
MLTC	198

Dr. Dunn provided the Committee with reports of members disenrolled from MetroPlus due to transfer to other health plans, as well as a report of new members transferred to MetroPlus from other plans.

Dr. Dunn informed the Committee that their membership has declined by approximately 12,600 members in the last four months. This is due to a combination of multiple factors including a high rate of members losing eligibility and failing to recertify, a decrease in the number of new applicants, and losses to two competitor health plans. MetroPlus has brought in a new class of marketing representatives who will be going out in the field as of this month to ensure that MetroPlus has a full quota of representatives. MetroPlus is also

frequently reassessing their marketing structure as well as increasing their outreach and touch campaigns to help with retention efforts.

In June, MetroPlus successfully completed their full Article 44 licensing audit by the New York State Department of Health. The review, which is normally completed over a five day period, was completed after only three days. The auditors were congratulatory about all of their in-house procedures and found no deficiencies in their internal processes. MetroPlus will likely have one area of deficiency concerning letters that CVS Caremark sends on their behalf for initial pharmacy denials. A corrective action plan was immediately put in place and the appropriate changes have been made.

MetroPlus has submitted their 2014 Medicare bid on time. The CMS desk audit has commenced. The Finance Department has 48 hours to respond to all data requests and has all staff at the ready to ensure a successful audit.

As reported previously, MetroPlus has completed and submitted applications, benefits, subscriber contracts and rates for the Health Care Marketplace (the Exchanges). MetroPlus has recently received positive feedback from New York State (NYS) on their network and NYS only offered very minor requests for adjustment to MetroPlus providers in their network. MetroPlus is eagerly awaiting release of the competitive rates, which are scheduled for release at the end of this month.

INFORMATION ITEM:

1. Patient Satisfaction – FY 2013 in Review

Presenting to the Committee was Lauren Johnston, Senior Assistant Vice President/Chief Nursing Officer, Office of Patient Centered Care. Ms. Johnston began the presentation by informing the Committee that satisfaction surveys are conducted in the following: acute care inpatients including rehab and behavioral health; outpatient including emergency department, primary care, medicine, surgery, pediatrics, etc.; survey conducted annually in dialysis and patient centered medical home; long term care facilities; home care; and employee and physician engagement.

Ms. Johnston provided the Committee with results of patient feedback for the time frame of July 1, 2012 to June 25, 2013. Performance in the emergency department shows that patients like our physicians but have a hard time getting through the door. In comparing the HHC facilities, Coney Island has the highest performance scores in eight out of the nine attributes. On the outpatient side the graphs shows improvement over the FY. The attributes of 'access' and 'moving through your visit' are that areas that performance was rated low – but these are two areas where there is current focus and initiatives in place to improve. HHC's Diagnostic & Treatment Centers tend to score higher than the acute care hospitals on the out-patient side – their best practices needs to be shared with the acute outpatient departments as a tool for improvement. On the inpatient side CMS tightly controls what you ask, when you ask, how you ask, and the language you ask the question in – there is no variation thus they are able to compare hospitals throughout the United States. Highest scoring HHC facility some of the inpatient attributes were Coney Island, Kings County, Bellevue, Woodhull and Queens. Ms. Johnston shared CMS public data for the period of June 2011 through July 2012 with the Committee that demonstrates how HHC facilities compare to non-HHC facility in each borough.

Ms. Johnston concluded her presentation by describing activities occurring to increase patient experience ratings. Executive Steering Committee that consists of all the Executive Directors and Chief Nursing Executives that reviews existing best practices for implementation such as: hourly rounding; leader rounding; RN/MD/patient conference on admission regarding 'plan of care'; discharge phone calls; and daily multidisciplinary huddles on units. Press Ganey assists us with deciding on where to focus efforts on where we can obtain the best leverage. On the inpatient side the focus is on '*Rate 9-10*' with a goal to meet the State

average of 50 percentile. On the out-patient side, our primary focus is on access such as ease of getting through to the clinic on the phone; ease of scheduling your appointment; and the courtesy of staff in the registration area. In the emergency department the focus is on overall assessment including: waiting time before staff noticed your arrival; waiting time before you were brought to the treatment area; waiting time in the treatment area before you were seen by a doctor; and information about waits and delays.

There being no further business the meeting adjourned at 11:35 A.M.

MetroPlus Health Plan, Inc.
Report to the
HHC Medical and Professional Affairs Committee
September 12th, 2013

Total plan enrollment as of August 26th, 2013 was 424,789. Breakdown of plan enrollment by line of business is as follows:

Medicaid	362,841
Child Health Plus	12,396
Family Health Plus	33,510
MetroPlus Gold	3,269
Partnership in Care(HIV/SNP)	5,447
Medicare	7,044
MLTC	282

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.

Our membership experienced a decline of nearly 4,000 since my last report to the committee. This month, we lost members because of a State correction which removed approximately 1,500 MetroPlus members with presumed Third Party Health insurance coverage. We also experienced a lower than usual new member enrollment for August. On the good news side, enrollment improved during August and recertifications improved as well. The preliminary membership numbers for September finally show much lower losses, a change from what we have seen over the past 5 months.

MetroPlus continues to prepare for our participation on the NYS Exchange. The rates for products on the Exchange were released in July and MetroPlus offered the lowest cost products for three out of four metal levels. MetroPlus is continually assessing the risks and potential benefits of this pricing level. This month, New York State released the name for the Health Benefit Exchange. The Exchange is now called New York State of Health: The Official Health Plan Marketplace. In order to facilitate the enrollment process, NYS will begin training for Certified Application Counselors (CACs) in September. Exchange CACs will provide the same core application assistance services available through the Exchange, Navigators, and licensed agents or brokers and must be able to provide information on the full range of Qualified Health Plan (QHP) options for which applicants are eligible. MetroPlus will train some of our current Facilitated Enrollers to dually serve as CACs that can aid eligible members with enrollment into the Exchange, as well as hiring a small staff of dedicated CACs.

This month, we calculated HHC Quality Rankings based on 2012 QARR (Quality Assurance Reporting Requirements) scores. To determine the rankings, MetroPlus used 17 QARR measures and three member satisfaction CAHPS (Consumer Assessment of Healthcare Providers and Systems) measures. The overall ranking was determined by how a facility placed for each measure selected. In 2012, Gouverneur Health was ranked in first place and Kings County earned the “most improved” designation, from the prior year.

The Department of Health (DOH) has significantly revised the policy and timetable for the Nursing Home population and benefit to be carved into Medicaid managed care for both non-duals and dual eligible individuals. Medicaid recipients permanently placed in a nursing home before the transition date for their region will not be required to enroll in a managed care plan for the duration of their nursing home placement. In New York City, Westchester and Long Island, after January 1, 2014, adults requiring a permanent nursing home stay will be mandatorily enrolled in a plan: mainstream Medicaid managed care for non-duals or Managed Long Term Care (MLTC) for duals. Upstate counties will begin implementation April 1, 2014. Children under age 21 will not transition until April 1, 2015. Given the new policy, DOH is estimating approximately 20,600 managed care enrollments of individuals requiring permanent nursing home care statewide in the first year of implementation. Approximately 19,000 of those will be dual-eligibles, and 1,600 Medicaid-only.

This month, DOH and CMS announced the Fully Integrated Duals Advantage (FIDA) Memorandum of Understanding. FIDA is a State of New York partnership with CMS to test a new model for providing Medicare-Medicaid enrollees with a more coordinated, person-centered care experience. Enrollment will be phased in over several months. Beneficiaries receiving community-based long-term services and supports will be able to opt in to the demonstration beginning on July 1, 2014. On September 1, 2014, eligible beneficiaries who have not made a choice to opt in or out will be assigned to a Medicare-Medicaid Plan through a process that will match beneficiaries with the most appropriate plan. Beneficiaries receiving facility-based long-term services and supports will be able to opt into the demonstration beginning October 1, 2014. Those who have not made a choice to opt in or out will be assigned to a Medicare-Medicaid Plan beginning no earlier than January 1, 2015. Beneficiaries will be able to opt out of the demonstration or select an alternative Medicare-Medicaid Plan at any time. MetroPlus has been approved to participate in the FIDA demonstration project and will be prepared to provide services in 2014.

Finally, OASAS, OMH, and DOH have announced a revised time line for implementing the transition of Behavioral Health services to Medicaid managed care. Implementation target dates have been delayed and are now: January 1, 2015, for adults in New York City, July 1, 2015, for adults in the rest of the state, and January 1, 2015, for children statewide.

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

August-2013

		Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13
Total Members	Prior Month	445,134	442,379	433,060	432,709	431,193	429,931	428,383
	New Member	16,688	13,317	15,434	14,607	14,515	15,269	12,331
	Voluntary Disenroll	2,988	2,697	3,094	2,547	2,539	2,892	2,219
	Involuntary Disenroll	16,455	19,939	12,691	13,576	13,238	13,925	13,706
	Adjusted	-121	-127	-135	-100	310	1,449	0
	Net Change	-2,755	-9,319	-351	-1,516	-1,262	-1,548	-3,594
	Current Month	442,379	433,060	432,709	431,193	429,931	428,383	424,789
Medicaid	Prior Month	379,870	378,269	370,356	370,111	369,030	368,071	366,239
	New Member	14,055	11,011	12,699	12,051	11,792	12,338	9,827
	Voluntary Disenroll	2,453	2,305	2,598	2,161	2,138	2,451	1,850
	Involuntary Disenroll	13,203	16,619	10,346	10,971	10,613	11,719	11,375
	Adjusted	-86	-93	-110	-84	306	1,366	0
	Net Change	-1,601	-7,913	-245	-1,081	-959	-1,832	-3,398
	Current Month	378,269	370,356	370,111	369,030	368,071	366,239	362,841
Child Health Plus	Prior Month	13,462	13,092	12,928	12,849	12,745	12,664	12,566
	New Member	387	410	450	447	464	387	344
	Voluntary Disenroll	30	58	43	31	26	21	36
	Involuntary Disenroll	727	516	486	520	519	464	478
	Adjusted	-15	-16	-15	-20	-20	-8	0
	Net Change	-370	-164	-79	-104	-81	-98	-170
	Current Month	13,092	12,928	12,849	12,745	12,664	12,566	12,396
Family Health Plus	Prior Month	36,465	35,719	34,337	34,199	33,738	33,448	33,601
	New Member	1,830	1,480	1,872	1,645	1,768	2,004	1,762
	Voluntary Disenroll	239	193	284	198	216	252	180
	Involuntary Disenroll	2,337	2,669	1,726	1,908	1,842	1,599	1,673
	Adjusted	-1	-2	-1	1	4	22	0
	Net Change	-746	-1,382	-138	-461	-290	153	-91
	Current Month	35,719	34,337	34,199	33,738	33,448	33,601	33,510

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

August-2013

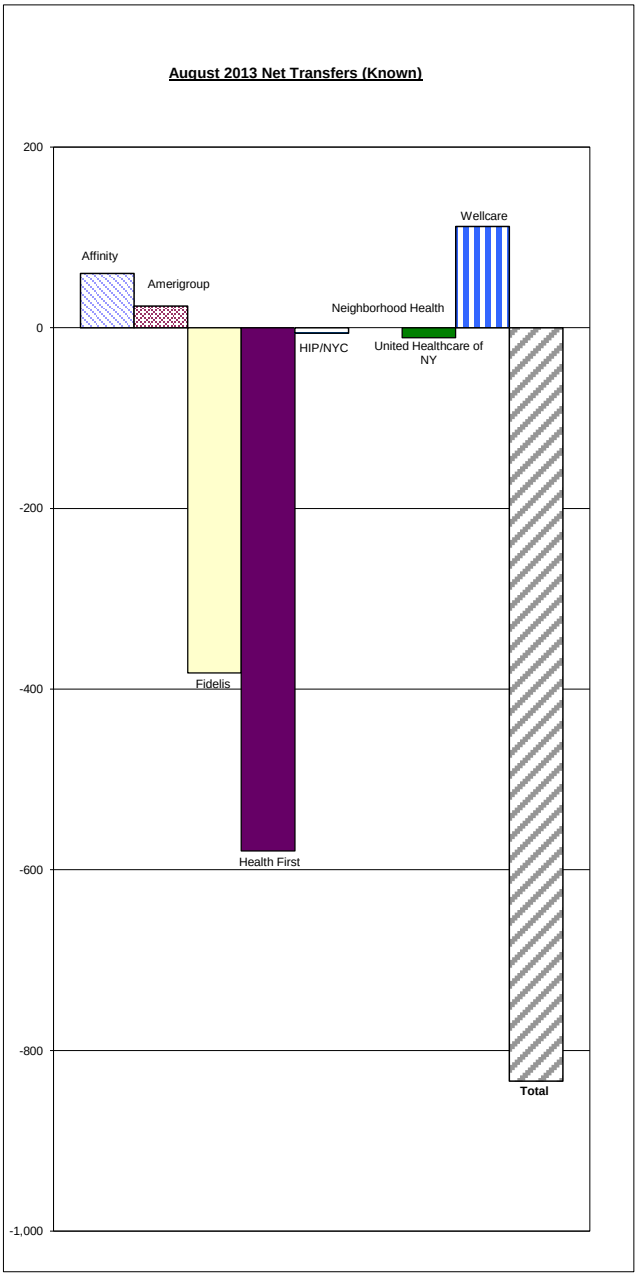
		Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13
HHC	Prior Month	3,337	3,217	3,230	3,253	3,261	3,295	3,325
	New Member	29	33	39	27	41	56	0
	Voluntary Disenroll	113	0	0	0	0	0	0
	Involuntary Disenroll	36	20	16	19	7	26	56
	Adjusted	-2	-2	-1	7	24	66	0
	Net Change	-120	13	23	8	34	30	-56
	Current Month	3,217	3,230	3,253	3,261	3,295	3,325	3,269
SNP	Prior Month	5,643	5,579	5,541	5,511	5,495	5,459	5,459
	New Member	90	89	90	92	92	101	61
	Voluntary Disenroll	50	35	41	30	43	44	29
	Involuntary Disenroll	104	92	79	78	85	57	44
	Adjusted	-17	-14	-8	-4	-5	1	0
	Net Change	-64	-38	-30	-16	-36	0	-12
	Current Month	5,579	5,541	5,511	5,495	5,459	5,459	5,447
Medicare	Prior Month	6,351	6,481	6,614	6,687	6,780	6,795	6,936
	New Member	280	262	239	291	292	313	294
	Voluntary Disenroll	102	106	128	127	116	124	124
	Involuntary Disenroll	48	23	38	71	161	48	62
	Adjusted	0	0	0	0	0	0	0
	Net Change	130	133	73	93	15	141	108
	Current Month	6,481	6,614	6,687	6,780	6,795	6,936	7,044
Managed Long Term Care	Prior Month	6	22	54	99	144	199	257
	New Member	17	32	45	54	66	70	43
	Voluntary Disenroll	1	0	0	0	0	0	0
	Involuntary Disenroll	0	0	0	9	11	12	18
	Adjusted	0	0	0	0	1	2	0
	Net Change	16	32	45	45	55	58	25
	Current Month	22	54	99	144	199	257	282

Disenrollments TO Other Plans		Aug-13			Sept-12 to Aug-13		
		FHP	MCAD	Total	FHP	MCAD	Total
	INVOL.	0	1	1	1	8	9
	VOL.	13	77	90	169	1,414	1,583
Affinity Health Plan	TOTAL	13	78	91	170	1,422	1,592
	INVOL.	0	0	0	2	17	19
	VOL.	12	177	189	230	2,448	2,678
Amerigroup/Health Plus/CarePlus	TOTAL	12	177	189	232	2,466	2,698
	INVOL.	0	1	1	3	25	28
	VOL.	66	497	563	916	7,941	8,857
Fidelis Care	TOTAL	66	498	564	919	7,966	8,885
	INVOL.	0	0	0	1	54	55
	VOL.	58	769	827	815	10,262	11,077
Health First	TOTAL	58	769	827	816	10,317	11,133
	INVOL.	0	0	0	0	9	9
	VOL.	5	71	76	99	920	1,019
HIP/NYC	TOTAL	5	71	76	99	929	1,028
	INVOL.	0	0	0	1	3	4
	VOL.	0	0	0	63	755	818
Neighborhood Health	TOTAL	0	0	0	64	758	822
	INVOL.	0	2	2	4	381	385
	VOL.	7	111	118	160	1,374	1,534
United Healthcare of NY	TOTAL	7	113	120	164	1,755	1,919
	INVOL.	0	0	0	2	5	7
	VOL.	3	19	22	43	356	399
Wellcare of NY	TOTAL	3	19	22	45	361	406
	INVOL.	1	19	20	35	1,980	2,015
	VOL.	180	1,741	1,921	2,623	25,755	28,378
Disenrolled Plan Transfers:	TOTAL	181	1,760	1,941	2,659	27,737	30,396
	INVOL.	1	8	9	28	559	587
	VOL.	0	59	59	7	855	862
Disenrolled Unknown Plan Transfers:	TOTAL	1	67	68	35	1,415	1,450
	INVOL.	1,049	10,486	11,535	12,247	116,223	128,470
	UNK.	0	1	1	21	47	68
	VOL.	0	50	50	6	864	870
Non-Transfer Disenroll Total:	TOTAL	1,049	10,537	11,586	12,274	117,134	129,408
	INVOL.	1,051	10,513	11,564	12,310	118,762	131,072
	UNK.	0	1	1	22	50	72
	VOL.	180	1,850	2,030	2,636	27,474	30,110
Total MetroPlus Disenrollment:	**TOTAL**	**1,231**	**12,364**	**13,595**	**14,968**	**146,286**	**161,254**

Disenrollments FROM Other Plans	Aug-13			Sept-12 to Aug-13		
	FHP	MCAD	Total	FHP	MCAD	Total
Affinity Health Plan	14	137	151	186	1,919	2,105
Amerigroup/Health Plus/CarePlus	21	192	213	290	2,906	3,196
Fidelis Care	15	167	182	182	2,474	2,656
Health First	24	224	248	199	2,121	2,320
HIP/NYC	2	68	70	65	1,041	1,106
Neighborhood Health	0	0	0	137	1,412	1,549
United Healthcare of NY	12	97	109	131	1,488	1,619
Wellcare of NY	25	109	134	187	1,091	1,278
Total	113	994	1,107	1,377	14,452	15,829
Unknown/Other (not in total)	1,675	8,878	10,553	19,283	120,311	139,594

Data Source: RDS Report 1268a&c Updated 08/26/2013

Net Difference	Aug-13			Sept-12 to Aug-13		
	FHP	MCAD	Total	FHP	MCAD	Total
Affinity Health Plan	1	59	60	16	497	513
Amerigroup/Health Plus/CarePlus	9	15	24	58	440	498
Fidelis Care	-51	-331	-382	-737	-5,492	-6,229
Health First	-34	-545	-579	-617	-8,196	-8,813
HIP/NYC	-3	-3	-6	-34	112	78
Neighborhood Health	0	0	0	73	654	727
United Healthcare of NY	5	-16	-11	-33	-267	-300
Wellcare of NY	22	90	112	142	730	872
Total	-68	-766	-834	-1,282	-13,285	-14,567



MetroPlus Health Plan

New Member Transfer From Other Plans

	2012_09		2012_10		2012_11		2012_12		2013_01		2013_02		2013_03		2013_04		2013_05		2013_06		2013_07		2013_08		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	
AETNA	0	20	2	13	0	23	0	12	0	20	1	30	2	14	6	29	4	24	6	16	2	25	2	13	264
Affinity Health Plan	21	212	15	201	15	190	7	128	19	152	19	139	15	141	21	170	11	128	16	149	13	172	14	137	2,105
Amerigroup/Health Plus/CarePlus	29	332	20	263	36	280	22	188	24	211	21	205	22	237	28	271	21	259	17	217	29	251	21	192	3,196
BC/BS OF MNE	1	47	2	40	5	67	3	40	5	30	2	36	2	24	1	47	4	36	2	30	1	26	5	26	482
CIGNA	1	18	2	22	1	27	0	25	1	25	3	32	6	16	4	12	4	27	4	20	3	29	5	19	306
Fidelis Care	13	215	11	203	23	284	12	158	6	164	11	191	15	197	21	251	14	195	16	233	25	216	15	167	2,656
GROUP HEALTH INC.	3	17	2	22	2	32	3	17	2	22	2	30	1	25	5	19	0	21	3	19	3	32	1	13	296
Health First	22	177	13	165	18	190	5	117	14	147	11	148	18	162	15	182	14	150	13	171	32	288	24	224	2,320
HEALTH INS PLAN OF GREATER N	1	23	2	19	1	34	1	39	2	27	5	33	3	20	4	30	2	34	1	21	4	19	4	22	351
HIP/NYC	8	128	4	96	4	106	5	52	6	78	5	94	7	83	9	91	10	73	2	90	3	82	2	68	1,106
Neighborhood Health Provider PHPS	12	186	13	144	19	194	13	110	18	130	19	157	11	128	11	118	11	99	10	141	0	5	0	0	1,549
OXFORD INSURANCE CO.	2	10	0	7	1	19	0	8	3	17	2	18	3	17	2	10	0	10	0	8	2	13	1	14	167
UNION LOC. 1199	10	26	11	39	14	50	9	21	13	36	10	40	6	35	8	35	12	41	8	37	22	72	14	27	596
United Healthcare of NY	16	110	10	121	5	151	6	111	7	110	15	104	18	120	10	150	8	152	9	128	15	134	12	97	1,619
Unknown PLan	1,674	10,483	1,502	9,191	1,765	13,457	1,184	7,178	1,380	9,093	1,701	11,781	1,352	8,616	1,730	10,213	1,542	9,761	1,669	9,389	1,839	10,245	1,643	8,744	137,132
Wellcare of NY	12	88	16	79	18	85	8	70	5	91	16	108	18	90	18	102	13	51	16	101	22	117	25	109	1,278
TOTAL	1,825	12,092	1,625	10,625	1,927	15,189	1,278	8,274	1,505	10,353	1,843	13,146	1,499	9,925	1,893	11,730	1,670	11,061	1,792	10,770	2,015	11,726	1,788	9,872	155,423

Report ID: MHP1268C
Report Run Date: 8/15/2013

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 08/14/2013

Other Plan Name	Category	2012_09		2012_10		2012_11		2012_12		2013_01		2013_02		2013_03		2013_04		2013_05		2013_06		2013_07		2013_08		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	
AETNA	INVOLUNTARY	0	2	0	1	0	2	0	0	0	0	0	1	0	3	1	0	0	13	0	1	2	118	0	4	148
	VOLUNTARY	0	0	0	0	0	0	0	0	0	0	0	0	1	2	1	4	0	1	0	0	1	0	0	0	10
	TOTAL	0	2	0	1	0	2	0	0	0	0	0	1	1	5	2	4	0	14	0	1	3	118	0	4	158
Affinity Health Plan	INVOLUNTARY	0	0	0	0	0	0	1	0	0	1	0	2	0	1	0	1	0	1	0	1	0	0	0	1	9
	VOLUNTARY	11	133	11	93	21	152	7	87	9	84	24	123	13	155	17	155	18	128	13	114	12	113	13	77	1,583
	TOTAL	11	133	11	93	21	152	8	87	9	85	24	125	13	156	17	156	18	129	13	115	12	113	13	78	1,592
Amerigroup/ Health Plus/CarePlus	INVOLUNTARY	2	1	0	1	0	0	0	2	0	2	0	1	0	1	0	3	0	3	0	1	0	2	0	0	19
	UNKNOWN	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	VOLUNTARY	11	236	14	182	17	210	11	168	22	163	25	207	18	194	32	222	20	228	21	227	27	234	12	177	2,678
	TOTAL	13	237	14	183	17	210	11	170	22	166	25	208	18	195	32	225	20	231	21	228	27	236	12	177	2,698
BC/BS OF MNE	INVOLUNTARY	0	1	0	4	0	1	0	1	1	1	0	2	0	2	0	2	0	24	0	2	0	207	0	0	248
	VOLUNTARY	0	2	1	1	1	4	1	1	0	1	1	2	0	3	0	0	1	0	1	0	1	1	0	0	22
	TOTAL	0	3	1	5	1	5	1	2	1	2	1	4	0	5	0	2	1	24	1	2	1	208	0	0	270
CIGNA	INVOLUNTARY	0	1	0	1	0	0	0	3	0	2	0	3	1	1	0	0	0	22	1	3	0	324	1	5	368
	VOLUNTARY	0	0	0	1	0	0	0	1	0	1	0	0	0	1	1	2	0	0	0	1	0	0	0	0	8
	TOTAL	0	1	0	2	0	0	0	4	0	3	0	3	1	2	1	2	0	22	1	4	0	324	1	5	376
Fidelis Care	INVOLUNTARY	0	0	0	2	0	1	0	6	1	2	0	1	1	0	0	5	1	1	0	2	0	4	0	1	28
	VOLUNTARY	99	792	90	653	79	877	40	549	84	635	73	713	66	650	95	756	56	592	75	555	93	672	66	497	8,857
	TOTAL	99	792	90	655	79	878	40	555	85	637	73	714	67	650	95	761	57	593	75	557	93	676	66	498	8,885
GROUP HEAL	INVOLUNTARY	1	2	1	2	1	1	0	5	0	1	1	3	0	4	1	0	0	19	0	1	0	135	0	1	179

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 08/14/2013

		2012_09		2012_10		2012_11		2012_12		2013_01		2013_02		2013_03		2013_04		2013_05		2013_06		2013_07		2013_08		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	
GROUP HEALTH INC	VOLUNTARY	0	0	1	2	1	1	0	0	0	0	1	1	0	1	1	2	0	1	1	0	0	0	1	0	14
	TOTAL	1	2	2	4	2	2	0	5	0	1	2	4	0	5	2	2	0	20	1	1	0	135	1	1	193
Health First	INVOLUNTARY	0	0	0	5	0	1	1	5	0	8	0	0	0	2	0	10	0	3	0	7	0	13	0	0	55
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
	VOLUNTARY	69	910	60	836	74	931	63	662	55	768	60	843	63	855	84	1,009	67	811	69	817	93	1,051	58	769	11,077
	TOTAL	69	910	60	841	74	932	64	667	55	776	60	844	63	857	84	1,019	67	814	69	824	93	1,064	58	769	11,133
HEALTH INS PLAN OF GREATER NY	INVOLUNTARY	0	2	0	0	1	1	0	6	0	1	0	2	0	3	0	3	0	12	0	3	0	162	0	1	197
	VOLUNTARY	0	0	0	1	0	1	0	2	0	2	1	0	1	1	0	1	0	1	0	0	0	0	1	0	12
	TOTAL	0	2	0	1	1	2	0	8	0	3	1	2	1	4	0	4	0	13	0	3	0	162	1	1	209
HIP/NYC	INVOLUNTARY	0	1	0	0	0	0	0	1	0	0	0	1	0	2	0	2	0	0	0	0	0	2	0	0	9
	VOLUNTARY	10	91	13	52	17	91	6	68	5	82	13	81	4	85	10	83	3	70	9	79	4	67	5	71	1,019
	TOTAL	10	92	13	52	17	91	6	69	5	82	13	82	4	87	10	85	3	70	9	79	4	69	5	71	1,028
Neighborhood Health Provider PHPS	INVOLUNTARY	1	0	0	0	0	1	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
	VOLUNTARY	13	133	10	122	14	170	5	61	4	115	17	121	0	33	0	0	0	0	0	0	0	0	0	0	818
	TOTAL	14	133	10	122	14	171	5	61	4	117	17	121	0	33	0	0	0	0	0	0	0	0	0	0	822
OXFORD INSURANCE CO.	INVOLUNTARY	0	3	0	0	0	0	0	1	0	3	0	7	0	3	0	0	0	4	0	1	0	44	0	0	66
	VOLUNTARY	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1	0	0	0	0	0	0	0	3	0	6
	TOTAL	0	3	0	0	0	0	0	1	0	3	0	7	0	5	1	0	0	4	0	1	0	44	3	0	72
UNION LOC. 1199	INVOLUNTARY	2	0	0	3	1	2	0	2	0	2	2	2	1	2	1	4	0	25	1	2	0	237	0	4	293
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 08/14/2013

		2012_09		2012_10		2012_11		2012_12		2013_01		2013_02		2013_03		2013_04		2013_05		2013_06		2013_07		2013_08		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	
UNION LOC. 1199	VOLUNTARY	16	22	5	21	12	29	4	21	3	25	8	27	6	13	12	15	11	18	6	12	10	14	11	20	341
	TOTAL	18	22	5	24	13	31	4	23	3	27	10	29	8	15	13	19	11	43	7	14	10	251	11	24	635
United Healthcare of NY	INVOLUNTARY	0	0	0	1	0	1	0	2	0	1	0	5	1	2	1	4	1	17	0	2	1	344	0	2	385
	VOLUNTARY	11	91	7	86	21	144	12	76	16	86	13	138	17	113	19	151	14	109	19	130	4	139	7	111	1,534
	TOTAL	11	91	7	87	21	145	12	78	16	87	13	143	18	115	20	155	15	126	19	132	5	483	7	113	1,919
Wellcare of NY	INVOLUNTARY	0	0	0	1	0	1	0	0	0	0	0	0	1	0	0	2	0	1	1	0	0	0	0	0	7
	VOLUNTARY	3	30	3	31	3	45	2	24	5	27	3	38	3	21	9	26	4	33	2	32	3	30	3	19	399
	TOTAL	3	30	3	32	3	46	2	24	5	27	3	38	4	21	9	28	4	34	3	32	3	30	3	19	406
Disenrolled Plan Transfers	INVOLUNTARY	6	13	1	21	3	12	2	34	2	26	3	30	5	26	4	36	2	145	3	26	3	1,592	1	19	2,015
	UNKNOWN	0	0	0	0	0	0	0	0	0	1	0	1	1	0	0	0	0	0	0	0	0	0	0	0	3
	VOLUNTARY	243	2,440	215	2,081	260	2,655	151	1,720	203	1,989	239	2,294	192	2,129	282	2,426	194	1,992	216	1,967	248	2,321	180	1,741	28,378
	TOTAL	249	2,453	216	2,102	263	2,667	153	1,754	205	2,016	242	2,325	198	2,155	286	2,462	196	2,137	219	1,993	251	3,913	181	1,760	30,396
Disenrolled Unknown Plan Transfers	INVOLUNTARY	1	9	0	80	2	21	0	63	2	42	8	17	1	42	5	17	2	26	1	41	5	193	1	8	587
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
	VOLUNTARY	0	77	0	54	0	91	0	54	2	29	0	67	0	90	1	94	2	98	0	73	2	69	0	59	862
	TOTAL	1	86	0	134	2	112	0	117	4	71	8	85	1	132	6	111	4	124	1	114	7	262	1	67	1,450
Non-Transfer Disenroll Total	INVOLUNTARY	1,194	10,142	888	8,886	1,227	10,552	154	5,531	132	3,811	1,638	12,455	1,912	15,863	932	9,543	1,096	10,103	1,102	9,735	923	9,116	1,049	10,486	128,470
	UNKNOWN	2	4	4	15	2	2	0	5	0	2	7	7	1	2	0	5	1	1	4	1	0	2	0	1	68
	VOLUNTARY	0	82	0	55	0	83	0	53	0	58	0	89	1	86	1	78	2	71	0	98	2	61	0	50	870
	TOTAL	1,196	10,228	892	8,956	1,229	10,637	154	5,589	132	3,871	1,645	12,551	1,914	15,951	933	9,626	1,099	10,175	1,106	9,834	925	9,179	1,049	10,537	129,408

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 08/14/2013

		2012_09		2012_10		2012_11		2012_12		2013_01		2013_02		2013_03		2013_04		2013_05		2013_06		2013_07		2013_08		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**	1,201	10,164	889	8,987	1,232	10,585	156	5,628	136	3,879	1,649	12,502	1,918	15,931	941	9,596	1,100	10,274	1,106	9,802	931	10,901	1,051	10,513	131,072
	UNKNOWN	2	4	4	15	2	2	0	5	0	3	7	9	2	2	0	5	1	1	4	1	0	2	0	1	72
	VOLUNTARY	243	2,599	215	2,190	260	2,829	151	1,827	205	2,076	239	2,450	193	2,305	284	2,598	198	2,161	216	2,138	252	2,451	180	1,850	30,110
	TOTAL	1,446	12,767	1,108	11,192	1,494	13,416	307	7,460	341	5,958	1,895	14,961	2,113	18,238	1,225	12,199	1,299	12,436	1,326	11,941	1,183	13,354	1,231	12,364	161,254

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate and execute a contract with The Nash Group ("Nash") for enterprise–wide nursing optimization. The contract shall be for a period of three years with one, three-year option to renew exercisable solely by the Corporation, in an amount not to exceed $7 million for the entire term of the contract, including the initial and optional renewal terms.

WHEREAS, the Corporation desires to deploy staff more efficiently and reduce annual staffing costs; and

WHEREAS, the Corporation will enhance continuity of care, diminish incidental shifts, vacancies and lessen recruitment needs, improve patient flow and close admission and discharges gap, and meet financial expectations without laying off staff or changing skill mix; and

WHEREAS, a Negotiated Acquisition ("NA") was issued on May 24, 2013 in accordance with the Corporation's operating procedures; and

WHEREAS, the selection committee evaluated the proposals using criteria specified in the NA, and the committee recommended that The Nash Group be awarded the contract; and

W**HEREAS**, facilities will monitor utilization, deployment and progress toward agreed upon staffing and financial targets; and

WHEREAS, the overall responsibility for monitoring the contract shall be under 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 Nash Group ("Nash") for enterprise–wide nursing optimization. The contract shall be for a period of three years with one, three-year option to renew exercisable solely by the Corporation, in an amount not to exceed $7 million for the entire term of the contract, including the initial and optional renewal terms.

Executive Summary
Proposed Contract with The Nash Group
for Nursing/Staffing Optimization

The accompanying resolution requests approval to negotiate and enter into a contract with The Nash Group (Nash) to deploy nursing staff more efficiently and reduce annual supplemental staffing costs which was $118.8 million in FY2012.

HHC spent $118.8 million for supplementary staffing in FY2012, this is in addition to the more than 8,000 salaried employees who provide direct patient care. These expenses are ongoing and contribute to the financial threats HHC is facing. Currently there is a variety of practices with regard to staff deployment, including surveillance staffing, leave coverage, replacement factors and targets. As a result, it is difficult to generate accurate staffing reports within the corporation. Therefore, contracting with a vendor who has this expertise and proven track record is a logical next step in enhancing and improving the process.

The vendor will provide analysis, technology, and support to implement effective strategies in HHC facilities that will improve operations for the nursing units. This project will enhance continuity of care, diminish incidental shifts, vacancies and lessen recruitment needs, improve patient flow and close admission and discharges gap, meet financial expectations without laying off staff or changing skill mix, and allow more staff to be brought to the bedside at no additional cost.

A Negotiated Acquisition ("NA") was issued on May 24, 2013, in accordance with the Corporation's operating procedure. Four (4) vendors were invited to respond to the Negotiated Acquisition, three (3) vendors responded by submitting proposals. All three (3) vendors were invited to present to the committee, evaluations were completed by the selection committee and rated using criteria specified in the NA. The selection committee recommended that The Nash Group be awarded the contract. The Nash Group is offering professional services via its GNYHA GPO contract.

The Nash Group has assisted healthcare organizations since 1992. Their proven methods foster best practices in nurse staffing, conform with financial imperatives, improve staff retention and satisfaction, and deliver measurable cost savings and ROI. They have clients throughout the country, including Maimonides, NYU Medical Center and Continuum.

The contract shall be for a period of three (3) years with one (1), additional three (3) year option to renew exercisable solely by the Corporation, in an amount not to exceed $7 million for the entire term of 6 years.

CONTRACT FACT SHEET

New York City Health and Hospitals Corporation

Contract Title: Nursing/Staffing Optimization

Project Title & Number: Nursing/Staffing Optimization DCN#:2099

Project Location: 346 Broadway, Room 1136, New York, NY 10003

Requesting Dept: Division of Medical and Professional Affairs, Office of Patient Centered Care

Successful Respondent:	The Nash Group
Contract Amount:	not to exceed $7 million
Contract Term:	Three years with one (1) renewal three year option, exercisable solely by the Corporation

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

Range of Proposals: $7 million to $11 million

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

Funding Source:
_ General Care _ Capital
_ Grant: Explain _____
X Other: Explain Central Office Budget

Method of Payment:
_ Lump Sum _ Per Diem X Time and Rate
_ Other: explain _____

EEO Analysis: Approved

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

Vendex Clearance _Yes _ No X N/A __Pending (Vendor is part of GPO)

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

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

HHC would like to negotiate a contract with The Nash Group, who will provide consulting and technical support required to reduce staffing costs, streamline deployment functions, and develop real-time strategies to adjust to fluctuations in patient census and acuity. This project will focus on nursing workforce optimization as well as the analysis of the departmental deployment functions.

HHC spent $118.8 million for supplementary staffing in FY2012, this is in addition to the cost of more than 8,000 salaried employees who provide direct patient care. These expenses are ongoing and contribute to the financial threats HHC is facing. Currently there is a variety of practices with regard to staff deployment, including surveillance staffing, leave coverage, replacement factors and targets. As a result, it is difficult to generate accurate, timely staffing reports within the corporation. Therefore, contracting with a vendor who has this expertise and proven track record is a logical next step in enhancing and improving the process.

The vendor will provide consulting services, technology and on-going support. They will perform an analysis of the current and proposed future state of HHC staffing. During the vendor's engagement they will apply a standardized evidence-based approach to the most efficient deployment of staff based on patients' needs. HHC will also be able to produce facility and corporate level reporting on demand.

Contract Review Committee

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

Yes, May 22 and July 12, 2013, approved September 4, 2013

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:

The original projected budget was based on acute care hospitals only, the new projected budget is inclusive of all HHC acute care hospitals, diagnostic and treatment centers and long term care/nursing facilities. The budget will be controlled and monitored centrally.

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

Committee Members:

Chairperson	
Lauren Johnston	*SAVP Office of Patient Centered Care*
Members	
Miriam Carasa	*Chief Nurse, WMMHC*
Joann Gull	*Chief Nurse, EHC*
Moftia Aujero	*Chief Nurse, BHC*
Lillian Diaz	*Chief Nurse, MHC*
Frederick Covino	*AVP, Corp Budget*
Paul Contino	*Chief Technology Officer, IT*
Mirasol Vasquez	*Associate Director, Nursing - Staffing, BHC*
Nancy Doyle	*SAVP, Human Resources*
Yvette Villanueva	*HR – Generations Plus*
Julius Wool	*Executive Director, QHC*
Janet Karageozian	*Senior Director, IT Business Applications*
Mary Carty	*Associate Director Nursing, MHC*

List of Firms Responding:

Assay
MedAssets
The Nash Group

List of Firms Evaluated:

Assay
MedAssets
The Nash Group

Firm Selected:

The Nash Group

Describe the process used to select the proposed contractor, the selection criteria, and the justification for the selection:

In order to solicit the appropriate vendors the Negotiated Acquisition (NA) process was utilized. Four vendors were contacted and asked to submit proposals. Three of these vendors responded and participated in the process and submitted full proposals. Each vendor was invited to present their proposal to the Committee, and did such. After this meeting, the committee requested additional information from each vendor and invited them back to present again. Upon conclusion of the second presentation meetings, but before the evaluation, any questions the Committee had were brought to the vendors for clarification. Once the Committee was satisfied that each of their questions were answered, the evaluations were completed and returned to Committee Chairpersons office. All the evaluations were reviewed and tabulated and the results revealed The Nash Group as the vendor of choice. The Nash Group is offering professional services via its GNYHA GPO contract.

Costs/Benefits:

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

The level of complexity of the calculations completed by the vendor is proprietary and beyond the ability of current corporation resources. As an objective third party the vendor brings needed resources to collect and analyze data as well as implement agreed to changes in a standardized, evidence-based manner.

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?

N/A

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

Ross Wilson, MD - Senior Vice President/Corporate Chief Medical Officer, Division of Medical and Professional Affairs

Lauren Johnston, FACHE – Senior Assistant Vice President, Office of Patient Centered Care

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

Received By E.E.O. *7/8/2013*
Date

Analysis Completed By E.E.O 7/9/13 Manasses C. Williams
Date *Name*

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

346 Broadway • Room 500B • New York, NY 10013 • Tel: 212-788-3380 • Fax: 212-788-3689

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

TO: Beth Brooks
Assistant Director
Central Office – Patient Centered Care

FROM: Manasses C. Williams

DATE: July 9, 2013

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

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

Project Location(s): HHC – Corporate Wide

Contract Number: _____ Project Number:_____

Submitted by: Central Office – Patient Centered Care

EEO STATUS:

1. [x] Approved

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

3. [ ] Not approved

4. [ ] Conditionally approved subject to EEO Committee Review

COMMENTS:

c:

Nursing Staffing Optimization Services

Medical & Professional Affairs/IT Committee

September 12, 2013

The Context

- Ongoing financial pressure on HHC
- The majority of personnel costs are nursing related, and nursing is the cornerstone for patient care
- Within the total “nursing” expenditure of $818m in FY 2012, we spent $119 million for “nursing” overtime and agency staffing
- The science of logistics is used extensively in complex delivery systems in planning the deployment of staff.
- Preliminary studies at two HHC sites projected that using optimization would yield significant savings, while enhancing patient care in the most efficient manner at the lowest cost.

What is “Optimization”?

- A standardized, evidenced-based approach using real time data for the most efficient deployment of staff based on patients needs
  - Reduces the incidence when units are short staffed, and decreasing the use of premium pay used to cover last minute absences.
- 24/7/365 review of planning and monitoring of staff deployment in all levels of acuity – acute, ambulatory and long term care

How will HHC Nursing Optimize?

- Use consulting services, technology and on-going support with the goal of reducing cost while maintaining or enhancing service and staff
- Vendor, Corporate and facility leadership and staff to understand the needs and expectations of each
- Patient placement algorithms to match staff competencies and supply
- Facility and corporate level reporting on demand
- Roll out over 18 months, with continued support over life of contract

Procurement Methodology

- Negotiated Acquisition process was utilized
- 4 vendors were invited to submit proposals
- Advertisement posted in the City Record
- 3 major vendors in the field responded with written and verbal presentations
- Evaluation committee included leaders from nursing, facilities, human resources, finance, business intelligence and applications management
- The Nash Group was the unanimous choice

Contract

- Contract structured as three years with an option for three additional years
- Consulting costs are phased in over the first 3 years, as facilities begin the process
- Licensing fees paid over life of engagement, commencing with on-site consulting
- Payments for each site do not commence until assessment is complete – at least 6 months from each facility kick-off

Cost of the Program

	FY 14*	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20*	6 yr Cost
Consulting	$34,697	$500,747	$916,307	$948,763	$948,763	$948,763	$237,191	$4,535,232
Technology	$16,798	$220,414	$494,451	$532,947	$532,947	$532,947	$133,237	$2,463,740
Total Cost	**$51,496**	**$721,161**	**$1,410,758**	**$1,481,710**	**$1,481,710**	**$1,481,710**	**$370,428**	**$6,998,972**

* Partial years

a reduction of less than 1.5% of our annual supplemental costs more than pays the highest annual fee for the program

Resolution

Authorizing the President of the New York City Health and Hospitals Corporation to negotiate and execute a contract with The Nash Group to provide nursing staffing optimization services to NYCHHC

New York City Health and Hospitals Corporation
Windows 7 and Office 2010
Deployment Status

Medical & Professional Affairs/IT Committee

Sal Guido, AVP- Infrastructure

September 12, 2013

Desktop Standardization

EITS has created a Desktop Taskforce team comprising members all the hospital networks' IT departments. The taskforce was charged with standardizing the desktops in the corporation.

- Upgrade all desktops that were 4 years and older
- Standardize desktop Base Image
- Desktop Look and Feel
- Hardware Standardization
- Security (virus protection and disk encryption)
- Roles and Responsibilities

Windows 7 & Office 2010 Deployment Strategy

Project Rationale

- Windows XP SP3 End of Sale – **October 22, 2010**
- Windows XP SP3 End of Mainstream Support – **April 14, 2010**
- Windows XP SP3 End of Extended Support – **April 8, 2014**
- Windows 7 Released - **October 2009**
- Microsoft Office 2010 Released - **April 2010**
- March 2010 Enterprise IT Services Infrastructure Services worked with Microsoft to develop a strategic to upgrade the Corporation to the latest Operating System.
- Hardware/System requirements.

Migration Results

Facility	Projected	Actual	Workstations Migrated	# Ahead/Behind Schedule	Total Workstations	Total Workstation Migrations Remaining	# of Machines that cannot be Migrated to Windows 7	% Workstations Completed
Central Office	1,757	1,604		(153)	1,757	117	36	93%
Bellevue	4,259	3,102	82\	(1,157)	4,259	1,128	29	74%
Coler-Goldwater	957	930		(27)	957	17	10	98%
Gouverneur	711	697		(14)	711	3	11	100%
Metropolitan	1,947	1,753		(194)	1,947	110	84	94%
Belvis	192	192		-	192	0		100%
Morrisania	251	237		(14)	251	14		94%
Lincoln	2,728	2,519		(209)	2,728	30	179	99%
Harlem	2,752	2,563		(189)	2,752	85	104	97%
Coney Island/Seaview	2,277	2,139		(138)	2,277	0	138	100%
Kings/East NY	3,985	3,746		(239)	3,985	131	108	97%
Woodhull/Cumberland	2,830	2,802		(28)	2,830	0	28	100%
Elmhurst	3,558	3,167	20	(391)	3,558	350	41	90%
Queens	2,146	2,027		(119)	2,146	119		94%
Jacobi	3,115	3,024		(91)	3,115	0	91	100%
North Central	1,009	1,009		-	1,009	0		100%
	34,474	**31,511**	**20**	**(2,963)**	**34,474**	**2,104**	**859**	94%

Next Steps:

- Determine remainder of desktop requiring refresh
- Test Windows 8 for desktop
  - Windows 8 was released in 2012
  - Testing of Windows 8 has started in limited deployments
- Evaluate Virtual Desktop Infrastructure (VDI)

Question & Comments

Integrated Clinical Information System

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

September 2013

Agenda

- **Program Charter**
- **Accomplishments to Date**
  - **Software Load**
  - **Work Flow Preview Sessions**
- **Site / Facility Sequencing for EPIC Roll Out**
- **High Complexity Areas**
- **Next 90 Days**

Program Charter

Program Charter: Executive Overview

- The goal of the ICIS Program is to implement an integrated clinical information system that will meet HHC's need for an agile and dependable EHR. ICIS must be capable of supporting HHC's strategic and operational needs over the coming decades. Prime among these is the transformation of HHC into a "top notch" Accountable Care Organization (ACO) with the capacity to manage quality, improve care, and control cost.

Program Charter: Executive Overview

- ICIS will be implemented at every HHC hospital, Skilled Nursing Facility, Diagnostic and Treatment Center, and community-based clinic. More than 8,000 physicians, 2,500 residents, 9,000 nurses, and many other clinical and non-clinical professionals will be impacted by ICIS. The solution will be scalable and highly-available with full disaster recovery capabilities to minimize downtime. It will integrate with existing HHC clinical and enterprise applications and will support extensive business intelligence and reporting functionality.

Accomplishments to Date

Accomplishments to Date

- Epic Foundation Database has been loaded on HHC servers and is operational and accessible for HHC EITS staff members

- 95 EITS Staff have been Epic Certified in their respective modules

- Three of four work flow preview session weeks have been completed to review the Epic Foundation functionality

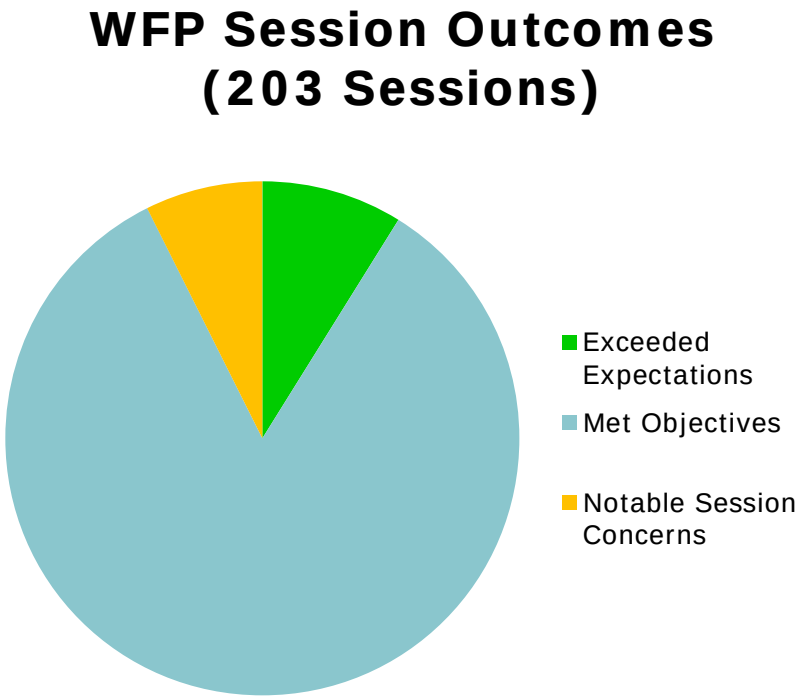
Accomplishments to Date: Work Flow Preview Sessions

Attendance

Date	Expected	Attended	Variance	Percent
9-Jul	903	646	257	71.5%
10-Jul	958	702	256	73.3%
11-Jul	789	536	253	67.9%
30-Jul	808	577	231	71.4%
31-Jul	936	692	244	73.9%
1-Aug	906	581	325	64.1%
20-Aug	652	446	206	68.4%
21-Aug	754	552	202	73.2%
22-Aug	754	528	226	70.0%

Accomplishments to Date: Work Flow Preview Sessions

WFP Session Outcome Summary		
Count of Session ID		
Outcome	Total	Percentage
Exceeded Expectations	18	8.87%
Met Objectives	170	83.74%
Notable Session Concerns	15	7.39%
Grand Total	203	



SITE/FACILITY SEQUENCING FOR EPIC ROLL OUT UPDATE

Site / Facility Sequencing for EPIC Roll Out

Criteria for Selection

- Readiness Assessment
  - Staff Readiness
  - Major Construction Projects
  - Major surveys (TJC)
- Complexity
  - Lab
  - Referral Network
  - Existing QD footprint
- Technology Infrastructure

NEXT 90 DAYS

Next 90 days

Action Items

- Complete final round of Work Flow Preview Sessions
- Complete initial round of EPIC training and certification
- Define and operationalize business work groups for in-depth content and workflow design
- Begin activation planning for first sites

High Complexity Areas of Focus

- Determining laboratory restructuring project impact on both business operations and software design
- Collaborating with Soarian team for Registration and Scheduling touch points to ensure Soarian is stabilized prior to Epic activation at Elmhurst and Queens
- Coordinating the Enterprise Medical Person Index (eMPI): one patient- one record implementation with the Epic roll out schedule

QUESTIONS ?

August 2013

iCISNEWS

ICIS WORKFLOW PREVIEWS: WEEK 2!

It is not often that users have the opportunity to give their input in the build-out of a computer system that they will be using. But that is exactly what is happening right now at HHC. The ICIS project is going to transform the way clinicians care for patients – and clinicians want to make sure that it is the best system possible.

That was the message throughout Week 2 of the ICIS Workflow Previews and it was the reason that Subject Matter Experts (SMEs) from across the HHC universe came to the New York Athletic Club for sessions on July 30 – August 1. They came to learn how the new Epic electronic health record (EHR) system will – and should – function. Over 1,600 SMEs filed into the historic building to hear Epic consultants give overviews of the user-friendly, interactive network.

"The motto of these meetings could be summarized as 'standardizing our best practices,'" said Jose Guillermo, ICIS Clinical Business Analyst. "There are hundreds of hospital systems across the country using Epic and each is allowed to tweak it to their individual standards and needs. That's what we're doing in all these sessions."

The sessions featured a panel of Epic consultants, ICIS team members and HHC SMEs. The teams coordinated step-by-step demonstrations of the system for the audience of SMEs while team members took notes on any questions brought up by attendees.

"I FELT THE SESSIONS WERE PROFESSIONALLY RUN, INSPIRING CONFIDENCE IN THE PROCESS. THEY PROVIDED AN OPPORTUNITY BOTH TO BECOME FAMILIAR WITH THE PRODUCT AND TO NETWORK, COLLABORATE AND GET USED TO MAKING DECISIONS AS A CORPORATION. STAFF WAS ALSO RESPONSIVE WHEN OPPORTUNITIES FOR IMPROVEMENT WERE SUGGESTED."

- Aaron Elliott, MD
Chief Medical Information Officer, Bellevue Hospital

"SPIRITED" RESPONSES

It has become very apparent to anyone who has sat in on any of the Workflow previews that HHC staff are not the shy, retiring types. Their responses to the presentations were "spirited, to say the least," as one SME noted, to the laughter of all in attendance.

"I REALLY ENJOYED EPIC TRAINING AT NYAC. VERY INFORMATIVE."

- Michael Hyde, RN
Operating Room Head Nurse
North Central Bronx Hospital

Indeed, HHC clinicians and administrators have had a lot to say about the Epic system because they felt that their real-world experience in treating patients was vital in creating a system that would be most user-friendly – and useful for patients. There were many times when a doctor or nurse (or both) would raise a red colored paper (a signal for objection to what is being presented) and proceed to "educate" the panel on how things truly work in an HHC facility.

NEW SESSIONS

Many meeting participants were surprised to learn that not only were their ideas being incorporated into the system, but new sessions were being created to address various concerns. These include professions and treatments that were not represented in the

Continued on page 4

CALLING ALL EXPERIENCED EPIC USERS!

DID YOU USE EPIC AT AN OLD JOB? WHAT DID YOU THINK?

WE WANT TO KNOW!

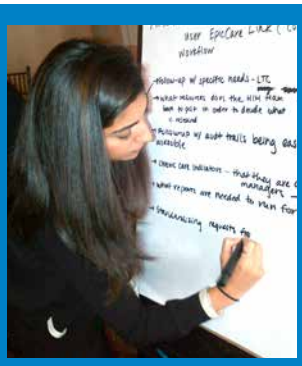
CONTACT US AT ICIS NEWS SO THAT WE CAN SHARE YOUR STORY WITH YOUR HHC COLLEAGUES:

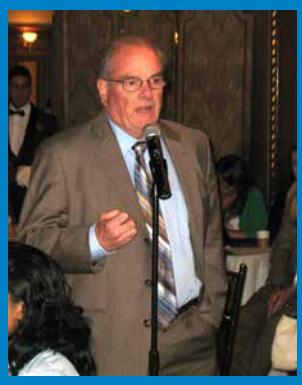
ICIS@NYCHHC.ORG

/nycHHC @HHCnyc /HHCnyc

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

ICIS Integrated Clinical Information System





WANT TO SEE MORE PHOTOS FROM WEEK 2 WORKFLOW PREVIEWS?

CLICK HERE TO SEE THEM ALL ON SHAREPOINT!

INTERVIEW WITH MICHAEL KOVALYCSIK

Michael Kovalycsik is a Clinical Business Analyst, a pharmacist and an IT professional. He also happens to be the first person in Epic's history to receive perfect scores on all the exams, projects, and homework assignments that are required for Willow Inpatient Certification. We sat down with him to learn more.

"WE WAITED WITH BATED BREATH FOR MICHAEL'S FINAL RESULT – WOULD HE BE THE FIRST IN WILLOW-INPATIENT HISTORY TO SCORE 100% ON EVERY ASSESSMENT? HE WAS. AND SINCE THEN HIS CONTRIBUTIONS HAVE REMAINED INVALUABLE. I'M THRILLED TO BE WORKING WITH MICHAEL ON THIS PROJECT."

-Peter Bonamici
Epic Willow-Inpatient Application Manager

IN: First of all, congratulations on your impressive achievement! Before we get into how you became the first person in Epic's history to earn perfect scores on all your exams, could you tell us a bit about your background?

MK: Thanks! I'm a pharmacist with a doctorate degree (PharmD) from Rutgers University. I've worked in various areas of pharmacy practice, including the pharmaceutical industry, retail pharmacy, and managed care.

IN: So you've been around in the pharma world.

MK: *(laughs)* I guess you could say that.

IN: What motivated you to become involved in clinical informatics?

MK: Good question! I've been interested in the area for a while. I think it combines my interest and abilities in IT with my background as a pharmacist.

IN: How does that work?

MK: Clinical informatics is an area where pharmacists can uniquely apply their knowledge and skills to technology. When you work as a pharmacist with actual patients, you gain certain insights and have a better idea of how things work in the real world. I think that ultimately leads to improved patient care, better outcomes, and safer treatments.

IN: So you've got to tell us your secret. How'd you achieve perfect scores on all the projects, exams, and homework for your certification? Epic says you're the first in their history to ever do this.

MK: *(laughs)* Well, Willow Inpatient is a pretty demanding and time intensive certification. It's a pharmacist-driven module, and since that's my background, I already had a lot of the foundational knowledge base that's essential for certification. I understood a lot of the key concepts, and I think that allowed me to learn the system in much greater detail.

IN: Were some parts easier or more challenging than others?

MK: Oh, absolutely. For instance, IV medications are the most challenging since there's a great deal of work to be done in order to simplify ordering and dispensing of the medications. It's imperative that all meds are done perfectly. Otherwise, go-lives won't go smoothly, and patient safety could possibly be compromised due to incorrectly built meds.

IN: So experience like yours was pretty essential.

MK: Yes, you could definitely say that. For examples, for the IV medications part of my coursework, having trained "pharmacist eyes" that pay attention to these kinds of details – and knowing the medications – were tremendously helpful. I think being a pharmacist was the biggest factor in my success, and the second

Continued on page 3

ICIS WORKFLOW PREVIEWS WEEK 2 ...BY THE NUMBERS:

- NUMBER OF HHC ATTENDEES: 1,850 (577 ON DAY 1; 692 ON DAY 2; 581 ON DAY 3)
- NUMBER OF WORKFLOW SESSIONS HELD: 66
- PERCENTAGE OF WORKFLOW SESSIONS IN WHICH ALL PLANNED CONTENT WAS COVERED: 94%
- PERCENTAGE OF VALIDATION POINTS VOTED "GREEN"/ "I AGREE WITH THIS": 89
- NUMBER OF ADDITIONAL SESSIONS IDENTIFIED AS NEEDED: 5
- AVERAGE TEMPERATURE IN CENTRAL PARK DURING THREE DAYS OF WEEK 1 VS. WEEK 2 (DEGREES FAHRENHEIT): 95 VS. 74




Interview (cont'd.)

biggest factor was investing time and effort in completing the certification.

IN: What were some of the biggest challenges you faced during the preparation process?

MK: I'd have to say it was learning the system in full detail. Epic wants you to understand the workflow of an HHC pharmacist, versus just knowing one aspect of the process. To do well on your exams, you've got to understand not just the different settings, but also their effect on workflow. The hardest part was the amount of depth and detail that you need to learn.

IN: How long did it take to go from the end of your classes to certification?

MK: I started my training at the end of March 2013. I went to classes at Epic in late March, early April and mid-May, and was certified at the beginning of June. Epic estimates that it's about 65 hours of training in total, not counting of course the studying and preparation you do on your own.

IN: Why do you think it's so significant that you were the first person to get these perfect scores?

MK: Ultimately, I think it's about much more than any personal recognition for me. I'm part of a great group of people here at HHC. I'm just happy to see that pharmacists can have such a significant role in IT. It's really important in ensuring that health information technology supports optimal and safe medication use.

IN: What do you think a new EHR system will mean for the future of the pharmacy profession?

MK: Ultimately, I think it'll help facilitate an ongoing shift from dispensing medications to increasing involvement in direct patient care. A new EHR will provide pharmacists with the tools needed to proactively monitor patients and intervene to ensure optimal outcomes, safer care and decreased costs. I can also see the role of pharmacists in IT expanding greatly.

IN: How so?

MK: EHR systems like Epic allow providers to access high-quality references, rules, and guidelines that are comprehensive, usable, actionable, and configurable. These systems also include advanced clinical decision support that proactively alerts prescribers and helps prevent errors, ensure optimal medication therapy, and decrease costs. This functionality is pretty powerful, but building it requires very strong clinical and technical knowledge.

IN: So you think that pharmacists are well suited to this?

MK: I think so. Pharmacists are trained to understand both the clinical and technical aspects of the system. In an organization of this size, with its broad scope of medication services, I think involving more pharmacists in IT will mean safer and more effective clinical information systems.

IN: What advice would you give HHC employees who are still training and yet to be certified?

MK: I'd say above all to put in the time to go through the material, study it, and know it. What you're learning is basically the foundation of what we'll be doing over the next few years. It's important to understand that. If you have questions about anything, Epic is there to answer them. Beyond that, and I know it sounds simple, but really, you just have to put in the time and learn your stuff. Also, there are so many great people in the ICIS teams. You can learn from them. That includes how they study and how their individual roles have similarities to yours. The people here are a resource and I learn more from them all the time.

CEREMONY MARKS ICIS TEAM MEMBERS GETTING CERTIFICATION, PERFECT SCORES

HHC's ICIS team had a pleasant surprise on the first day of the week's Workflow Previews: Bert Robles, Senior Vice President and Corporate Chief Informatics Officer and Dr. Louis Capponi, Chief Medical Informatics Officer, met them in a session room at the New York Athletic Club to give out certificates to everyone who had received their Epic certification.

Fifty eight team members were awarded 71 different certifications ranging from Beacon Oncology and Bedtime Bed Management to OpTime and Stork Obstetrics Information System. The awards were distributed "graduation-style," joked Bert, as he handed out diplomas and posed for pictures. Dr. Capponi asked if someone had "Pomp and Circumstance" on their iPhone before congratulating the group.

But as light-hearted as the ceremony was, it was the culmination of much hard work by those in attendance. In order to get Epic certification, these individuals had to go through an extremely rigorous training and work regimen.

It starts with instruction at the company's state-of-the-art facilities in Verona, Wisconsin (just outside the state capitol, Madison), where trainees come to "live and breathe Epic," as Vanima Lalsa (In-Patient Clinical Documentation, pictured at left) put it after the ceremony. Arriving either alone or with their teams, they spend consecutive days – staggered over several weeks, based on scheduling – learning their specialties.

"First you learn the fundamentals. Then, depending on your group, you go back for more training, followed by more exams. It's very demanding but it makes you feel like you're really expert in your job," said Vanima.

Post-training, ICIS team members come back to New York with assignments that they have to complete and study for tests that they have to pass in order to get certification. All while still doing their "day jobs."

"Your accomplishments speak for themselves," said Bert, just before handing out the diplomas. "But we wanted to show you that we recognize your hard work and we recognize your success."

To see more photos of the ceremony, click here.

Workflow Previews (cont'd.)

original Workflows, but were mentioned by attendees through emails or in-person.

In fact, five new sessions are being planned by Epic and ICIS. This is in addition to the 28 that were identified as being necessary during the Week 1 meetings.

"These sessions educate everyone in different ways" said Bob Bowman, EHR Program Manager, during a break in sessions. "We're exposing them to this wonderful technology and hopefully conveying the message how it will be helpful to them; while they [SMEs] are identifying issues and concerns to us that we're unaware of."

Weeks 3 and 4 will see a new crop of SMEs coming to learn – and teach. So far, according to most participants, that seems to be the best part of the process.

ICIS Workflow Preview Session Feedback Survey	Week 1 (7/9 - 7/11)	Week 2 (7/30 - 8/1)
Number of people who responded to the survey	187	266
Percentage of responders who found sessions "informative" or "very informative"	90	91
Percentage of Epic consultants who gave positive feedback on their sessions	92	92
Percent saying there was enough communication about the sessions	77	88

FEEDBACK SURVEYS: NUMBERS TALK

After each week of Workflow Previews, the ICIS team sends opinion surveys to HHC attendees asking for their feedback on the sessions. Below are samples of Workflow Preview Week 2 participant feedback. To view all survey feedback for Week 2, click here.

DID YOU FIND THE SESSIONS TO BE INFORMATIVE?

"Terrific discussions on process."

"Extremely informative but not relevant to Adult Day Program."

"Lots of give and take. Was interesting to hear from a lot of people."

"The HIM EPIC staff is extremely knowledgeable, not only in the HIM Modules, but others as well. Extremely professional."

"Well planned and organized."

WHAT WAS MOST USEFUL TO YOU?

"Feedback from other labs."

"Able to see the demonstration of the EPIC system and validate whether that supports our current workflows."

"Discussions, questions, and answers."

"Having the ability to see how the system would work."

"Seeing the demo and hearing the workflows from the facilities."

"Opinions being heard; able to suggest and agree to a common workflow that will work for everyone."

WHAT WAS LEAST USEFUL TO YOU?

"Listening to the same topics people would get stuck on."

"All parts of the sessions were useful."

"Would have preferred to have the presentation ahead of schedule to review. I couldn't find it on SharePoint."

"Only Nursing documentation was discussed. There was not enough time to discuss all the issues. Most of the items were put into the 'parking lot.'"

"They were all good. I even went to a few that I was not registered for."

WHAT OTHER TOPIC(S) WOULD YOU LIKE TO HEAR ABOUT?

"A deeper discussion of what information will be needed from the sites for the initial build of the system."

"How to make patient care better."

"Any topic geared towards improving patient care."

"Wireless mobile access, access from outside the intranet."

"Meds, nursing care plan, PACU related topics."

"External provider billing."

GENERAL COMMENTS/ QUESTIONS:

"Thank you for inviting us, ICIS Workflow Preview Sessions. To be with my colleagues from across HHC interacting and working collaboratively in one room is very inspiring! Having been involved in Bellevue's Picis Project gave me a unique perspective on implementation of an integrated perioperative electronic system. I am looking forward to getting involved and learning HHC's of Epic System."

"Finally a comprehensive EMR system!!!"

"It will be interesting to see how things move forward."

"Extremely informative, place was great and Epic staff were very knowledgeable and receptive to questions."

"I write letters summarizing patient medical information for various reasons: workplace, insurance, QI, etc. Presently these can be scanned into the EMR. It would be convenient and efficient for these to be part of the EMR."

"PARKING LOT" ITEMS ARE NOW AVAILABLE ON SHAREPOINT

THE RESULTS OF WORKFLOW PREVIEWS 1 AND 2 ARE NOW AVAILABLE ON THE ICIS SHAREPOINT SITE. THE DECISIONS FOR EVERY VALIDATION POINT (GREEN OR RED) AND THE STATUS OF ALL PARKING LOT ITEMS CAN BE FOUND HERE. ICIS TEAM MEMBERS ARE RESPONSIBLE FOR KEEPING THIS INFORMATION UP TO DATE AND FOR FOLLOWING UP ON ALL OUTSTANDING ITEMS.

A FORUM FOR FEEDBACK DIRECTLY WITHIN THE SITE IS UNDER CONSTRUCTION. FOR NOW, ANY QUESTIONS CAN BE SUBMITTED TO THE ICIS COMMUNICATIONS TEAM AT ICIS@NYCHHC.ORG

UPCOMING EVENTS:

- Workflow Preview Sessions Week 4: September 23-25 (HHC facility TBD)
- HHC ICIS Leadership Overview: October 8 (Harlem Hospital)

CONTACT US

The ICIS Project Team welcomes your questions & comments.
icis@nychhc.org

Meaningful Use Stage 2 Status

Your name

September 5, 2013

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

nyc.gov/hhc

Medicare EHR Incentive Program

- October 1st, 2013 Stage 2 Begins for eligible hospitals
- Eligible hospitals and CAHs attest for a three-month reporting period; Payments decrease for hospitals that start receiving payments in 2014 and later
  - October 1st, January 1st, April 1st July 1st Attestation dates
- **July 1st, 2014** Last day for eligible hospitals to begin their attestation
- September 30th, 2014 Reporting year ends for eligible hospitals and CAHS
- October 1st, 2014 Entire year for subsequent years of participation; Eligible hospitals and CAHs that do not successfully demonstrate meaningful use of certified EHR technology will be subject to Medicare payment adjustments beginning in FY 2015

Demonstrate Meaningful Use Under Stage 2 Criteria

Eligible hospitals and CAHs must meet 16 core objectives and 3 menu objectives

- Thresholds have been raised
- Use of EHR for a larger portion of the patient population
- Some new/complex objectives were introduced
  - Automatically track medications from order to administration using assistive technologies (barcoding) in conjunction with an electronic medication administration record (eMAR/BCMA)
  - Require patients to use health information technology
  - Require providers who transition or refer a patient to another setting of care or provider of care to provide a summary of care record electronically

Core Objectives Timeline

CPR 5.4	153 days	Tue 1/1/13	Thu 8/1/13
CPR 6.0	143 days	Fri 6/14/13	Tue 12/31/13
MU Stage 2 Core Objectives	148 days	Fri 6/7/13	Tue 12/31/13
CPOE	97 days	Mon 8/19/13	Tue 12/31/13
Demographics	97 days	Mon 8/19/13	Tue 12/31/13
Vital Signs	97 days	Mon 8/19/13	Tue 12/31/13
Smoking Status	97 days	Mon 8/19/13	Tue 12/31/13
Clinical Decision Support	82 days	Mon 9/9/13	Tue 12/31/13
Patient Portal	148 days	Fri 6/7/13	Tue 12/31/13
Protect PHI/Risk Assessment	196 days	Tue 1/1/13	Tue 10/1/13
Clinical Lab Test Results	240 days	Mon 10/1/12	Fri 8/30/13
Generate Patient Lists	87 days	Mon 9/2/13	Tue 12/31/13
Patient-Specific Education Resources/Krames	87 days	Mon 9/2/13	Tue 12/31/13
Medication Reconciliation	148 days	Fri 6/7/13	Tue 12/31/13
Summary of Care	87 days	Mon 9/2/13	Tue 12/31/13
Immunization Registries	92 days	Mon 8/26/13	Tue 12/31/13
Reportable Lab Results	92 days	Mon 8/26/13	Tue 12/31/13
Syndromic Surveillance Data	92 days	Mon 8/26/13	Tue 12/31/13
eMAR/BCMA	195 days	Mon 12/3/12	Fri 8/30/13

HHC Status By MU2 Objective

Core #1 CPOE	Complete	Core #11 Medication Reconciliation	Caution
Core #2 Demographics	On Target	Core #12 Summary of Care	Caution
Core #3 Vital Signs	On Target	Core #13 Immunization	Complete
Core #4 Smoking	On Target	Core #14 ECLRS	Caution
Core #5 CDS	On Target	Core #15 Syndromic Surveillance	Caution
Core #6 Pt Portal	Caution	Core #16 eMAR	Date at Risk
Core #7 Protect EHI	On Target		
Core #8 Lab Structured Data	On Target	Menu #1 Advanced Directive	On Target
Core #9 Pt Lists	On Target	Menu #2 Electronic Notes	On Target
Core #10 Pt Education	On Target	Menu #3 Imaging Results	On Target

Program Heat Map

	BHC	MHC	ELM	QHC	JMC	NCB	HLM	LHC	KHC	CIH	WHH
Core # 1 CPOE	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Complete
Core # 2 Demographics	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target
Core # 3 Vital Signs	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target
Core # 4 Smoking	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target
Core # 5 CDS	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target
Core # 6 Pt Portal	Caution	Caution	Caution	Caution	Caution	Caution	Caution	Caution	Caution	Caution	Caution
Core # 7 Protect EHI	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target
Core # 8 Lab Structured Data	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target
Core # 9 Pt Lists	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target
Core #10 Pt Education	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target
Core #11 Medication Reconciliation	Caution	Caution	Caution	Caution	Caution	Caution	Caution	Caution	Caution	Caution	Caution
Core #12 Summary of Care	Caution	Caution	Caution	Caution	Caution	Caution	Caution	Caution	Caution	Caution	Caution
Core #13 Immunization	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Complete
Core #14 ECLRS	Caution	Caution	Caution	Caution	Caution	Caution	Caution	Caution	Caution	Caution	Caution
Core #15 Syndromic Surveillance	Caution	Caution	Caution	Caution	Caution	Caution	Caution	Caution	Caution	Caution	Caution
Core #16 eMAR	Date at Risk	On Target	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Date at Risk	On Target
Menu # 1 Advanced Directive	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target
Menu # 2 Electronic Notes	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target
Menu # 3 Imaging Results	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target	On Target

QuadraMed QCPR Upgrade Timeline

Today

MU2 Attestation Period #2

MU2 Attestation Period #3

2014

Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul

NBHN v6.0 (beta testing)

NBHN QCPR v6.0 Upgrade

QCPR v5.4 Upgrade

All other Networks (v6.0 testing)

QCPR v6.0 Upgrade

Provider Training

Jacobi/NCB

Harlem/Lincoln

Elmhurst/Queens

Kings

Metropolitan

Bellevue

Woodhull

Coney Island

Issues

Description	Status	Measure	Comments
Networking (BCMA)	In Progress	Core #16 eMAR	Networking and Wireless Access Points for pharmacy and initial inpatient care areas for BCMA related activities.
Pharmacy Inventory Scanning (BCMA)	In Progress	Core #16 eMAR	Other internal resource issues have taken priority over the pharmacy bar coding inventory. Nursing BCMA go-live cannot happen until this task is complete.

Risks & Decisions Log

Risks

Description	Status	Measure	Comments
ECLRS Modification - All Sites	External Dependencies	Core #14 ECLRS	Concern about time-line to complete new programming for ECLRS interface
Syndromic Surveillance Interface - All Sites	External Dependencies	Core #15 Syndromic Surveillance	Concern about time-line for new Syndromic Surveillance interface
Patient Portal - All Sites	Major Implementation	Core # 6 Pt. Portal	Concern about time-line for patient portal implementation
Summary of Care (CCD) - All Sites	Major Implementation	Core #12 Summary of Care	Working on requirements for measure

Decisions

Description	Status	Measure	Comments
Medication Reconciliation - All Sites	In Progress	Core #11 Medication Reconciliation	Finalizing process

Activities Log

Activities Planned	
MU Stage 2 Reports	Deliver reporting tools for compliance monitoring
Early Adopters of QCPR 6.0	Planning/scheduling installation of QCPR 6.0 for all HHC Development domains
Beta Site Implementation	Prepare for and plan for NBx QCPR 6.0 go live

Thank You!