AGENDA

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE

Meeting Date: November 6th, 2014
Time: 12:00 PM
Location: 125 Worth Street, Room 532

BOARD OF DIRECTORS

CALL TO ORDER — **DR. CALAMIA**

ADOPTION OF MINUTES

- ***October 2, 2014***

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

METROPLUS HEALTH PLAN — **DR. SAPERSTEIN**

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

ACTION ITEMS:

1. **Authorizing the President of the New York City Health and Hospitals Corporation to implement the attached Operating Procedure 180-9 entitled "HHC's Human Subject Research Program Policies and Procedures."** — **DR. WILSON**

INFORMATION ITEMS:

1. **Patient Satisfaction** — **MS. JOHNSTON**
2. **DSRIP** — **DR. JENKINS**

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

MINUTES

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE BOARD OF DIRECTORS

Meeting Date: October 2, 2014

ATTENDEES

COMMITTEE MEMBERS

Vincent Calamia, MD, Committee Chair
Josephine Bolus, RN
Antonio D. Martin, Executive Vice President/Corporate Chief Operating Officer (representing Dr. Ram Raju in a voting capacity)

HHC CENTRAL OFFICE STAFF:

Sharon Abbott, Assistant Director, Corporate Planning and HIV Services
Machelle Allen, MD, Deputy Chief Medical Officer, Office of Health Care Improvement
Maria Arias-Clarke, Assistant Director, Corporate Budget
Janette Baxter, Senior Director, Risk Management
Jen Bender, Associate Director, Media Relations
Suzanne Blundi, Deputy Counsel, Office of Legal Affairs
Nicholas V. Cagliuso, Assistant Vice President, Office of Emergency Management
Louis Capponi, MD, Chief Medical Informatics Officer
Tammy Carlisle, Associate Executive Director, Corporate Planning
Eunice Casey, Senior Management Consultant, Corporate Planning
Deborah Cates, Chief of Staff, Board Affairs
Dave Chokshi, Assistant Vice President, Care Management
Paul Contino, Chief Technology Officer
Megan Cunningham, Associate Director, Accountable Care Organization
Barbara Deiorio, Senior Director, Internal Communications
Christine Desrosiers, Office of Legal Affairs
Joel Font, Consultant, Enterprise IT Service (EITS)
Mary Ann Etiebet, Director, Medical and Professional Affairs
Juliet Gaengan, Senior Director, Clinical Affairs
Sal Guido, Assistant Vice President, Infrastructure Services
Joanne Haberlin, Senior Director, Corporate Risk Management Legal Affairs
Scott Hill, Account Executive, QuadraMed
Caroline Jacobs, Senior Vice President, Safety and Human Development
Lauren Johnston, Senior Assistant Vice President/Chief Nursing Officer, Patient Centered Care
Imah Jones, Senior Director, Research
Barbara Keller, Deputy Counsel, Legal Affairs
Mei Kong, Assistant Vice President, Patient Safety

Patricia Lockhart, Secretary to the Corporation
David Larish, Director Procurement, Operation
Ronald Low, MD, Senior Director, Office of Statistic and Data analysis
Katarina Madej, Director, Marketing
Ana Marengo, Senior Vice President, Communications & Marketing
Randall Mark, Chief of Service, President Office
Ian Michaels, Director, Communication & Marketing
Hilary Miller, Consultant, Enterprise Information Technology System
Jeff Morrow, Consultant, Enterprise Information Technology System
Charlotte Neuhaus, Senior Management Consultant, Corporate Planning Services
Ellen O'connor, Chief Nurse Officer, Jacobi Medical Center
Bert Robles, Senior Vice President, Chief Information Officer
Salvatore Russo, Senior Vice President & General Counsel, Legal Affairs
Lynnette Sainbert, Assistant Director, Board Affairs
Jared Sender, Enterprise Information Technology Service
Lori Schomp, Senior Consultant MIS
David Shi, Senior Director, Medical & Professional Affairs
Nicholas Stine, MD Chief Medical Officer, Accountable Care Organization
Pat Slesarchik, Assistant Vice President, Labor Relations
Yolanda Thompson, Asst. Director, IT
Diane Toppin, Senior Director, M&PA Divisional Administrator
Steven Van Schultz, Director, IT Audits
Joyce Wales, Senior Assistant Vice President, Behavioral Health
Ross Wilson, Senior Vice President/Corporate Chief Medical Officer, Medical and Professional Affairs

FACILITY STAFF:

Ernest Baptiste, Executive Director, King County Hospital Center
Yolanda Bruno, Medical Director, Coler-Carter Specialty Hospital
Vito Buccellato, Chief Operating Officer, Coney Island Hospital
Aaron Cohen, Chief Financial Officer, Bell
Elizabeth Gerdts, Chief Nurse Executive, North Central Bronx Hospital
Ghassan Jamaleddine, Medical Director, Kings County Hospital Center
Neal Glaser, Affiliation Administrator, Coler-Cater Specialty Hospital
Robert Hughes, Executive Director, Coler –Carter Specialty Hospital
John Maese, MD, Medical Director, Coney Island Hospital Center
Arnold Saperstein, MD, Executive Director, MetroPlus Health Plan
Denise Soares, Senior Vice President, Generations+/No. Manhattan Network, Harlem Hospital Center
Arthur Wagner, Senior Vice President, Southern Brooklyn/Staten Island Network
Marcellus Walker, MD Medical Director East New York D&TC
Maurice Wright, MD, Medical Director, Harlem Hospital Center

OTHERS PRESENT

Moira Dolan, Senior Assistant Director, DC37
Richard McIntyre, Siemens
Kristyn Raffaele, Analyst, OMB
Lori Schomp, OMB
Dhruneanne Wood, Analyst OMB

MEDICAL AND PROFESSIONAL AFFAIRS/
INFORMATION TECHNOLOGY COMMITTEE
Thursday, October 2, 2014

Dr. Vincent Calamia, Chair of the Committee, called the meeting to order at 1:00 pm. The minutes of the September 11, 2014 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 Accountable Care Organization

On September 16th, the Centers for Medicare & Medicaid Services (CMS) announced final performance results for Accountable Care Organizations (ACOs) in the first year of the Medicare Shared Savings Program. This group of around 250 ACOs represent the highest-performing health care systems across the country, and HHC's ACO was one of the top 25% who were able to beat both quality and cost benchmarks. The HHC ACO placed in the 74th percentile for quality, while reducing costs by 7%, mostly through reducing avoidable hospitalizations.

The ACO continues to actively develop its population management approach on the ground across HHC. The ACO Population Dashboard has been updated with many new features for understanding our population and guiding outreach, including a predictive model developed in collaboration with NYU Professor of Health Policy and Public Service, Dr. John Billings. This model allows us to predict every ACO patient's risk of hospitalization over the next 12 months, and focus outreach and coordination efforts to the patients who are at greatest risk.

HHC's Board of Directors approved a resolution to appoint Dr. Raju as Director and Chair of the ACO's Board of Directors.

The ACO is partnering with HHC's Medicaid Health Home and community based providers to ensure that the ACO's dual-eligible patients who meet Health Home criteria receive care coordination services. This process is beginning with a pilot at Gouverneur, through which ACO patients will be referred to Village Care for Health Home supports.

DSRIP

Our planning for the DSRIP application is on track for the December deadline, with the hugely complex task being assisted by staff from all parts of our organization and many external organizations. The task continues to be daunting, but with huge opportunity for improving patient care and transforming our organization.

Patient Centered Care

The HHC 2014 Nursing Excellence Awards are honoring 6 nurses from across the corporation and Carolyn Jones, the producer of the film "American Nurse", on Tuesday October 28. Each year we honor an outstanding person for their support of nurses and nursing. The 2013 honoree was Ms. Josephine Bolus, NP.

As part of our ongoing efforts to improve the experience of our patients, we are partnering with Press Ganey to test an innovative approach for immediate patient feedback using technology, in ambulatory care at Kings, Jacobi and Cumberland. In addition, we are working with Press Ganey to providing leadership development for culture change at Queens, and a new program for development and education of front line staff, that uses a focus on the "reduction of suffering" as a driver of change.

IT Platform for Care Management

In the context of an expanding role for Health Home and the rapidly developing role for care management driven by DSRIP and Managed Behavioral Health, HHC is seeking a vendor for a comprehensive, fully integrated Care Coordination and Management IT solution. We need a product that houses the patient's care plan, can be accessed by all care team members within and outside HHC, can interface with electronic medical records and RHIOs using a unique patient identifier, can track all patient contact, metrics, report to regulatory and reimbursement entities and facilitate billing for care.

We are using an expedited process for procurement due to urgency posed by DSRIP and changes to the Health Home reimbursement model as of January 1, 2015. The existing CPMS (Care Plan Management System) will continue to be utilized for the patient portal to meet Meaningful Use requirements.

Preparing for Managed Behavioral Health

Through a competitive procurement, HHC has engaged McKinsey to rapidly expand preparation for Managed Behavioral Healthcare and Health And Recovery Plans (HARP). This transition is now scheduled to go into effect in NYC April 2015. This enhanced work includes transforming care through clinical redesign, and further integration of behavioral health and primary care services. We will be working with MetroPlus, Health First and other payers to identify new payment models within managed care.

HHC Peer Counselor Award

On September 12th, NYC DOHMH, Office of Consumer Affairs, awarded a Certificate of Recognition to one of HHC Peer Counselors, Javier Guzman, for his "outstanding service in the field of Peer Wellness Coaching and his commitment to improving the lives of the New York City consumer community." Mr. Guzman is part of a team of Peer Counselors working from Central Office across our facilities running Peer led groups in Ambulatory and Inpatient Behavioral Health services.

Hospital Medical Home Grant from DOH

HHC facilities continue to participate in the NYS Hospital-Medical Home Demonstration Program Award. This is 3 year award worth approximately $95 million from the NYS Department of Health to strengthen the Patient-Centered Medical Home (PCMH) care delivery model in our primary care teaching clinics. Award disbursements are dependent on facilities meeting performance and improvement milestones. In September 2014, we received a total of $28.3 million corresponding to 75% of the Year Two payments and 25% of the Year Three payments. To date, HHC has received approximately $66 million from the NYS DOH as part of this demonstration program. This grant has been essential to our continued work to improve the transition of all our primary care sites to an effective Patient Centered Medical Home model. It has also been instrumental in the development of our Collaborative Care program for the detection and management of depression in the primary care setting.

HHC Simulation Center (IMSAL)

IMSAL has launched two recent initiatives in addition to regular course delivery. Dr Bajaj, IMSAL's OB/GYN Simulation Educator has developed a one day program consisting of six simulations and debriefs and four presentations to orientate staff to the soon to be re-opened North Central Bronx Labor and Delivery units. The first of these was held on Monday, September 29 and received outstanding evaluations. Dr Bajaj has focused the day on developing teamwork and communication between all members of the healthcare team. She has assembled over 100 staff during the two days the courses will be delivered with an inter professional team consisting of L&D providers, nurses, patient care assistants and ward clerks, blood bank, patient transport, neonatal providers and nurse teams, and postpartum teams. The staff recognize the importance of testing their new systems and ensuring when patients are admitted they will know exactly how everything works. Comments from the evaluations state the staff indicate that patient outcomes will be improved through the teams working more effectively together and discussing any knowledge gaps prior to the floors re-opening.

The second initiative is the simulation program to assess and feedback on the readiness of all of our Emergency Departments, to identify and isolate possible Ebola patients. Two simulated patients from IMSAL have been visiting HHC Emergency Rooms, one with a low risk EVD status and her partner. The project has been a collaboration between the Office of Healthcare Improvement, Infections Diseases at Elmhurst hospital, HHC Emergency Management & IMSAL. There are new learnings with each different ER visit and debrief. The simulation is followed by a debriefing session with the Medical Director, Chief Nursing Officer, Infectious Diseases, Infection Control, ER Medical and Nursing Leaders and the EVD team. The program is being well received.

The 2014-2015 Flu season

HHC has commenced flu vaccination of all health care workers and patients, in preparation for the upcoming flu season. Last season HHC vaccinated 82% of all its staff, the best ever result, but still short of the 90%+ result required for "herd immunity". Our leadership has set an ambitious target of a 10% increase in vaccination performance across the system, a level that several of our sites achieved last year and hence we believe is both necessary and achievable. HHC will again follow the NY state guidelines that all healthcare workers who are not vaccinated will have to wear a mask

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 September 1, 2014 was 468,849. Breakdown of plan enrollment by line of business is as follows:

Medicaid	385,769
Child Health Plus	11,845
Family Health Plus	12,395
MetroPlus Gold	3,465
Partnership in Care (HIV/SNP)	5,122
Medicare	8,350
MLTC	673
QHP	40,507
SHOP	723

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 seen some loss of Exchange membership due to non-payment from members who have passed their one- or three-month grace period (based on their financial status).

Since the last report I gave this Committee in September was an Annual Report focused on major accomplishments and challenges during the HHC FY14, this report includes details on significant events that occurred during the months of July and August 2014.

For 2014, MetroPlus succeeded in this new ACA-driven healthcare landscape by offering consumers the lowest cost products for three out of four metal levels in the individual market and by working very closely with HHC to project the impact of our Exchange products on both the plan and HHC, as well as ensuring that resources were properly allocated for this new line of business. We have successfully submitted the proposed 2015 Exchange rates that included an increase to meet costs based on actuarial predictions. The State gave us a 6.9% increase across the board for each of the lines of business. It appears that we will come in second lowest. Affinity is approximately $10/month less than us, Fidelis will be $0.24 more than us, and HealthFirst will be about $5 more than us. Our Silver Plan is at $381/month.

In July, MetroPlus entered into an agreement with the eleven HHC Acute Care facilities to offer a grant for MetroPlus Care Managers. The purpose of this grant is to fund 17 positions as part of an expansion of the HHC Emergency Department (ED) Care/Case Management Project. The new Care Managers are already on site at some facilities, while other facilities are recruiting. The Care Managers are fully integrated and engaged members of the Inpatient Project RED and ED Care Management Interdisciplinary Teams, facilitating the MetroPlus members' progress during their stay in the inpatient and ED setting. The program has shown encouraging results and we expect that this expansion will continue to positively impact our members as patients are admitted and discharged at our HHC facilities.

On July 16, 2014, MetroPlus received a revised timeline from CMS for FIDA implementation. The implementation date was pushed back to January 1, 2015. The marketing period will begin on December 1, 2014. However, education and training of the providers contracted for FIDA has to be completed between September and November of 2014. During this time frame, our Provider Service Representatives will educate over 13,000 providers on the upcoming launch of the FIDA product – either internally or through the PHP Coalition.

On August 10, 2014, MetroPlus received a response from the State on the BH-QHP-MCO and BH HARP RFQ application that was submitted early in June. Senior leadership met with the State in early September (OMH, OSAS, SDOH, and DOHMH). We are continuing ongoing meetings with two State liaisons to help achieve all cures and readiness initiatives required. We will submit a revised and enhanced version based on the State's letter of response indicating where clarification was needed. At this time, the State is expressing that the HARP line of business will be implemented April 1, 2015 (pushed back from the January 1st date). Internally, MetroPlus is creating the infrastructure to make this new line of business operational. This new implementation date has no bearing on the January 1st timing of delegation to Beacon. MetroPlus will be utilizing Beacon Health Strategies to manage our Behavioral Health services and network for all lines of business beginning January 1, 2015. MetroPlus is working with HHC to ensure that the HHC facilities and providers are included in any network offered by Beacon. We are also going to work with our contracted providers to ensure as much overlap as possible, and to ensure that the transition will provide minimal disruption to members and providers.

As part of MetroPlus' continuing efforts to improve services to our members and provide useful feedback to our providers, the QM department has started their educational forums at HHC facilities. The meetings focus on the facility's overall HEDIS performance, P4P results, improving medical record documentation, using ImpactPro data to identify members with gaps in care and non-compliant on HEDIS measures, Patient Satisfaction Survey results (CAHPS), and Clinical Risk Group (CRG) scores.

In July 2014, as an additional, strategic effort to increase member satisfaction and retention, MetroPlus has signed a hospital and physician contract with Jamaica Hospital and Flushing Hospital in Queens. Together with their Physician-based IPA, these facilities make up the Medisys Health Network. This is a great addition to our provider

network, as both of these hospitals currently service a large number of MetroPlus members and service areas where MetroPlus has a large membership base. This relationship will provide much more access for our members residing in Queens. We hope it will also enable us to grow our membership in these communities. The contract went live on August 1, 2014, includes both Primary and Specialty Care, and includes all lines of business. These facilities have a Nursing Home and a considerable number of providers in specialties we were previously lacking.

MetroPlus is working with HHC to assist in the development and implementation of the corporate strategy related to DSRIP. Contracting, Network Relations, Finance, MIS, and other functional areas are all involved in this project. MetroPlus may also partner with other providers and facilities in the community to meet the statewide goals put in place by the DSRIP program.

INFORMATION ITEMS:

Caroline M. Jacobs, Senior Vice President, Patient Safety and Mei Kong, Assistant Vice President of Patient Safety reported on the following:

Patient Safety Update 2014

Enterprise-wide strategic priorities - Workforce development, TeamSTEPPS® engagement, Improving patient experience. Year 2014 patient safety priorities - Just Culture engagement, Medication safety.

Patient Safety Culture Survey - Partnerships with external agencies and labor unions, Committee of Interns and Residents, - SEIU Healthcare (CIR/SEIU). GNYHA and HANYS New York State Partnership For Patients (NYSPFP). Agency for Healthcare Research and Quality (AHRQ)/Health Research and Educational Trust (HRET)/American Hospital Association (AHA), Institute for Safe Medication Practices (ISMP) and National Patient Safety Foundation (NPSF). Overview of other patient safety activities

Enterprise-wide Strategic Priority - TeamSTEPPS® Engagement: TeamSTEPPS is an evidence-based framework to optimize team performance. It is comprised of four teachable - learnable skills

FY14 Hoshin Kanri employee engagement goal = Increase participation in TeamSTEPPS training by 10% or 1,416 employees, TeamSTEPPS and Nonviolent Crisis Intervention is a new module added in FY 14, TeamSTEPPS and Limited English Proficiency (LEP) is a new program funded by AHRQ/HRET/AHA, will be made available across HHC in FY15.

Just Culture Engagement FY14 = New Supervisor and New Manager Programs are 2 components of HHC's Workforce Development Program, Two-day Just Culture Certification Course to be rolled out to 80 facility leaders in January 2015.

Operationalizing TeamSTEPPS and "connecting the dots" with other strategic priorities - Queens Health Network, Improving Patient Experience, Patient Involvement Survey Data Translated into 12 languages - 5,328 surveys completed in CY 2013.

No Decisions About Me Without Me" - Embedded TeamSTEPPS Tools to Engage Patients.

Medication Safety - Enterprise Medication Safety Council, Purpose - improve medication processes to reduce errors and potential harm, FY 2014 focus areas; Improving collection of medication intervention data, Improving use of "high-alert" medications - Anti-coagulants –Insulin – Opioids, Improving medication reconciliation processes, Conducting Medication Safety Grand Rounds and Producing the Medication Safety Newsletter.

Medication Interventions - Improving Anticoagulation Therapy, Developed and disseminated, Anticoagulation Handbook For Clinicians and Anticoagulation Therapy Guide for Patients (translated into 12 languages).

Medication Reconciliation; Medication Safety Newsletter, Diabetes Mellitus and Insulin Therapy

All Employee Patient Safety Culture Survey – June 2014, AHRQ Survey on Patient Safety Culture;
Evidence-based tool comprised of over 40 questions that assess employee opinions about patient safety issues, medical errors, and event reporting, All facility staff, medical staff, agency staff and volunteers invited to participate, Statistically significant 63% response rate enterprise-wide - approx. 25,000 respondents (national average response rate 54%), Employee response rate and perceptions of safety culture varied by level of care (hospital, LTC, DTC), size of facility, tenure, discipline, etc.

Requires a local "solution approach", continuing to analyze data to support local improvements

Patient Safety Culture Survey - Enterprise-wide; Primary area of strength – Organizational learning/continuous improvement (National average 73% positive),The extent to which staff feel we are actively doing things to improve patient safety, Aggregate % positive responses ranged from 70% (hospital and DTC) to 79% (LTC), and Employees with tenure of one year or less 82% positive

Primary opportunity for improvement – Non-punitive response to error (National average 44% positive)- The extent to which staff feel that their mistakes and event reports are not held against them, and that mistakes are not kept in their personnel file; % positive response rates ranged from 30% (hospitals) to 57% (LTC).

Patient Safety Culture Survey - Example of variability by level of care and Overall Perception of Safety - % of respondents who stated that the procedures and systems in the organization are good at preventing errors and that there is a lack of patient safety problems.

Patient Safety Culture Survey - Next steps- Facilities engaged in "action planning", Facility Patient Safety Officers and Associates helping us discern specific area(s) to focus on, Just Culture Certification course for 80 facility leaders, January 2015, Help teams of staff learn how to effectively and consistently apply the Just Culture Algorithm and principles, Embed principles into policy and procedure and performance management processes, PSO/PSA participation in the National Patient Safety Foundation's Certified Professional in Patient Safety (CPPS) Course (Spring 2015).

Partnerships: CIR and HHC Resident Patient Safety Survey, Background; HHC's Office of Patient Safety and CIR's Patient Safety Labor-Management Committee have collaborated for the last 6 years - Annual patient safety conference, Conducted focus groups, Survey developed by HHC and CIR, Survey distributed by CIR team – over seven months. Method: "Top-down" and "bottom-up" methodologies were leveraged for participant recruitment, A core group of resident leaders drove the project and recruited colleagues to participate, CIR contract organizers publicized the project interdepartmentally.

Core patient safety team from HHC and CIR communicated to the facilities patient safety officer and associate, program director, and facility leaders to encourage participation.

CIR and HHC - Resident Patient Safety Survey - Purpose of Survey; Identify what residents know about patient safety processes at HHC, Evaluate residents' perception of, and experience with, patient safety,
Identify ways to improve the residency experience and to make their patient safety training more robust, align labor and management goals on patient safety and collaborate on efforts to improve patient safety for the population we serve. Patient Safety Alert, Patient Safety and Wrong Site Surgery.

NYS Partnership for Patients and CMS/HHS funded initiative; begun in 2010; Goals to achieve by December 2014; reduce preventable harm (hospital acquired conditions) in the aggregate by 40%,
Reduce preventable readmissions in the aggregate by 20%; 170 participating hospitals state-wide and
12 focus areas

Comparison of HHC Performance to NYSPFP Statewide Performance; Other Patient Safety Activities -
Three large-scale conferences, The Future of Healthcare - Featuring Dr. Martin Makary, Author of the New York Times bestseller "Unaccountable", Improving Patient Safety Outcomes by Understanding the Root Cause of Errors, A joint project of HHC/CIR-SEIU, and NYSNA, Patient Safety Begins with a Compassionate Healthcare Provider - Exploring the nexus between patient safety, employee safety and employee wellness. Annual Patient Safety Champions Award Ceremony and Forum - Creating Joy, Meaning, and Safer Health Care - Building a Culture of Worker and Patient Safety and Patient Safety Expo.

Other Patient Safety Activities - Sharing learnings and successes locally and nationally; Presentations at
American Association of Critical Care Nurses – NYC Chapter New York State Association of Nurse Anesthetists, National Patient Advocacy Conference, and National Patient Safety Foundation Annual Congress. Faculty to AHRQ TeamSTEPPS Collaborative, NYSPFP, and America's Essential Hospitals -
Faculty to September 2014 NYSPFP/Institute for Safe Medication Practices (ISMP) Opioid Safety Webinar series. Developing and disseminating patient safety resources and tools - Action Planning
Patient Safety Officer and Patient Safety Associate planning retreat to set agenda for FY 15 and 16 (September 2014).

Bert Robert, Senior Vice President, Information Technology Service reported on the following updates.

Meaningful Use Stage 2 Year 1 Update

At the September M&PA/IT committee I provided a brief update as to HHC's status to attest for Meaningful Use (MU) Stage 2 prior to the September 30th deadline. Today, I want to share with you the achievements of the HHC facilities and staff in implementing the MU Stage 2 Objectives which have been a struggle for healthcare systems nationally.

In mid-September, the Centers for Medicare and Medicaid Services (CMS) reported that for Eligible Hospitals, only 143 of the 3800 Hospitals that attested to MU Stage 1 have attested to Stage 2 across the United States.

Using the 2014 Edition Certified Electronic Health Record Technology (CEHRT) and 2014 Stage 2 Objectives and Clinical Quality Measures (CQM) the following seven (7) HHC Hospitals have met the attestation requirements for MU Stage 2:

- Coney Island Hospital
- Bellevue Hospital
- Jacobi Medical Center
- North Central Bronx Hospital
- Kings County Hospital
- Queens Hospital Center
- Elmhurst Hospital Center

The following four (4) facilities met MU Stage 2 using the 2011 Edition CEHRT 2013 Stage 1 Objectives and CQM:

- Lincoln Hospital

- Harlem Hospital
- Metropolitan Hospital
- Woodhull Hospital

On August 29th CMS published a final rule that gives flexibility and breathing room for health care providers in how they use CEHRT.
Based on public comment and feedback from stakeholders, the Flexibility Rule allowed eligible providers to use the 2011 Edition CEHRT, a combination of 2011 and 2014 Edition CEHRT or 2014 CEHRT for an EHR reporting period in 2014. All eligible professionals, eligible hospitals, and Critical Access Hospitals (CAHs) are required to use the 2014 Edition CEHRT in 2015.

As a result, HHC suffered no loss of incentive monies nor financial penalties because all HHC facilities are able to fully participate in the incentive program.

Over the past year, all HHC facilities faced multiple hurdles in their quest to achieve MU Stage 2. Several of these challenges were:

- QCPR Delays
- Formatting of the Visit Summary
- Patient Portal Launch –July 1st (which did not allow for adequate training and adoption of the new workflow).

All HHC hospitals and staff should be recognized for their effort in overcoming these challenges and meeting these rigorous MU standards.

Our success would not be realized if it were not for the countless clinical and administrative staff who worked diligently to meet the objectives to attain MU. Special recognition should be given to the leadership within Medical & Professional Affairs, our CMO, Dr. Ross Wilson, CNO Lauren Johnston, Dr. Christina Jenkins, and Dr. Machelle Allen. Dr. Louis Capponi, our former CMIO should be recognized for his perseverance and thoroughness in shepherding HHC through the process this past year. Our gratitude also extends to Elaine Chapnik and our Office of Legal Affairs, Maxine Katz and the Finance Team as well as Mei Kong in Patient Safety. We need to recognize the Facility Qmed staff as well as the Facility CMIOs, the Patient Engagement Team led by Inger Dobson and Facility Patient Portal liaisons and staff who signed patients up. We should also recognize the HIM Directors Council led by Lebby Delgado, and the Pharmacy Directors Council led by Joseph D'Agostino and Lorraine Szabo.

At the facilities, we need to thank Network and Hospital Executive leadership, the Qmed staff, the Medical Directors and Chiefs of Staff, Nursing and Departmental leadership. Lastly within Enterprise IT Services, I want to thank the Network CIOs who managed and reported the progress of their respective sites as well as the EITS Patient Portal, Infrastructure, Security, Integration, Business, Training and Finance teams. The success of this initiative was based on the collective effort of the entire HHC organization. The work unfortunately does not stop here. All of us need to remain vigilant over the next twelve (12) months in order to meet Stage 2 Year 2. The next phase of this program requires us to maintain our commitment to meeting the measure thresholds and improving the quality, safety and efficiency of HHC's healthcare technology for the good of our patients.

There being no further business, the meeting was adjourned at 2:15 pm.

MetroPlus Health Plan, Inc.
Report to the
HHC Medical and Professional Affairs Committee
November 6, 2014

Total plan enrollment as of October 1, 2014 was 467,823. Breakdown of plan enrollment by line of business is as follows:

Medicaid	389,919
Child Health Plus	12,047
Family Health Plus	9,419
MetroPlus Gold	3,349
Partnership in Care (HIV/SNP)	5,034
Medicare	8,395
MLTC	720
QHP	38,241
SHOP	699

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. As FHP membership is rolling into Medicaid, we will continue to see increases in the latter. However, the Medicaid membership increase experienced in the month of October was greater than the transfer (rollover) from FHP. We have also seen a loss of Exchange membership due to non-payment from members who have passed their one- or three-month grace period (based on their financial status).

The first item of importance that I would like to bring to this Committee's attention is Sovaldi; namely the cost associated with this Hep C medication. In the first six months of 2014, we have spent $30M on Sovaldi for only 10% of the member population with a Hep C diagnosis code. We anticipate our spending on this drug to reach approximately $70M for this calendar year. This presents a significant financial impact not only on MetroPlus, but also on the HHC risk balance. Since NYS has unsuccessfully attempted to firm up the clinical guidelines for coverage of Sovaldi, MetroPlus is therefore abiding by the guidelines CVS CareMark (our Pharmacy vendor) has put in place.

In our effort to increase membership (by enrolling new members as well as maximizing existing member retention) we are implementing several marketing and communication campaigns, via both internal and external activities, that will help us reach our goals. In addition, based on feedback we received throughout the year from our members, being able to offer an interactive web portal that will allow our members to access their accounts online, print their IDs, view their claims, etc is of critical importance in achieving member satisfaction. MIS is actively working on finalizing this portal so it can go live by November 1, 2014.

MetroPlus is developing aggressive marketing strategies to promote FIDA. This line of business is scheduled to go live on January 1, 2015. We are waiting for the State to provide us with the necessary materials for its implementation (ID card and Member Handbook templates). The Compliance Department and Regulatory Affairs are reviewing this line of business and will be conducting targeting reviews of key risk areas related to this product.

The State has revised the regulation of having Provider Directories printed and mailed to our Exchange and Medicaid members. We are now permitted to provide the Directory in alternate methods. Our Communications and Regulatory Affairs teams are working together to decide on alternate formats and how this is to be communicated to our members.

MetroPlus hosted an audit by the Federal Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) on October 9, 2014. MetroPlus was one of four Managed Care Plans selected for review which was focused on New York's Medicaid program integrity procedures and processes. The focus of this CMS review was centered on three particular Medicaid program areas – federal Affordable Care Act provisions related to provider enrollment and screening, state managed care oversight, and managed care entities (MCEs). The Bureau of Quality Assurance (BQA), within the OMIG, was responsible for coordinating all responses to CMS.

In preparation for this audit MetroPlus' Compliance Department coordinated the corporate response and gathered all the data necessary for the CMS audit team. Areas affected and under review were the Special Investigations Unit (SIU), Provider Credentialing & Provider Contracting units. The review was composed of an offsite desk audit as well as a one day review onsite. The timeframe of the review was the last 4 fiscal years. Overall, the audit went well and there were no issues raised during the process by the CMS auditors. There will be additional information requested by CMS and this will be communicated to MetroPlus by the local Office of Medicaid Inspector General. We anticipate this information request to come to MetroPlus within the next two weeks.

We have also been working closely with our providers, educating them on our new Pay-for-Performance (P4P) program. This program is a payment model that rewards providers and facilities for meeting targeted performance measures for the delivery of quality and efficient health services. The goal of this program is to improve the health of our members. Providers with a panel size of more than 200 MetroPlus members are eligible for the P4P program. Currently, P4P eligibility is limited to our Medicaid, CHP, FHP, and HIV SNP participating providers.

I would like to conclude my report by thanking and congratulating the MetroPlus Communications team for their innovative work that led to MetroPlus' award-winning performance in the 2014 American Health and Wellness Design Awards. The awards program honors the importance of design in communication the value of health and wellness, and the organizations, people, products, and services that foster better health. From roughly 1,000 entries to the annual competition, just a handful of designs were selected as winners – including the MetroPlus "How Do I Enroll?" and the MetroPlus Marketplace Individual and Small Business Tax Credit projects. Other winning organizations whose designs were recognized include the American Heart Association, Columbia University Medical Center, NSLIJ, and Kaiser Permanente.

Management Indicator Report # 1

For Enrollment Month 201410

Indicator #1A for Enrollment Month: October 2014

Disenrollments To Other Plans

		Enrollment Mont			Twelve Months Period		
		FHP	MCAD	Total	FHP	MCAD	Total
	INVOLUNTARY		19	19	25	326	351
	VOLUNTARY	6	55	61	88	814	902
Affinity Health Plan	**TOTAL**	**6**	**74**	**80**	**113**	**1140**	**1253**
	INVOLUNTARY		39	39	30	585	615
	VOLUNTARY		68	68	77	1381	1458
Amerigroup/Health Plus/CarePlus	**TOTAL**		**107**	**107**	**107**	**1966**	**2073**
	INVOLUNTARY	2	138	140	102	1623	1725
	VOLUNTARY	15	303	318	343	3991	4334
Fidelis Care	**TOTAL**	**17**	**441**	**458**	**445**	**5614**	**6059**
	INVOLUNTARY	1	193	194	124	2586	2710
	VOLUNTARY	18	517	535	414	6520	6934
Health First	**TOTAL**	**19**	**710**	**729**	**538**	**9106**	**9644**
	INVOLUNTARY		21	21	7	271	278
	VOLUNTARY	2	37	39	39	563	602
HIP/NYC	**TOTAL**	**2**	**58**	**60**	**46**	**834**	**880**
	INVOLUNTARY		47	47	14	414	428
	VOLUNTARY	3	38	41	51	678	729
United Healthcare of NY	**TOTAL**	**3**	**85**	**88**	**65**	**1092**	**1157**
	INVOLUNTARY		20	20	19	191	210
	VOLUNTARY	5	14	19	23	199	222
Wellcare of NY	**TOTAL**	**5**	**34**	**39**	**42**	**390**	**432**
	INVOLUNTARY	3	486	489	368	6282	6650
	VOLUNTARY	55	1053	1108	1093	14293	15386
Disenrolled Plan Transfers	**TOTAL**	**58**	**1539**	**1597**	**1461**	**20575**	**22036**
	INVOLUNTARY	1	15	16	32	577	609
	VOLUNTARY	2	80	82	10	499	509
Disenrolled Unknown Plan Transfers:	**TOTAL**	**3**	**95**	**98**	**42**	**1076**	**1118**
	INVOLUNTARY	1094	11057	12151	11238	129439	140677
	UNKNOWN		15	15	154	171	325
	VOLUNTARY		32	32	19	929	948
Non-Transfer Disenroll Total:	**TOTAL**	**1094**	**11104**	**12198**	**11411**	**130539**	**141950**
	INVOLUNTARY	1098	11558	12656	11638	136298	147936
	UNKNOWN		15	15	165	176	341
	VOLUNTARY	57	1165	1222	1122	15721	16843
Total MetroPlus Disenrollment:	**TOTAL**	**1155**	**12738**	**13893**	**12925**	**152195**	**165120**

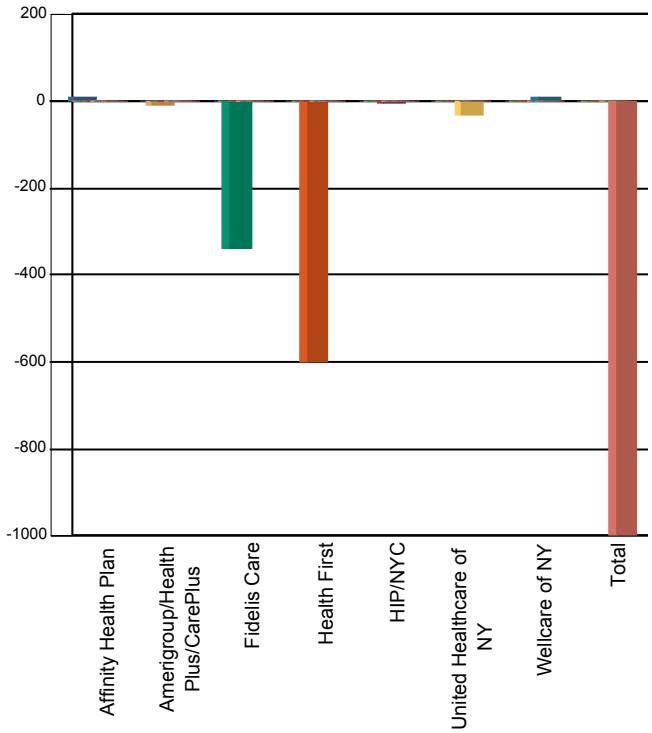
New MetroPlus Members Disenrolled From Other Plans

	FHP	MCAD	Total	Y FHP	Y MCAD	Y Total
Affinity Health Plan	2	87	89	80	1,392	1,472
Amerigroup/Health Plus/CarePlus	3	96	99	130	1,965	2,095
Fidelis Care	2	117	119	96	1,859	1,955
Health First	1	129	130	95	1,902	1,997
HIP/NYC		55	55	24	750	774
United Healthcare of NY		56	56	45	934	979
Wellcare of NY	1	48	49	98	996	1,094
Total	9	588	597	568	9,798	10,366
Unknown/Other (not in total)	14	4,807	4,821	7,841	82,808	90,649

Net Difference

	Enrollment Month			Twelve Months Period		
	FHP	MCAD	Total	FHP	MCAD	Total
Affinity Health Plan	-4	13	9	-33	252	219
Amerigroup/Health Plus/CarePlus		-11	-8	23	-1	22
Fidelis Care	-15	-324	-339	-349	-3,755	-4,104
Health First	-18	-581	-599	-443	-7,204	-7,647
HIP/NYC		-3	-5	-22	-84	-106
United Healthcare of NY		-29	-32	-20	-158	-178
Wellcare of NY	-4	14	10	56	606	662
Total	-49	-951	-1,000	-893	-10,777	-11,670

Enroll Month Net Transfers (Known)



Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 10/14/2014

Other Plan Name	Category	2013_11		2013_12		2014_01		2014_02		2014_03		2014_04		2014_05		2014_06		2014_07		2014_08		2014_09		2014_10		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	1	3	2	5	1	1	1	2	1	4	0	3	1	3	1	1	1	4	0	5	0	4	0	3	47
	VOLUNTARY	0	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
	TOTAL	1	4	4	5	1	1	1	2	1	4	0	3	1	3	1	1	1	4	0	5	0	4	0	3	50
Affinity Health Plan	INVOLUNTARY	1	2	0	3	0	4	3	29	1	3	1	16	11	90	0	19	5	94	2	22	1	25	0	19	351
	VOLUNTARY	14	125	14	100	9	77	7	52	10	77	11	104	0	1	4	78	0	0	7	52	6	93	6	55	902
	TOTAL	15	127	14	103	9	81	10	81	11	80	12	120	11	91	4	97	5	94	9	74	7	118	6	74	1,253
Amerigroup/ Health Plus/CarePlus	INVOLUNTARY	0	11	0	7	4	6	6	54	1	13	0	25	12	165	1	44	6	127	0	43	0	51	0	39	615
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
	VOLUNTARY	18	188	11	219	15	160	1	74	9	143	6	182	0	0	10	148	0	1	5	82	2	116	0	68	1,458
	TOTAL	18	199	11	226	19	166	7	128	10	156	6	207	12	165	11	192	6	129	5	125	2	167	0	107	2,074
BC/BS OF MNE	INVOLUNTARY	0	7	1	6	2	0	0	5	2	6	0	9	1	6	1	12	2	10	1	8	0	10	0	3	92
	VOLUNTARY	0	1	2	2	0	1	0	0	0	1	1	1	0	0	1	2	0	0	0	1	0	0	0	0	13
	TOTAL	0	8	3	8	2	1	0	5	2	7	1	10	1	6	2	14	2	10	1	9	0	10	0	3	105
CIGNA	INVOLUNTARY	0	4	0	3	0	1	1	4	0	4	0	3	0	5	0	1	0	1	1	4	0	0	0	0	32
	VOLUNTARY	1	0	0	2	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
	TOTAL	1	4	0	5	0	1	1	4	1	4	0	3	0	5	0	1	0	1	1	4	0	0	0	0	36
Fidelis Care	INVOLUNTARY	1	6	0	9	2	6	19	191	0	30	2	52	48	429	1	101	20	391	4	128	3	142	2	138	1,725
	UNKNOWN	0	0	0	0	0	0	0	1	0	0	0	0	0	0	2	0	0	0	0	0	2	0	0	0	5
	VOLUNTARY	59	534	71	577	40	424	8	162	41	404	35	454	0	0	42	416	0	0	10	314	22	403	15	303	4,334
	TOTAL	60	540	71	586	42	430	27	354	41	434	37	506	48	429	45	517	20	391	14	442	27	545	17	441	6,064

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 10/14/2014

		2013_11		2013_12		2014_01		2014_02		2014_03		2014_04		2014_05		2014_06		2014_07		2014_08		2014_09		2014_10		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.	INVOLUNTARY	0	5	0	0	0	0	0	6	0	4	0	4	1	4	0	3	0	7	0	1	1	1	0	2	39
	VOLUNTARY	0	1	0	1	0	2	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	2	0	0	7
	TOTAL	0	6	0	1	0	2	0	6	0	4	1	4	1	4	0	3	0	7	0	1	1	3	0	2	46
Health First	INVOLUNTARY	1	11	6	15	0	15	32	309	1	46	2	90	40	695	9	185	25	655	1	169	6	203	1	193	2,710
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	1	0	0	3
	VOLUNTARY	71	834	81	902	58	596	9	275	47	632	48	758	0	2	39	751	0	0	25	521	18	732	18	517	6,934
	TOTAL	72	845	87	917	58	611	41	584	48	678	50	848	40	697	49	936	25	655	27	690	24	936	19	710	9,647
HEALTH INS PLAN OF GREATER NY	INVOLUNTARY	1	1	1	0	0	0	0	2	1	1	0	2	0	1	0	0	0	2	0	1	0	3	0	1	17
	VOLUNTARY	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
	TOTAL	1	1	1	0	0	0	0	2	1	1	0	2	0	1	0	0	0	2	0	1	0	3	0	2	18
HIP/NYC	INVOLUNTARY	0	2	0	3	0	4	1	33	1	4	0	14	4	56	0	21	1	71	0	18	0	24	0	21	278
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
	VOLUNTARY	8	75	11	74	4	72	2	39	2	55	5	80	0	1	2	59	0	0	1	34	2	37	2	37	602
	TOTAL	8	77	11	77	4	76	3	72	3	59	5	94	4	57	2	80	1	71	1	52	3	61	2	58	881
OXFORD INSURANCE CO.	INVOLUNTARY	0	2	0	0	0	1	0	0	0	0	0	1	1	2	0	0	1	1	1	1	0	3	0	0	14
	VOLUNTARY	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	3
	TOTAL	0	2	0	1	0	1	0	0	0	0	0	2	1	2	0	1	1	1	1	1	0	3	0	0	17
UNION LOC. 1199	INVOLUNTARY	3	3	0	2	0	5	7	22	0	8	2	5	3	12	1	5	1	8	0	3	1	1	0	0	92
	VOLUNTARY	12	14	5	8	9	7	0	0	1	12	5	15	0	0	1	9	0	0	1	15	9	25	6	20	174
	TOTAL	15	17	5	10	9	12	7	22	1	20	7	20	3	12	2	14	1	8	1	18	10	26	6	20	266

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 10/14/2014

		2013_11		2013_12		2014_01		2014_02		2014_03		2014_04		2014_05		2014_06		2014_07		2014_08		2014_09		2014_10		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	
United Healthcare of NY	INVOLUNTARY	0	6	0	3	1	10	1	48	0	10	1	24	3	86	1	33	5	68	0	40	2	39	0	47	428
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	2
	VOLUNTARY	9	84	8	101	8	76	2	30	3	99	8	81	0	1	7	65	0	0	2	39	1	64	3	38	729
	TOTAL	9	90	8	104	9	86	3	78	3	109	9	105	3	87	9	98	5	68	3	79	3	103	3	85	1,159
Wellcare of NY	INVOLUNTARY	1	6	0	7	1	6	2	17	2	1	0	16	1	25	2	18	9	41	1	8	0	26	0	20	210
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	2
	VOLUNTARY	7	20	3	38	0	23	2	9	2	16	1	20	0	0	0	12	0	0	0	26	3	21	5	14	222
	TOTAL	8	26	3	45	1	29	4	26	4	17	1	36	1	25	2	30	11	41	1	34	3	47	5	34	434
Disenrolled Plan Transfers	INVOLUNTARY	9	69	10	63	11	59	73	722	10	134	8	264	126	1,579	17	443	76	1,480	11	451	14	532	3	486	6,650
	UNKNOWN	0	0	0	0	0	0	0	1	0	0	0	0	0	0	4	0	2	1	2	0	3	1	0	0	14
	VOLUNTARY	199	1,877	208	2,025	143	1,438	31	641	116	1,439	121	1,696	0	5	106	1,541	0	1	51	1,084	63	1,493	55	1,053	15,386
	TOTAL	208	1,946	218	2,088	154	1,497	104	1,364	126	1,573	129	1,960	126	1,584	127	1,984	78	1,482	64	1,535	80	2,026	58	1,539	22,050
Disenrolled Unknown Plan Transfers	INVOLUNTARY	3	39	2	37	1	27	1	75	1	27	9	29	4	72	4	52	5	130	0	32	1	42	1	15	609
	UNKNOWN	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	2
	VOLUNTARY	3	34	2	54	1	55	0	19	1	38	0	32	0	10	0	52	0	19	1	44	0	62	2	80	509
	TOTAL	6	74	4	91	2	82	1	94	2	65	9	61	4	82	4	105	5	149	1	76	1	104	3	95	1,120
Non-Transfer Disenroll Total	INVOLUNTARY	1,287	10,884	1,003	9,380	1,060	10,877	741	11,883	793	10,699	1,012	11,450	950	11,436	860	10,586	852	10,506	803	10,807	783	9,874	1,094	11,057	140,677
	UNKNOWN	1	0	1	2	45	0	2	6	2	1	13	13	14	12	21	15	29	22	26	44	0	41	0	15	325
	VOLUNTARY	5	123	2	115	3	71	0	46	2	80	2	88	0	47	2	84	0	107	1	77	2	59	0	32	948
	TOTAL	1,293	11,007	1,006	9,497	1,108	10,948	743	11,935	797	10,780	1,027	11,551	964	11,495	883	10,685	881	10,635	830	10,928	785	9,974	1,094	11,104	141,950

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 10/14/2014

		2013_11		2013_12		2014_01		2014_02		2014_03		2014_04		2014_05		2014_06		2014_07		2014_08		2014_09		2014_10		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**	1,299	10,992	1,015	9,480	1,072	10,963	815	12,680	804	10,860	1,029	11,743	1,080	13,087	881	11,081	933	12,116	814	11,290	798	10,448	1,098	11,558	147,936
	UNKNOWN	1	1	1	2	45	0	2	7	2	1	13	13	14	12	25	16	31	23	28	44	3	42	0	15	341
	VOLUNTARY	207	2,034	212	2,194	147	1,564	31	706	119	1,557	123	1,816	0	62	108	1,677	0	127	53	1,205	65	1,614	57	1,165	16,843
	TOTAL	1,507	13,027	1,228	11,676	1,264	12,527	848	13,393	925	12,418	1,165	13,572	1,094	13,161	1,014	12,774	964	12,266	895	12,539	866	12,104	1,155	12,738	165,120

MetroPlus Health Plan

New Member Transfer From Other Plans

	2013_11		2013_12		2014_01		2014_02		2014_03		2014_04		2014_05		2014_06		2014_07		2014_08		2014_09		2014_10		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	2	14	1	18	1	17	4	13	3	6	1	6	0	3	1	4	0	3	0	8	0	6	0	7	118
Affinity Health Plan	12	154	14	156	6	145	5	114	6	106	10	119	9	113	7	113	1	88	3	95	5	102	2	87	1,472
Amerigroup/Health Plus/CarePlus	22	211	26	230	16	189	7	165	11	205	17	173	8	141	7	186	5	119	3	115	5	135	3	96	2,095
BC/BS OF MNE	1	20	1	35	0	37	4	19	2	14	6	14	0	6	1	11	0	7	0	19	0	30	0	25	252
CIGNA	2	9	1	17	1	15	2	9	2	3	3	7	0	3	0	5	0	6	0	0	0	1	0	4	90
Fidelis Care	10	182	16	232	4	152	3	131	15	151	10	188	5	163	10	144	9	146	6	115	6	138	2	117	1,955
GROUP HEALTH INC.	3	17	2	14	1	20	0	11	1	9	1	14	0	10	0	11	0	2	0	5	0	13	0	9	143
Health First	13	196	17	199	7	189	9	123	5	151	15	166	7	127	8	159	7	147	4	134	2	182	1	129	1,997
HEALTH INS PLAN OF GREATER N	2	15	3	23	0	13	0	14	2	7	2	8	1	2	0	5	0	3	0	8	0	8	1	3	120
HIP/NYC	2	74	10	93	2	55	2	69	1	60	2	74	2	64	1	74	2	43	0	36	0	53	0	55	774
OXFORD INSURANCE CO.	1	10	1	12	1	13	0	3	1	5	0	6	0	3	0	2	0	5	1	2	0	7	0	0	73
UNION LOC. 1199	8	21	6	20	7	37	3	18	5	6	8	27	4	19	1	21	3	8	2	12	1	18	0	17	272
United Healthcare of NY	5	129	7	143	4	89	7	77	10	72	4	92	3	56	5	66	0	54	0	43	0	57	0	56	979
Unknown Plan	1,602	8,616	1,731	10,262	1,043	14,813	1,112	6,297	1,137	5,655	943	7,268	160	4,755	71	6,029	14	4,723	9	4,364	5	5,219	14	4,807	90,649
Wellcare of NY	17	103	27	100	10	97	5	98	11	82	9	122	6	103	6	82	1	52	3	52	2	57	1	48	1,094
TOTAL	1,702	9,771	1,863	11,554	1,103	15,881	1,163	7,161	1,212	6,532	1,031	8,284	205	5,568	118	6,912	42	5,406	31	5,008	26	6,026	24	5,460	102,083

Report ID: MHP1268C
Report Run Date: 10/15/2014

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

October-2014

		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14
Total Members	Prior Month	434,940	444,805	467,676	467,999	465,551	463,999	467,493
	New Member	28,819	40,692	19,519	17,240	17,564	20,108	17,993
	Voluntary Disenroll	2,145	277	2,061	349	1,497	1,964	1,448
	Involuntary Disenroll	16,809	17,544	17,135	19,339	17,619	14,650	16,215
	Adjusted	-26	-35	-51	-499	-799	1,001	0
	Net Change	9,865	22,871	323	-2,448	-1,552	3,494	330
	Current Month	444,805	467,676	467,999	465,551	463,999	467,493	467,823
Medicaid	Prior Month	358,549	362,960	370,765	375,254	377,971	380,994	386,718
	New Member	18,683	21,084	17,282	14,999	15,570	17,838	15,950
	Voluntary Disenroll	1,816	62	1,677	127	1,205	1,614	1,165
	Involuntary Disenroll	12,456	13,217	11,116	12,155	11,342	10,500	11,584
	Adjusted	-3	-7	-23	-477	-765	1,007	0
	Net Change	4,411	7,805	4,489	2,717	3,023	5,724	3,201
	Current Month	362,960	370,765	375,254	377,971	380,994	386,718	389,919
Child Health Plus	Prior Month	11,555	11,611	11,913	11,874	11,693	11,677	11,827
	New Member	464	800	491	445	489	675	806
	Voluntary Disenroll	38	53	51	56	51	67	37
	Involuntary Disenroll	370	445	479	570	454	458	549
	Adjusted	-12	-14	-19	-21	-30	-18	0
	Net Change	56	302	-39	-181	-16	150	220
	Current Month	11,611	11,913	11,874	11,693	11,677	11,827	12,047
Family Health Plus	Prior Month	26,222	24,595	22,796	20,144	17,551	14,961	12,402
	New Member	1,027	206	109	42	36	23	23
	Voluntary Disenroll	123	0	108	0	53	65	57
	Involuntary Disenroll	2,531	2,005	2,653	2,635	2,573	2,517	2,949
	Adjusted	-1	-1	0	-1	2	7	0
	Net Change	-1,627	-1,799	-2,652	-2,593	-2,590	-2,559	-2,983
	Current Month	24,595	22,796	20,144	17,551	14,961	12,402	9,419

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

October-2014

		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14
HHC	Prior Month	3,346	3,382	3,408	3,430	3,494	3,495	3,502
	New Member	52	53	49	128	53	34	10
	Voluntary Disenroll	0	0	0	0	0	0	0
	Involuntary Disenroll	16	27	27	64	52	27	163
	Adjusted	-10	-14	-9	-1	7	37	0
	Net Change	36	26	22	64	1	7	-153
	Current Month	3,382	3,408	3,430	3,494	3,495	3,502	3,349
SNP	Prior Month	5,306	5,267	5,219	5,231	5,253	5,201	5,099
	New Member	86	68	131	129	73	57	36
	Voluntary Disenroll	40	22	56	8	39	79	36
	Involuntary Disenroll	85	94	63	99	86	80	65
	Adjusted	0	0	0	0	0	-19	0
	Net Change	-39	-48	12	22	-52	-102	-65
	Current Month	5,267	5,219	5,231	5,253	5,201	5,099	5,034
Medicare	Prior Month	8,016	8,007	8,116	7,937	8,142	8,250	8,347
	New Member	280	329	330	462	364	338	305
	Voluntary Disenroll	125	139	167	158	149	139	153
	Involuntary Disenroll	164	81	342	99	107	102	104
	Adjusted	1	1	1	1	1	-1	0
	Net Change	-9	109	-179	205	108	97	48
	Current Month	8,007	8,116	7,937	8,142	8,250	8,347	8,395
Managed Long Term Care	Prior Month	508	510	535	575	606	631	676
	New Member	16	39	52	44	39	59	66
	Voluntary Disenroll	0	0	1	0	0	0	0
	Involuntary Disenroll	14	14	11	13	14	14	22
	Adjusted	-1	0	-1	-1	-1	3	0
	Net Change	2	25	40	31	25	45	44
	Current Month	510	535	575	606	631	676	720

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

October-2014

		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14
QHP	Prior Month	21,012	27,978	44,317	42,902	40,168	38,093	38,206
	New Member	8,129	17,971	1,009	942	886	1,044	791
	Voluntary Disenroll	3	1	1	0	0	0	0
	Involuntary Disenroll	1,160	1,631	2,423	3,676	2,961	931	756
	Adjusted	0	0	0	1	-13	-15	0
	Net Change	6,966	16,339	-1,415	-2,734	-2,075	113	35
	Current Month	27,978	44,317	42,902	40,168	38,093	38,206	38,241
SHOP	Prior Month	426	495	607	652	673	697	716
	New Member	82	142	66	49	54	40	6
	Voluntary Disenroll	0	0	0	0	0	0	0
	Involuntary Disenroll	13	30	21	28	30	21	23
	Adjusted	0	0	0	0	0	0	0
	Net Change	69	112	45	21	24	19	-17
	Current Month	495	607	652	673	697	716	699

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation to implement the attached Operating Procedure 180-9 entitled "HHC's Human Subject Research Program Policies and Procedures."

WHEREAS, the existing research operating procedure of the New York City Health And Hospitals Corporation (HHC), adopted by the Board in 1991, reflected the then current regulations and restrictions related to human subject research; and

WHEREAS, since 1991, there have been substantial changes in both federal and state regulations and the national institute of health guidelines for the protection of human research subjects; and

WHEREAS, the implementation of this operating procedure will provide guidance to HHC and affiliate research personnel in an effort to protect human research participants' rights and safety and ensure regulatory and legal compliance.

NOW, THEREFORE BE IT RESOLVED that the HHC Board of Directors authorizes the President of the New York City Health and Hospitals Corporation to execute the attached operating procedure entitled "HHC Human Subject Research Protections Program Policies and Procedures"; and

BE IT FURTHER RESOLVED that the operating procedure adopted by the New York City Health and Hospitals Corporation Board of Directors in 1991 is to be repealed; and that the President of the New York City Health and Hospitals Corporation is authorized to execute any and all revisions to said operating procedure as it is customarily exercised for all HHC operating procedures.

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
nyc.gov/hhc
125 Worth Street, Room 527, New York, NY 10013 Tel: 212-788-3300 Fax: 212-267-6905

Office of Legal Affairs

MEMORANDUM

Date: October 28, 2014

To: Imah Jones
Senior Director

From: Joanne Haberlin
Senior Counsel

Re: "HHC HUMAN SUBJECT RESEARCH PROTECTIONS PROGRAM POLICIES AND PROCEDURES" - EXECUTIVE SUMMARY

HHC's Human Subject Research Program Operating Procedure **No.180-9** entitled Human Subject Research Protections Program Policies and Procedures will set forth the procedures that will outline the acceptable processes in order to conduct human subject research at HHC.

The goal of the program is to assist HHC in supporting and promoting research while protecting research participants' rights and safety and ensuring a regulatory and legally compliant environment for the conduct of ethical research.

The Operating Procedure is intended to set forth the requirements and recommendations with respect to the planning, development, and implementation of human subject research at HHC involving HHC patients, facilities, staff or resources or that is conducted at an HHC facility. In addition, the Operating Procedure addresses the financial aspects of research, such as billing compliance.

The following is an outline of the significant issues covered by the Operating Procedure:

Commencement of Research at HHC.

The Operating Procedure sets forth the requirements that a researcher must address prior to the commencement of research. The requirements include the criteria for eligibility; the process to determine the adequacy and feasibility of resources to support the research; research involving recombinant DNA and vulnerable populations;

The Operating procedure also covers the necessary requirements covering certain protections for human subjects and researchers, such as valid informed consent and certificates of confidentiality; and the reporting of information related to potential financial conflicts of

interest related to the research; and protecting HHC's interests in any publications or inventions resulting from research conducted at HHC.

Continuing Approval, Conclusion and Monitoring of Ongoing Research Projects.

The Operating Procedure addresses various issues with respect to investigators' continuing obligations during research projects, as well as compliance obligations of HHC personnel involved in research. Specifically, the Operating Procedure covers the processes for investigators to obtain continuing approval for research projects; the required closeout procedures upon the completion of a research project; the circumstances in which HHC may suspend or terminate a research project along with the auditing and monitoring responsibilities of both the Office of Research Administration and Corporate Compliance.

Investigational Drugs, Devices and Biological Materials.

The Operating Procedure addresses various issues with respect to investigational drugs, devices and biological materials used in research. It sets forth requirements under law and HHC policy for the use of an investigational drug or device in research, including the storage, handling and dispensing of investigational drugs and biologics, as well as contractual requirements for the transfer of such materials into and out of HHC, the use of anatomical gifts, and the disclosure of genetic information obtained through genetic testing..

Misconduct, Unanticipated Events and Noncompliance.

The Operating Procedure outlines processes to address conduct that departs from a research protocol or unexpected events during a research project.

Research Records, Reimbursement, Costs and Reporting.

The Operating Procedure sets forth the requirements under law, regulation and HHC policy with respect to various recordkeeping and financial aspects of research., emergency medical treatment and financial support provided to human research subjects who sustain research related injuries as a direct result of research participation; the process by which approval is obtained for costs incurred by HHC in connection with research involving an affiliate grantee and the means by which HHC can obtain reimbursement for those costs; and the billing and reconciliation processes for clinical research services provided to patients enrolled in studies.

If you have any questions please feel free to contact me.

Cc: Salvatore J. Russo, Esq.
Ross Wilson, MD

HHC Human Subject Research Program Operating Procedure

Medical and Professional Affairs/ Information Technology

Board of Directors Committee Meeting

November 6, 2014

HUMAN SUBJECT RESEARCH PROGRAM

POLICIES AND PROCEDURES

- The mission of HHC's Human Subject Research program is to promote collaboration between HHC and academic scientist clinical researchers and community based health care professionals to better understand a wide range of diseases through research.

- Research means a systematic investigation designed to develop or contribute to generalized knowledge.

- The delivery of health care is the primary function of HHC, but doing that in conjunction with teaching and research can improve the quality of care provided to those that we serve

- In an effort to address changes in both federal and state regulations, HHC has developed a comprehensive operating procedure to supersede the existing New York City Health Hospitals Clinical Investigation & Research Policy and Guideline adopted by HHC in 1991.

Scope

The operating procedure applies to all individuals and processes involved with human subject research occurring at HHC facilities or who utilize HHC staff or resources, including affiliate and non-affiliate employees.

Covers process requirements for the following:

- Planning
- Development,
- Implementation of research
- Financial aspects of research

Requirements Prior to the Commencement of Human Subject Research

1)Investigator eligibility criteria – education and training requirements

2)Researcher and administrator training- minimum requirements to commence and continue research

3) HHC and Facility research approval process – Research Administration process for vetting proposed research projects for feasibility

4) Human subject autonomy and privacy – education of research participants regarding risks and benefits of participating in research

5)Financial conflicts of interest in research – investigator reporting obligations with respect to financial interests that may bias research

6) HHC intellectual property interests – protection of HHC publication rights and interests in inventions resulting from research

Continuing Obligations during the conduct of Human Subject Research

1) Continuing HHC approval – Facility and HHC review of the progress and safety of a research project
2) Suspension or termination of research – Processes for suspension or termination due to safety, legal or administrative concerns
3) Research project closure – closeout procedures upon the completion of a research project
4) Auditing and monitoring – processes to ensure compliance with laws, regulations and these Policies and Procedures

USE OF DRUGS, DEVICES AND BIOLOGICAL MATERIALS IN HUMAN SUBJECT RESEARCH

1) Investigational drugs in HHC's possession – investigator and pharmacy responsibilities for storage, handling and dispensing of study drugs
2) Material transfer agreements – contracting requirements for sending materials to or receiving materials from other institutions
3) Use of biological materials – contracting and approval requirements for the collection, use, storage, and disclosure of specimens or tissue
4) Genetic information – consent requirements for performing genetic tests on research participants and disclosing genetic information
5) Anatomical gifts – approval requirements for the use of anatomical gifts in research

Unexpected Events, Misconduct and Non-Compliance during the Conduct of Human Subject Research

1) Research misconduct and noncompliance – procedures for reporting, investigating and reviewing allegations of research misconduct and noncompliance

2) Protocol violations and unanticipated problems – procedures for reporting conduct that departs from a research protocol or unexpected events during a research project

Recordkeeping and Financial Management

1) Research records - contents of and retention periods for research records
2) Hospital admission and treatment – treatment and financial support provided to research subjects injured during research participation
3) Research costs - process for approving costs incurred by HHC for research conducted by other institutions using HHC resources
4) Billing compliance – processes for billing appropriate payers for clinical research services provided to research participants
5) Residual balances – the disposition and permissible uses of surplus funds from research awards

Conclusion

The acceptance and implementation of the Operating Procedure will ensure guidance to HHC research personnel for the conduct of research, including the protection of human research participants' rights and safety, and to ensure both regulatory and legal compliance by the Corporation.

Office of Patient Centered Care

MPA/IT Board Meeting

November 6, 2014

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

Agenda

Patient Experience Data Review

- Inpatient HCAHPS
- Outpatient Medical Practice

2015 Innovations

- Real-Time Feedback with Point of Care Surveying
- Patient Experience Consulting w/ Press Ganey
- Queens Hospital Center Cultural & Communication Training
- Compassionate Connected Care

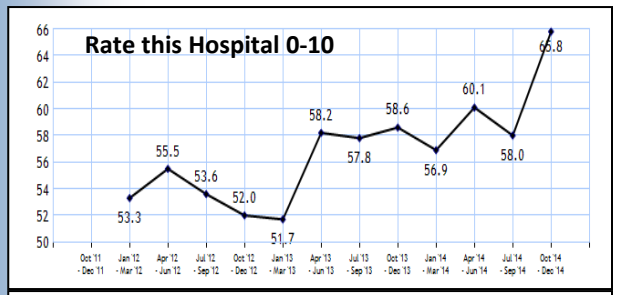
Open Discussion

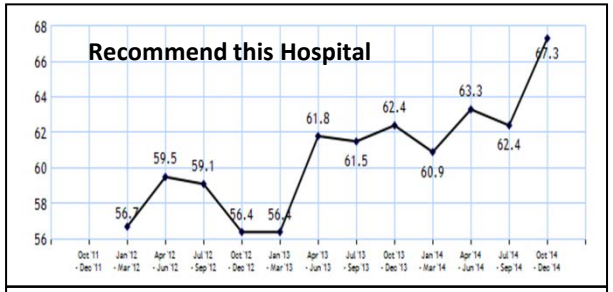
Corporate Annual
HCAHPS Comparison

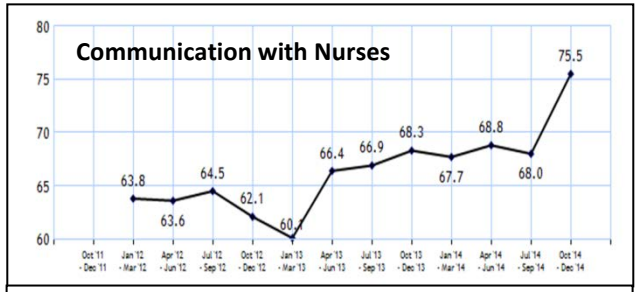
CAHPS	2012		2013		2014	
	Top Box	n	Top Box	n	Top Box	n
Rate hospital 0-10	53.8	11,796	57.0 ▲	13,016	58.6 ▲	10,091
Recommend the hospital	58.2	11,837	60.9 ▲	13,009	62.3 ▲	10,052
Cleanliness of hospital environment	62.9	11,971	64.3 ▲	13,137	66.3 ▲	10,161
Quietness of hospital environment	53.9	11,924	53.4 ▼	13,081	54.2 ▲	10,136
Comm w/ Nurses	63.5	12,011	65.8 ▲	13,213	68.3 ▲	10,223
Response of Hosp Staff	47.8	4,601	49.8 ▲	7,470	53.4 ▲	5,856
Comm w/ Doctors	73.7	11,980	76.0 ▲	13,182	77.3 ▲	10,201
Hospital Environment	58.4	11,948	58.8 ▲	13,109	60.3 ▲	10,149
Pain Management	56.9	5,503	59.4 ▲	8,812	60.6 ▲	8,322
Comm About Medicines	53.0	4,449	56.4 ▲	7,416	57.6 ▲	5,835
Discharge Information	76.8	7,214	78.6 ▲	11,715	79.6 ▲	9,089
Care Transitions	NA	NA	42.9	12,734	43.7 ▲	9,890

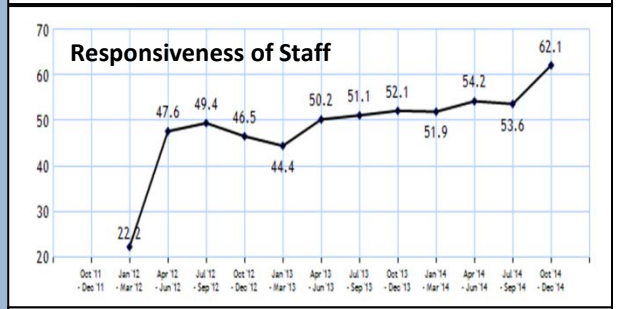
Displayed by Discharge Date
2014 Data is YTD as of 10/31/2014
N's based on the average number of the total responses for the domain

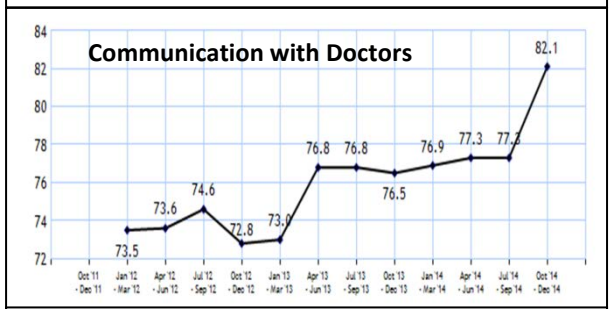
Corporate HCAHPS Facility Comparison

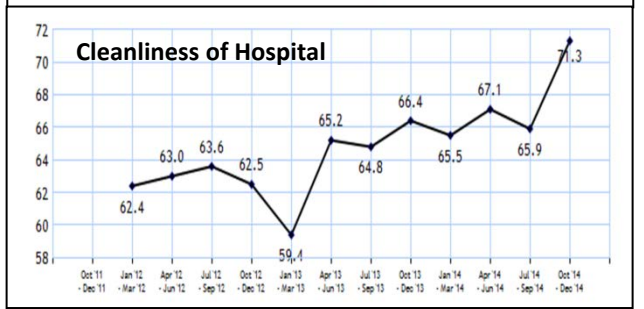


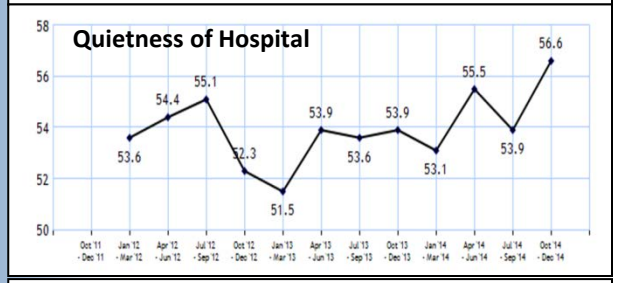


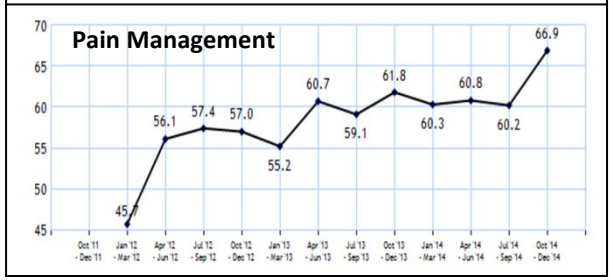


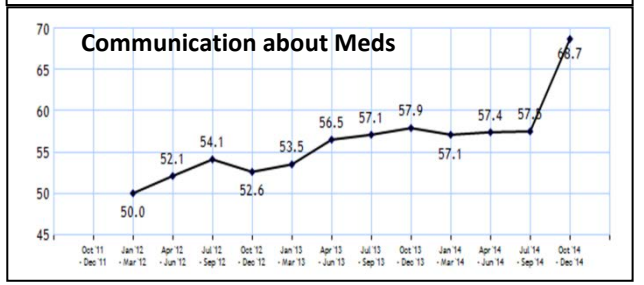


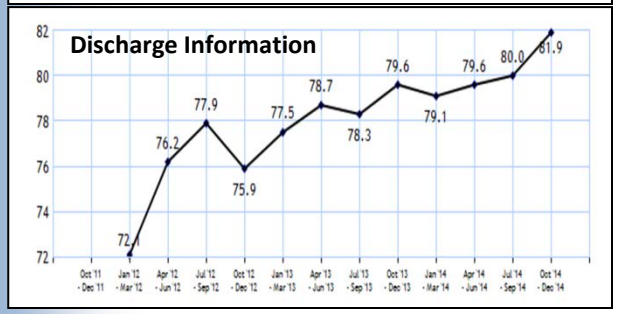








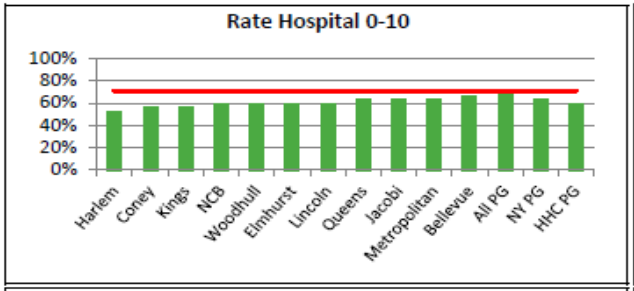


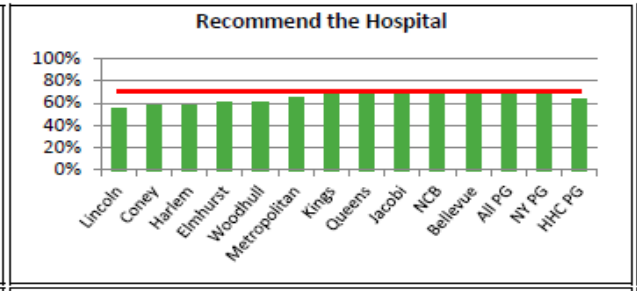


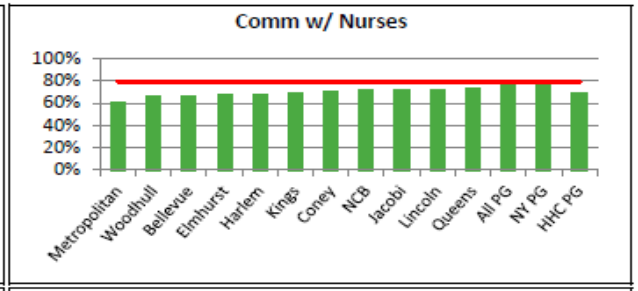
HCAHPS Summary Report
Discharge dates of Jan-Mar 2012 through Oct-Dec 2014
Run on 10/31/2014

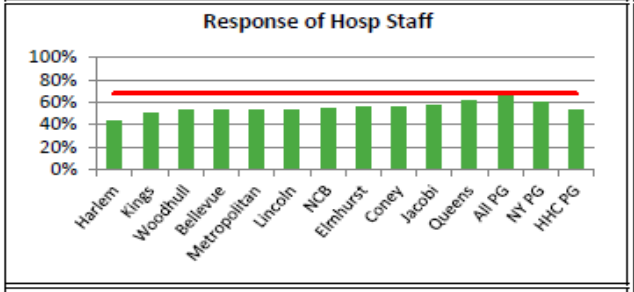
Corporate HCAHP Top Box Results

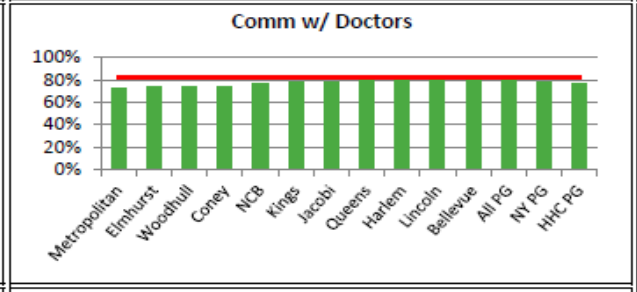
Patients Discharges April – June 2014

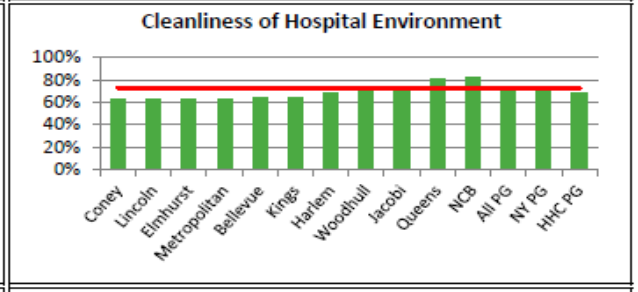


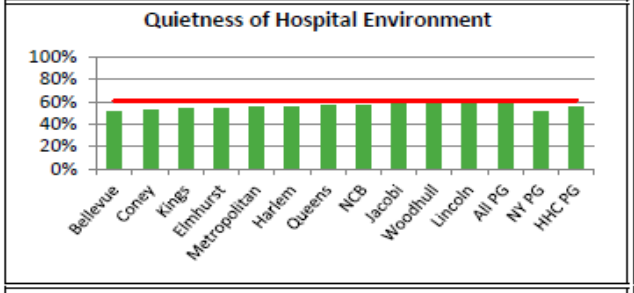


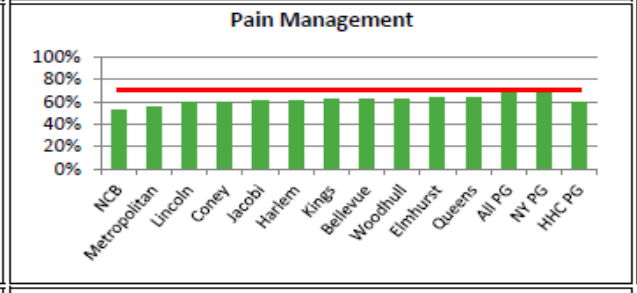


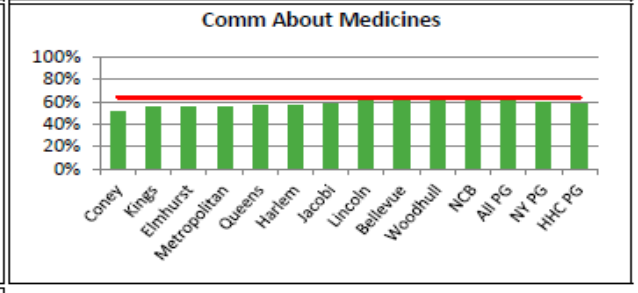


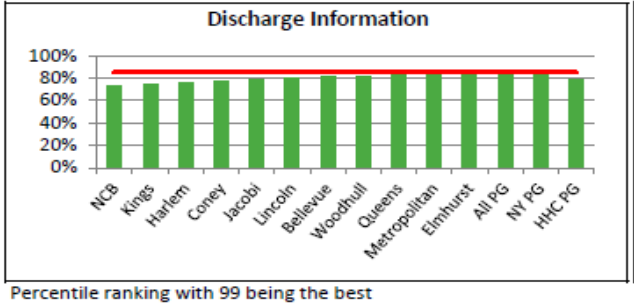


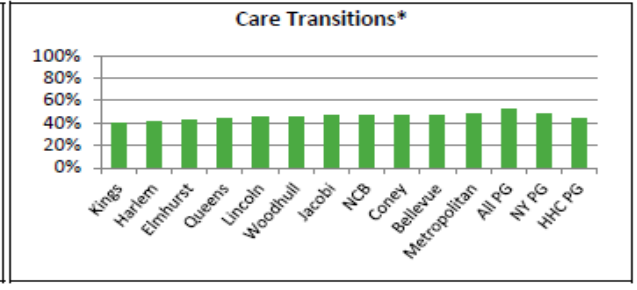












1. Peer Group scores are based on norm period 07/01/2014
2. CMS publicly reported national averages are based on discharges between 10/2012 and 9/2013
   *Care Transitions data is not included on Hospital Compare
3. Peer Group abbreviations:
   -All PG DB = All Press Ganey Database
   -HHC PG = Health & Hospital Corp Custom Peer Group
   -NY PG = New York State Peer Group

Percentile ranking with 99 being the best
Form 4.1A

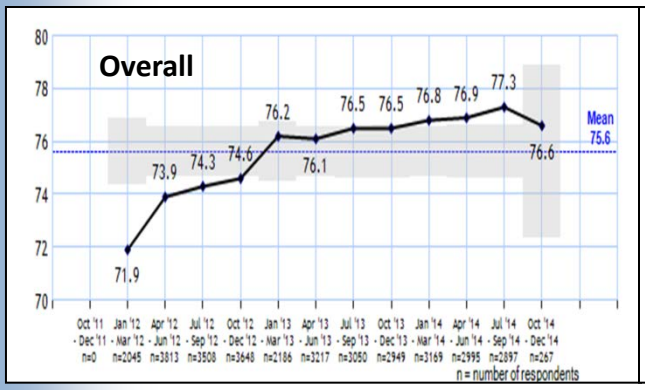
Created by Custom Reporting

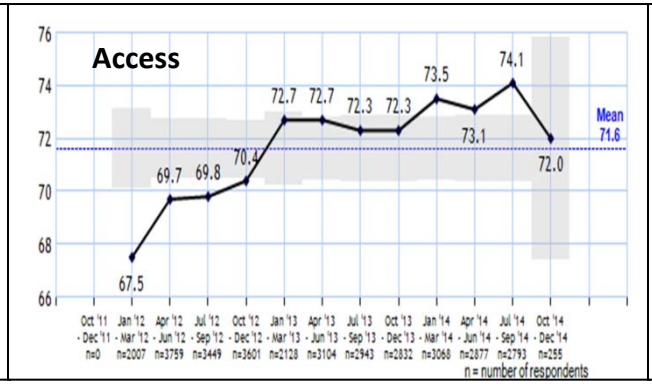
Corporate Annual Outpatient Comparison

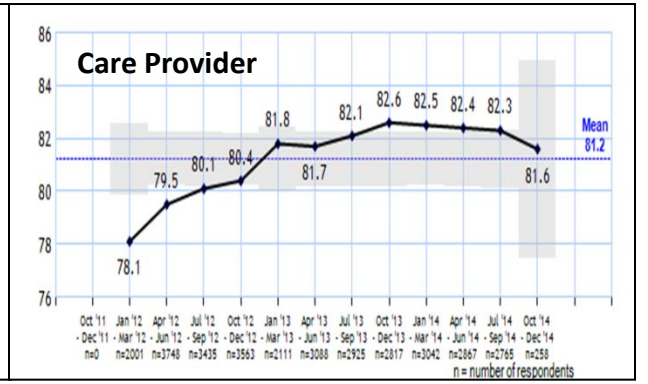
Standard Scores	2012		2013		2014YTD	
	Score	n	Score	n	Score	n
Overall	73.9	13,014	76.3 ▲	11,402	77.0 ▲	9,328
Access	69.6	12,816	72.5 ▲	11,007	73.5 ▲	8,993
Moving Through Your Visit	57.1	12,609	59.8 ▲	10,849	61.3 ▲	8,856
Nurse / Assistant	77.7	12,575	79.7 ▲	10,784	80.5 ▲	8,805
Care Provider	79.7	12,747	82.0 ▲	10,941	82.4 ▲	8,932
Personal Issues	80.7	12,742	83.0 ▲	10,937	83.2 ▲	8,935
Overall Assessment	78.7	12,734	82.0 ▲	10,967	82.4 ▲	8,966

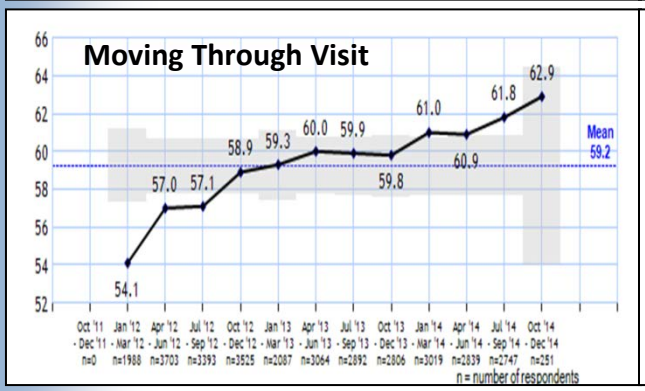
Displayed by Visit Date
2014 Data is YTD as of 10/31/2014

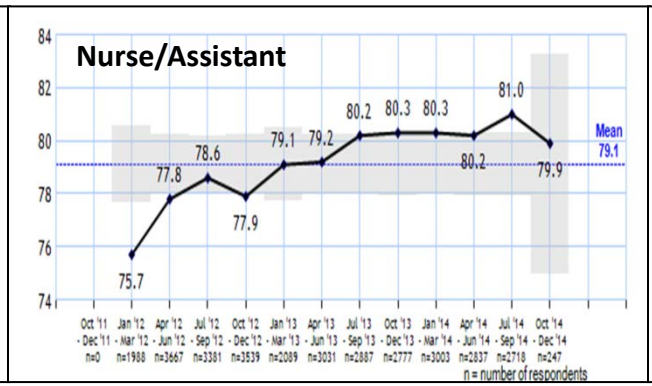
Corporate Outpatient Results

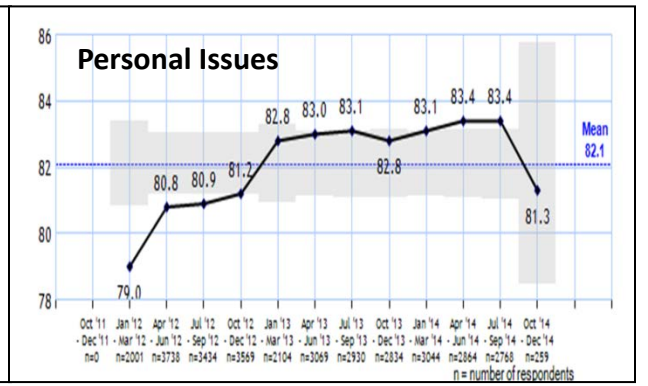


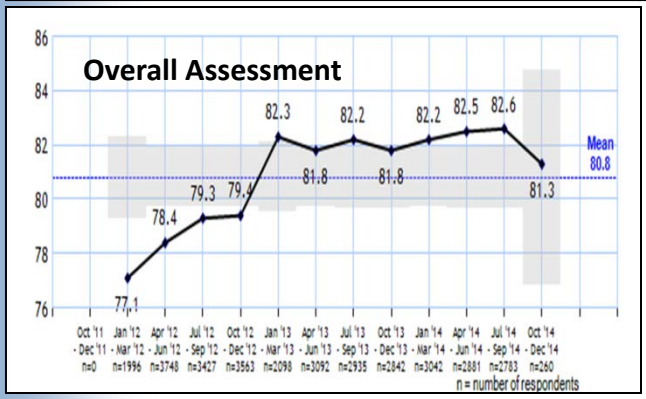






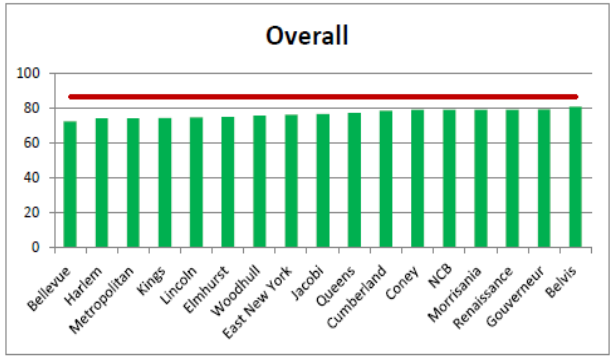


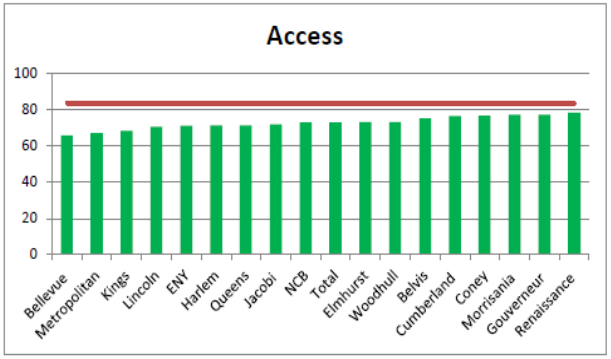


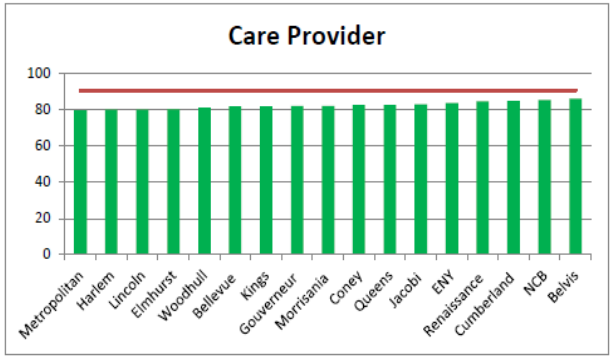


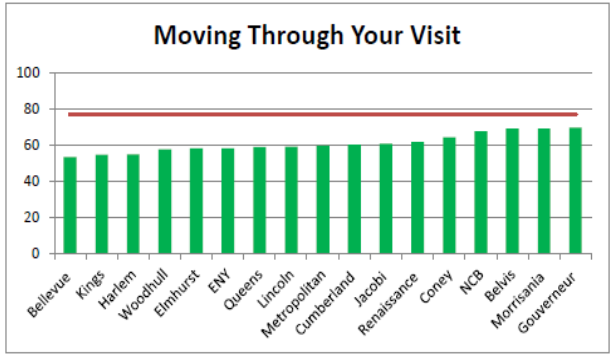
Outpatient Summary Report
Discharge dates of Jan-Mar 2012 through Oct-Dec 2014
Run on 10/31/2014

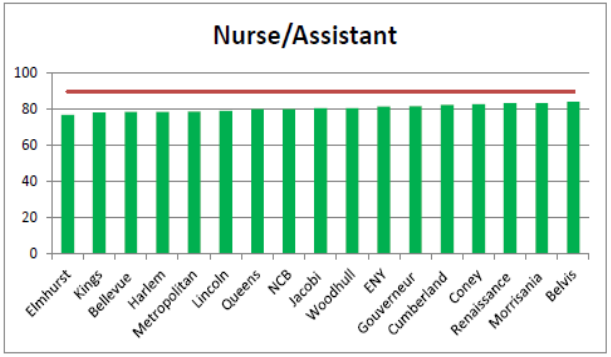
Corporate Outpatient Mean Score
Patients Discharges April – June 2014

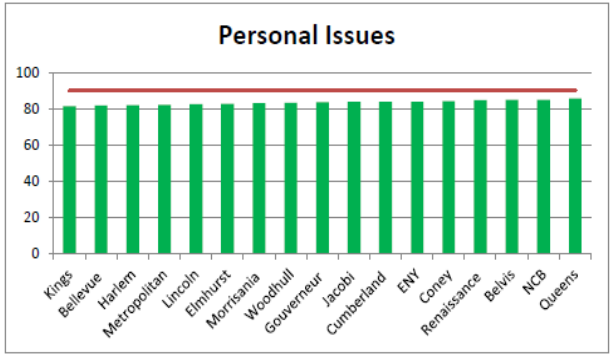


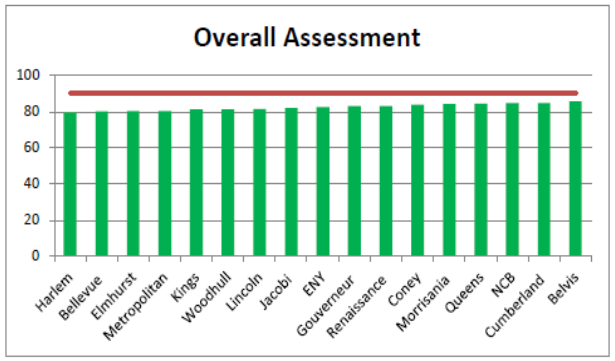








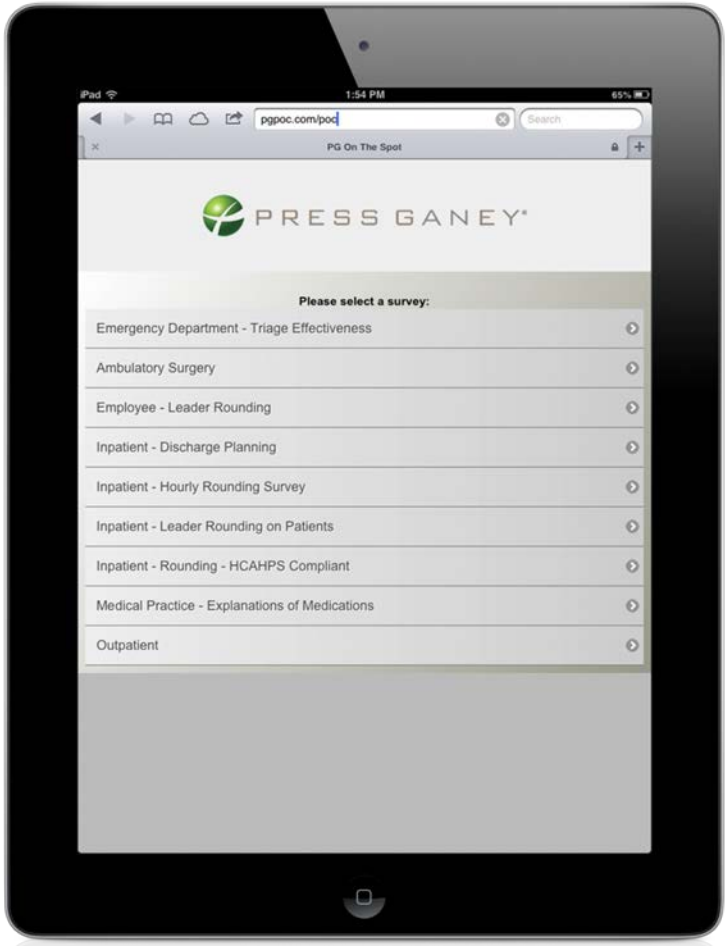




Data Displayed by Discharge Date , Received as of 10/31/2014.
Red Line indicates State of NY Average

Real-Time Feedback !
Point of Care Surveying Basics

- Survey administered at end of patient visit
- Uses a multi-mode approach (kiosk, stationary workstation, tablet, patient's smart device)
- No more than 10 questions
  - 9 Yes/No + 2 Open Ended
- Translated into each facility's top 5 language
- Pilot at 6 facilities on select units determined by project team
  - Kings, Jacobi, Cumberland, Elmhurst, Gouverneur, Queens
- Project plan is to spread to all practices within each pilot facility then spread corporate wide within the next 6 months



Patient Experience Consulting w/ Press Ganey

Goals & Objectives:

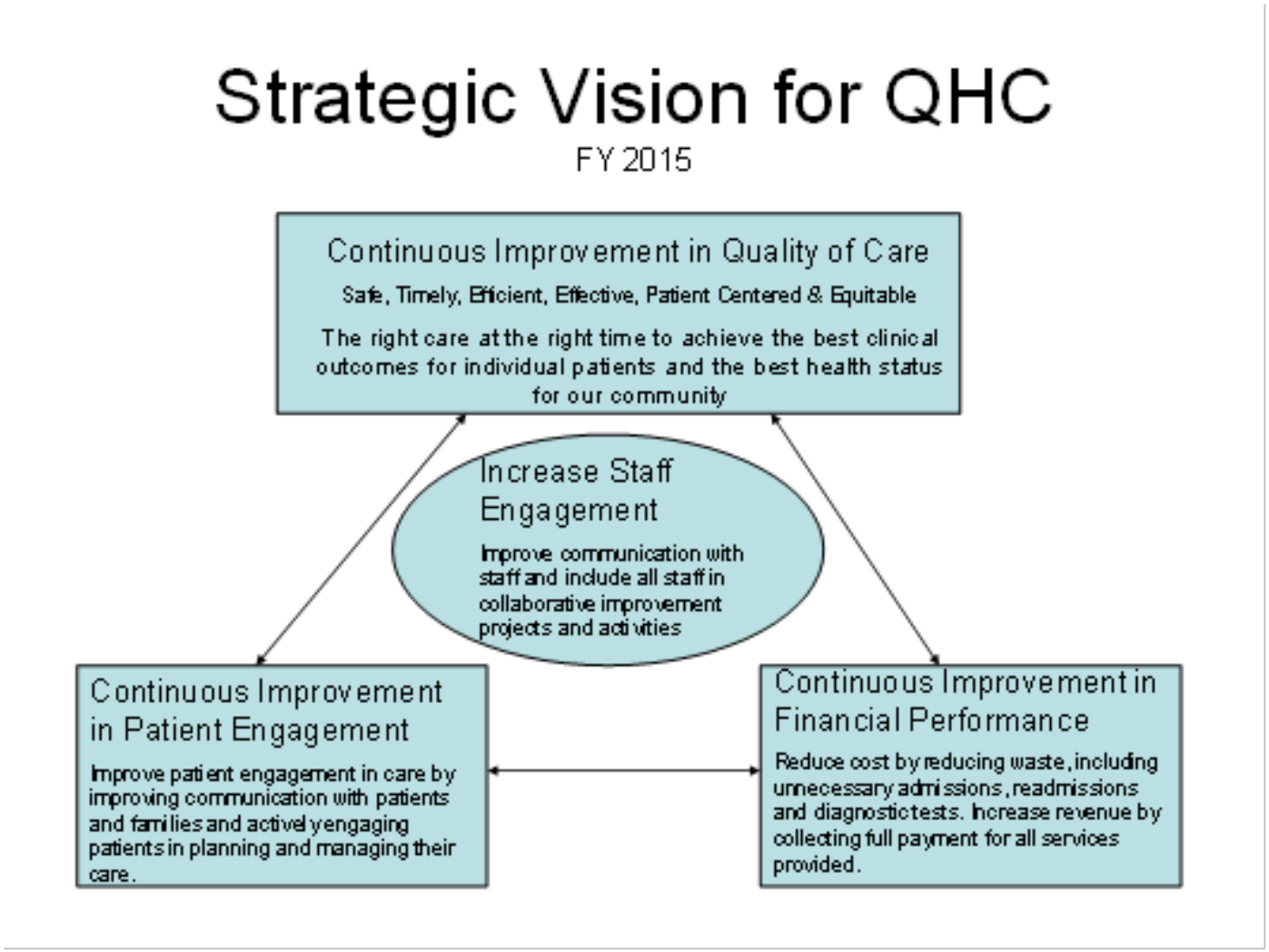
- Improve the overall experience for staff, physicians and patients

- 3 Pilot sites = Kings County, Jacobi, Cumberland

- Phased Approach
  1. Evaluate the current experience (SWOT)
  2. Define the desired staff, physician and patient experience
  3. Implement the critical elements of the program
  4. Monitor roll-out by facility
  5. Lay the foundation for future implementation across HHC

Queens Hospital Center

Patient Centered and Culturally Competent Communication



Compassionate Connected Care

- HHC as an early adopter
- Pilot in 2 units *(**Harlem and Lincoln Proposed***)
- Front line training (***2Days***), manager training (***1/2 Day***), an executive session, performance metrics, and ongoing support
- Builds skills around offering Compassionate Connected Care designed to reduce suffering
- Hypothesis = honing empathic skill sets that enable more patient-centered care improves outcomes and quality at lower costs
- Project Estimated Start = November 2014

HHC | DSRIP

Update for M+PA/IT Committee
Board of Directors

Ross Wilson, MD
Corporate Chief Medical Officer + SVP, Quality
CEO, HHC Accountable Care Organization
November 6, 2014

Today's Discussion

- **HHC DSRIP Overview**
- PPS Update: Configuration, Projects, and Partners
- Governance and Funds Flow

Overview

- **HHC is on-track to submit December 16th application for Delivery System Reform Incentive Payment (DSRIP) Program**
- **HHC will be the lead applicant, or fiduciary, of a single Performing Provider System (PPS) with four (4) borough-based hubs to meet local health and social needs**
  - We've selected DSRIP projects in alignment with borough CNAs
  - HHC's PPS has leadership role in driving collaboration between NYC PPSs
  - We are actively engaging and assessing potential PPS partners
  - We will operationalize a Centralized Services Organization (CSO)
- **We seek to optimize performance and total value to HHC in setting of significant unknowns:**
  - No clear plan yet for troubled Brooklyn hospitals
  - Surprising initial Medicaid attribution results statewide
  - NYS data exchange infrastructure (SHIN-NY) unlikely to support data exchange and reporting needs in desired timeframe

DSRIP Alignment with HHC Transformation Agenda

Aims:

1. Improve the health of Medicaid beneficiaries and the uninsured in each borough
2. Use DSRIP as an opportunity to transform HHC into a high-quality healthcare delivery system with strong partners that is sustainable in the long-run

Aligns with our emphasis on developing greater access to increased primary & ambulatory care and collaborating to address social determinants of health

Focuses on critical gaps in the care continuum, including behavioral health and care transitions

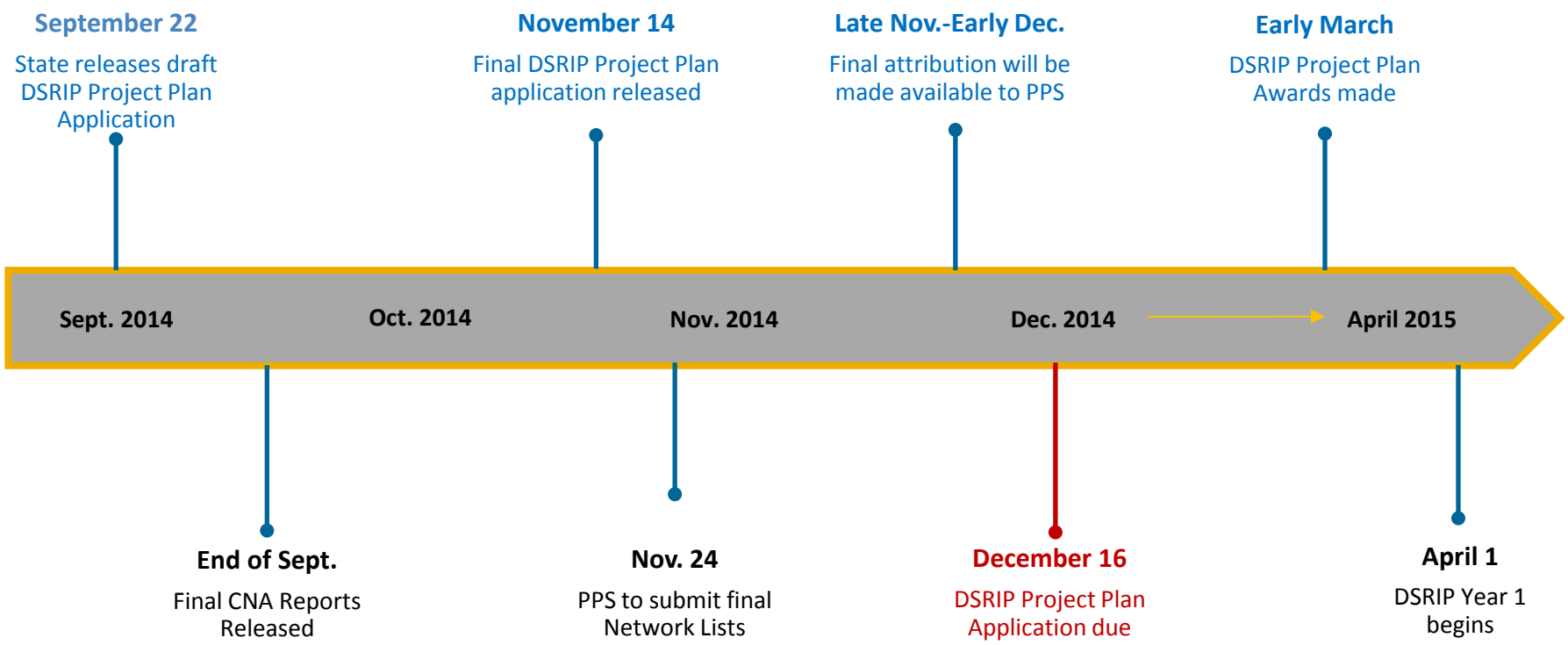
Alignment between DSRIP objectives and preparation for managed behavioral health

Meaningful community collaborations will allow us to develop strategic partnerships focused on engaging all patients and establishing a seamless care continuum and shared responsibility for vulnerable populations

DSRIP helps fund the development of a new population-based data analytics and information-sharing platform, connecting points of care with providers, community partners and patients

Over time, HHC expects to capture additional benefits of our accelerated transformation by leveraging our investments and incentive payments to continue to reduce our cost of care, and by expanding our ability to accept full responsibility for the overall cost and quality of care

DSRIP Project Planning Timeline (Year 0)

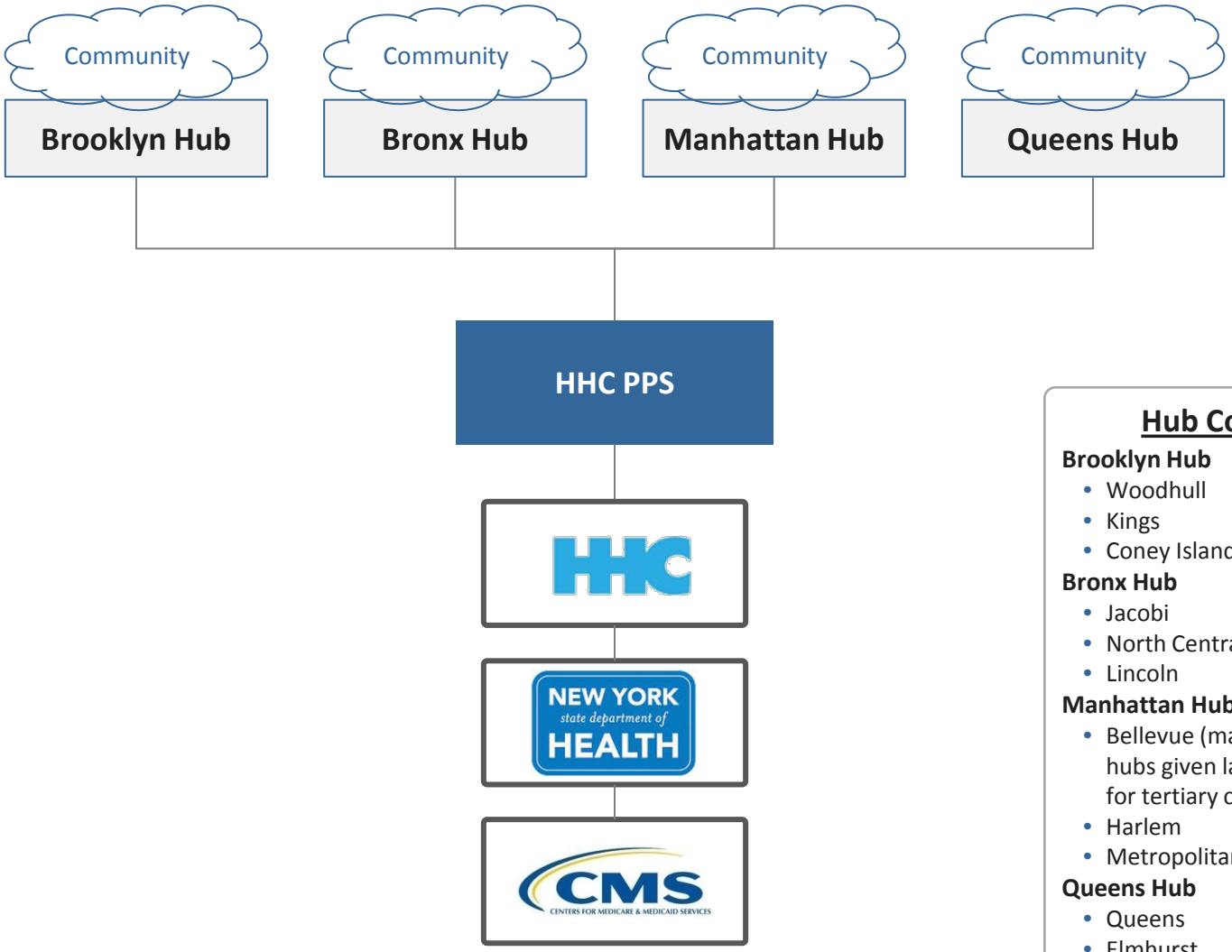


Implementation Planning

Blue text=Pending State deliverables

NOTE: Timeline may change at State's discretion.

HHC Leads a Single PPS with Four (4) Borough-Based Hubs



Hub Configuration

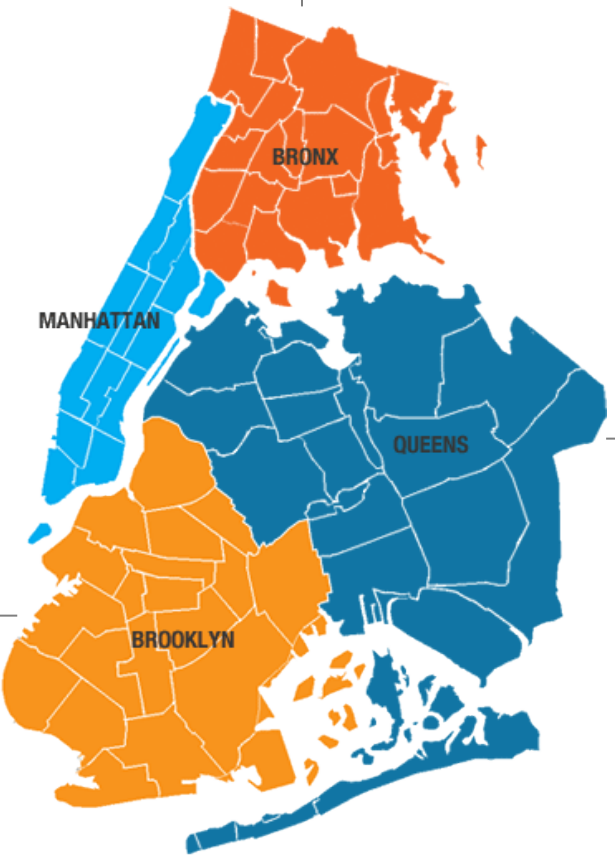
Brooklyn Hub
- Woodhull
- Kings
- Coney Island

Bronx Hub
- Jacobi
- North Central
- Lincoln

Manhattan Hub
- Bellevue (may have role in multiple hubs given large geographic draw for tertiary care services)
- Harlem
- Metropolitan

Queens Hub
- Queens
- Elmhurst

Joint Project Planning with Other NYC PPSs



SBH Health System BRONX

Bronx Partners for Healthy Communities

Lutheran HealthCare℠

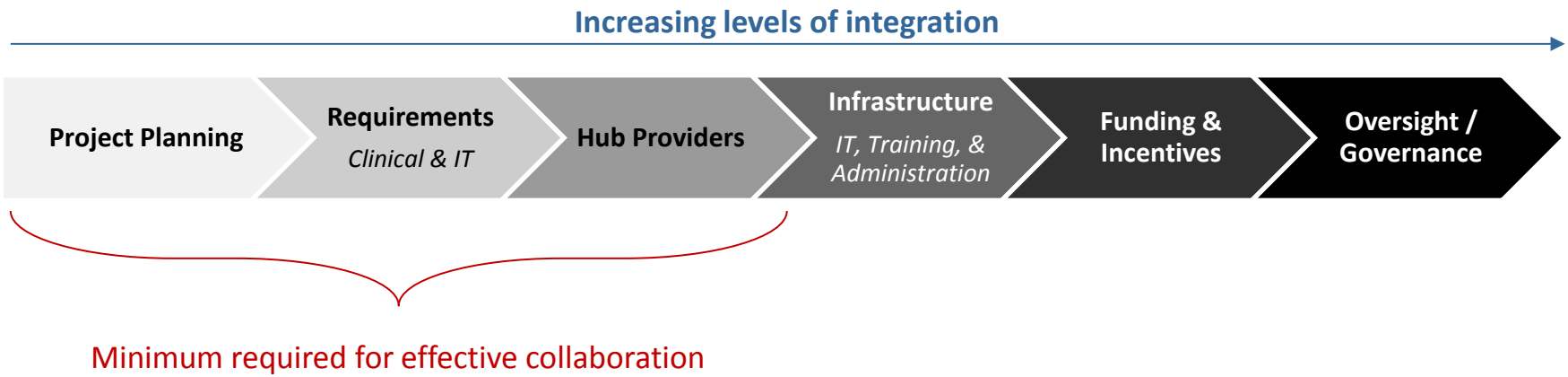
MediSys Health Network

Maimonides Medical Center

Community Care of Brooklyn

Levels of Integration with Other PPSs

Joint project planning is the first step in PPS-to-PPS collaboration. Over time, we may integrate more closely with other PPSs as warranted by trust and performance.



HHC PPS Projects are Aligned with CNAs

"Project 11" (2.d.i)

- **Assigns HHC-led PPS all uninsured + Medicaid non- and low-utilizers in Queens, Manhattan, Bronx, and portion of Brooklyn – regardless of where patient typically seeks care**
- **Goal is to identify, engage, keep track of, and re-connect patients to appropriate services**
- **Requires a multi-stakeholder and tailored approach for each subgroup**
- **Will build upon existing efforts and serve as backbone for our population health activities**

Domain 2: System Transformation	
2.a.i	Create Integrated Delivery Systems that are focused on Evidence Based Medicine / Population Health Management
2.a.iii	Health Home At Risk Intervention Program–Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services. *(Will include cardiovascular and diabetes project efforts.)*
2.b.iii	ED care triage for at-risk populations
2.b.iv	Care transitions model to reduce 30 day readmissions for chronic health conditions
2.d.i	"Project 11": Implementation of Patient Activation Activities to engage, educated, and integrate the UI, NU, and LU Medicaid populations into community-based care
Domain 3: Clinical Improvement Projects	
3.a.i	Integration of primary care and behavioral health services
3.a.iv	Development of Withdrawal Management (e.g., amb. detox., ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs
3.d.ii	Expansion of asthma home-based self-management program
3.g.i	Integration of palliative care into the PCMH model
Domain 4: Population-Wide Projects	
4.a.iii	Strengthen Mental Health and Substance Abuse Infrastructure across Systems
4.c.ii	Increase early access to, and retention in, HIV care

PPS Partnerships

- **All NYS PPSs are required to submit a final, binding partner list by Nov. 24th.**
  - The Medicaid providers on this list drive the total number of lives attributed to the PPS.

- **There are several categories of PPS partners. We are actively assessing the IT, organizational, and financial characteristics of potential partners so we may decide their role in future risk-sharing, clinical integration, and governance:**
  - City-Wide Partners (ex: home health provider who operates in 4 boroughs)
  - Borough-based, Hub- Partners (ex: an FQHC in Bronx)
  - Service Providers (ex: local pharmacy or DME supplier)
  - Community Collaborators/Organizations (ex: a CBO with strong ties to immigrant community)

- **The HHC PPS will not form legal entities. We will instead form contractual arrangements with partners as appropriate following their assessments. Contracting will occur in 1Q, 2015.**
  - First-pass formal assessment is survey tool (<8 hours to complete)
  - As fiduciary, we will perform more detailed assessment of large provider partners whose closure would destabilize services. At present, we have none.
  - Contracts to be designed + executed in 1Q, 2015 and will have transparent quality, data reporting, and other performance requirements

Governance Structure and Funds Flow

- **The HHC PPS governance structure has central and local components:**
  - Single steering committee comprised of HHC and other PPS partners with citywide impact or major attribution
  - Local, hub-level governance with HHC facilities and local PPS partners
  - PPS Advisory Committee (PAC) comprised of:
    - Membership from HHC's existing Community Advisory Boards (CABs)
    - Unions
    - Affiliates
    - Other key stakeholders, including CBOs

- **Over next 3 weeks, we will have confident estimate of funds distribution. The DSRIP application requires percentage allocation of funds among:**
  - Project implementation cost
  - Revenue loss (reduction in bed capacity, etc.)
  - Internal PPS provider bonus payments
  - "Other"