AGENDA  
MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE  

Meeting Date: March 14, 2013  
Time: 12:00 PM  
Location: 125 Worth Street, Room 532  

BOARD OF DIRECTORS  

CALL TO ORDER  
DR. STOCKER  

ADOPTION OF MINUTES  
-February 14, 2013  

CHIEF MEDICAL OFFICER REPORT  
DR. WILSON  

CHIEF INFORMATION OFFICER REPORT  
MR. ROBLES  

METROPLUS HEALTH PLAN  
DR. SAPERSTEIN  

ACTION ITEMS:  

1. Authorizing the President of the New York City Health and Hospitals Corporation (the “Corporation”) to negotiate a contract with CyraCom International, Inc., Language Line Services, and Pacific Interpreters, Inc. to provide over-the-phone-medical interpreting (OPI) services to the Corporation to meet the patient care needs of its limited English proficient patient population and comply with external review agency requirements for a term of three years with two-one year options to renew, solely exercisable by the Corporation, for an amount not to exceed $30,853,396.  

2. Authorizing the President of the New York City Health and Hospitals Corporation (the “Corporation”) to negotiate and enter into a sole source contract with Microsoft Corporation to purchase software licenses and related maintenance and support on an on-going basis in an amount not to exceed $34,500,000 for a three year period.  

3. Authorizing the President of the New York City Health and Hospitals Corporation (“the Corporation”) to negotiate and execute a contract and related agreements with North Shore-Long Island Jewish Health Systems, Inc. (“NSLIJ”) (i) to establish a jointly controlled not-for-profit hospitals cooperative (“CoOpLab”) that will provide laboratory services at cost to NSLIJ’s and the Corporation’s respective health systems in a new cooperative laboratory facility to be located within the City of New York for this purpose; (ii) for the period prior to CoOpLab obtaining the requisite licenses to provide such laboratory services to have NSLIJ’s existing not-for-profit corporation, which operates its core laboratory perform the Corporation’s reference laboratory work that is now sent to commercial vendors at cost and have the Corporation join such not-for-profit corporation as a member; and (iii) to provide for NSLIJ to indemnify the Corporation for any cost, damage or liability arising out of its laboratory activities prior to launch of the cooperative venture and out of any ongoing laboratory activities unrelated to the cooperative venture and for CoOpLab to purchase liability insurance to cover any claims that may arise in the conduct of CoOpLab’s cooperative business.  

AND  
Authorizing the President of the Corporation to effectuate the establishment of CoOpLab and take such other actions as he/she deems appropriate to establish the cooperative laboratory structure described below consistent with these Resolutions.  

INFORMATION ITEM:  

1. Chronic Illness Improvement at HHC: Hypertension  
DR. STEVENS  

OLD BUSINESS  

NEW BUSINESS  

ADJOURNMENT  

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
MINUTES

Meeting Date: February 14, 2013

MEDICAL AND
PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE BOARD OF DIRECTORS

ATTENDEES

Committee Members:

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

HHC Central Office Staff:

- Louis Capponi, MD, Chief Medical Informatics Officer
- Deborah Cates, Chief of Staff, Board Affairs
- Paul Contino, Chief Technology Officer
- Mary-Ann Etiebet, Director, Ambulatory Care Transformation
- Juliet Gaegnag, Senior Director, Clinical Affairs
- Marisa Salamone-Greason, Assistant Vice President, EITS
- Terry Hamilton, Assistant Vice President, Corporate Planning Services
- Caroline Jacobs, Senior Vice President, Safety and Human Development
- Lauren Johnston, Senior Assistant Vice President/Chief Nursing Officer, Patient Centered Care
- Irene Kaufman, Senior Assistant Vice President, Ambulatory Care Transformation
- Patricia Lockhart, Secretary to the Corporation
- 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
- John Morley, MD, Deputy Chief Medical Officer
- Charlotte Neuhaus, Senior Management Consultant, Corporate Planning Services
- 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
- Melville Sylvester, Assistant Director, Communications & Marketing
- Joyce Wale, Senior Assistant Vice President, Office of Behavioral Health
- Ross Wilson, MD, Senior Vice President/Corporate Chief Medical Officer

Facility Staff:

- Ernest Baptiste, Executive Director, King County Hospital Center
- Lynda D. Curtis, Senior Vice President, South Manhattan Network
- Arnold Saperstein, MD, Executive Director, MetroPlus Health Plan
- Denise Soares, Executive Director, Harlem Hospital Center

New York City Health and Hospitals Corporation
OTHERS PRESENT:

Moira Dolan, Senior Assistant Director, DC 37, Research & Negotiations Department
Scott Hill, Account Executive, QuadraMed
Richard McIntyre, Key Account Executive, Siemens
Megan Meagher, Analyst, Office of Management and Budget
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Medical and Professional Affairs/
Information Technology Committee
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MEDICAL AND PROFESSIONAL AFFAIRS/
INFORMATION TECHNOLOGY COMMITTEE
Thursday, February 14, 2013

Michael A. Stocker, MD, Chairman of the Board, called the meeting to order at 10:17 A.M. The minutes of the January 24, 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. Health Home

Since the Health Home soft launch in August 2012, enrollment activity in Phase I HHC facilities continued at a steady pace for targeted eligible populations. HHC COBRA and CIDP care coordinators have worked to outreach and enroll their legacy patients and succeeded in enrolling 70% of their assigned patients. Outreach workers, using the roster of newly eligible patients provided by NYSDOH, sought to locate these individuals and initiate community-based enrollment. Of approximately 1,600 eligibles, 616 were contacted with 74 agreeing to enroll in HHC Health Home. Through these combined outreach and enrollment strategies, HHC Health Homes have enrolled 558 patients.

Since Phase II sites in Queens and Manhattan were approved in December 2012, NYSDOH issued a new roster of patients on January 21, 2013. This roster is comprehensive, representing 3,900 eligible FFS and MetroPlus-managed patients from both Phase I and Phase II regions. Importantly, the quality and accuracy of the patient information is much improved and supersedes the previous roster that had been provided. An analysis of the roster again shows a population of high acuity with 67% of the population having composite scores 125-149 or low high acuity; 20% having a composite score of 150-174 (similar to the CIDP patient population); and finally 13% with the highest acuity and complexity and composite scores in the 175-200 range. The boroughs of Queens and Brooklyn have the majority share of this roster with 2,381 patients linked to their facilities where outreach activities have been initiated in February. CIDP and COBRA programs in Phase II boroughs have a total of 802 active legacy patients. Care coordinators have also initiated engagement and enrollment of these patients this month.

To help guide the enrollment process, the HHC Health Home Office has been holding training sessions on the use of health Home enrollment and consent. Staff from legacy programs at Queens and Elmhurst Hospitals has already been trained; training for Bellevue, Harlem and Metropolitan is scheduled to take place this month.

Infrastructure for HHC’s Health Home is being developed in a number of ways. The prototype for an interoperable Care Plan Management System (CPMS) will be ready for launch in March with user testing and training scheduled beginning in February and continuing through March. The web-based CPMS will be available to care team members via password; members of the Interboro RHIO will have view access to the care plans developed in the in the CPMS later this year. The Health Home Network is being developed through a phased-in strategy beginning with executing Data Exchange Application and Agreements (DEAAs) for the community-based organizations that were vetted and prioritized by HHC facility leadership in May 2012. We currently have completed DEAAs with 24 unique organizations and 16 additional DEAAs are in progress. HHC Health Home will begin to develop contracts with community providers who are currently providing COBRA services to HHC patients who are eligible for Health Home services.
2. Dialysis Transition Project Report

- Project Manager for Transition has commenced – David Veras from Woodhull MMHC
- HHC / Atlantic Dialysis Contract has been signed
  - PAGNY Contract to be signed soon (by 2/15/2013).
- Transition Schedule:
  - Woodhull Medical Center by March 4, 2013
  - Queens Medical Center by March 11, 2013
  - Coney Island Hospital by June, 2013
  - North Central Bronx Hospital by July, 2013
  - Jacobi Medical Center by August, 2013
  - Lincoln Medical Center tentatively by September, 2013
- Standardized flow sheet has been developed for utilization at all sites.
- IT Risk Assessment being conducted by HHC IT Security Dept. preparing for software integration between EPIC & QMS (Atlantic Dialysis EMR Software)
- ADMS is finalizing Policy & Procedure Manual to be distributed to each hospital for review and input.
- Fresenius Medical Care has been notified of transition and impending supplies & water testing contracts being phased out facility by facility at the point of their scheduled transition.
- Dialysis Equipment to be sold has been identified. Relinquishment & Depreciation is being conducted and will be produced to ADMS for purchase by Friday 2/15/2013 for Woodhull & Queens. Other facilities by April 2013.
- Working on standardizing and streamlining the HR & Nursing Onboarding process throughout HHC for all ADMS staff. Working closely with HR Directors and Nursing Directors.
- ADMS has updated their Liability Insurance Policy to cover Acute Facilities.
- ADMS Architect has visited NCB (2/6/13) & Lincoln (tentatively scheduled for 2/15 @2pm) to view space for new Chronic unit.
- Transition process to be presented at HR Directors, CNO Council and Chiefs of Internal Medicine – scheduled for Supply Chain Council and the CFO Council.

3. HHC’S Teen Health Improvement Program

The Mayor’s Young Men’s Initiative funded HHC’s Teen Health Improvement program that began in April 2012. The program’s mission is to improve population health outcomes among HHC’s adolescent patients by ensuring the accessibility and quality of health services HHC provides with a focus on sexual and reproductive health.

The Teen Health Improvement program has completed a needs assessment, and has a Health Improvement Panel at all 17 facilities. Supplies of contraceptives and patient education materials have been distributed to all facilities. In addition, the Standardized Patient program for pediatrics won 3rd prize among over 1,000 entrants at the International Meeting for Simulation in Healthcare. Adolescent Patient Satisfaction Survey is underway at all open facilities (not yet at Coney Island or Bellevue).

Future work includes:
- develop and deliver a multi-faceted provider training program;
- expand adolescent Standardized Patient program throughout HHC;
- assist pediatric/adolescent clinics qualify to be listed in widely-distributed DOHMH teen clinic listing;
develop teen-friendly web page promoting HHC’s services;
investigate opportunities for increasing revenue for adolescent care (e.g. via use of the Family Planning Benefit Program, a little-known Medicaid program that covers sexual health care, or better financial practices; and
support inter-facility collaboration regarding adolescent health quality improvement work.

4. Improving Access to Primary Care

As has been previously discussed providing adequate access to primary care is an essential component of the future HHC healthcare delivery system. It directly impacts many areas which include the capacity to enroll and maintain managed care patients as well as to attract beneficiaries to our new ACO. Current performance in providing adequate access and satisfying the needs of our patients needs to be improved. In order to progress this issue, an engagement with McKinsey & Co is commencing this month to assist the corporation to meet the needs of our current and future patients. This is a large and complex task and will be reported further in detail to the Committee as the work progresses.

CHIEF INFORMATION OFFICER REPORT

Bert Robles, Senior Vice President/Chief Information Officer provided the Committee with updates on the following initiatives:

**Meaningful Use (MU) Stage 2:**

This morning we have a Meaningful Use presentation for the committee but I also wanted to briefly update the members as to the Corporation’s status to meet Meaningful Use Stage II.

The Corporation continues efforts to meet requirements under the American Recovery and Reinvestment Acts (ARRA) program for Meaningful use of Electronic Health Records. This national program aims to increase the prevalence of electronic health record use across all providers of care including hospitals and community practitioners with the aim of forming a more connected healthcare system that is necessary to coordinate care, improve efficiency, decrease cost, and improve quality. This multi-year program has several Stages which will evolve over the coming years. Each Stage contains new requirements and providers are rewarded with incentive funds for achieving and sustaining each Stage.

In the fall of 2012, all eleven HHC facilities attested to achieving Stage 1 Meaningful Use. As a result, HHC received $17 million of incentive funding under the Medicare portion of the Program and another $43.5 Million in Medicaid incentive dollars. In Stage 1 of the program, Hospitals need to meet minimum thresholds with fourteen core program measures as well as five menu measures. This stage continues for another year. HHC will receive additional incentives in 2013, provided Hospitals continue to meet these minimum thresholds. HHC is currently on track to do so and we continue to monitor performance across the system. To monitor for ongoing compliance all eleven hospitals run monthly reports on these performance measures.

Even as HHC remains focus on sustaining Stage 1, the Corporation is preparing for Stage 2 of the program. Stage 2 of the program includes both new requirements not previously part of Stage 1, as well as increased achievement thresholds for existing requirements. Among the changes are the requirements for Bar Coding of medications as well as the ability for a patient to download an admission summary within 36 hours of hospital discharge. In addition, several of the measures, which were optional in Stage 1, are now required in stage 2, including transition of data to immunization registries, medication reconciliation, and patient specific
education resources. In addition to meeting the Meaningful Use Criteria described above, each hospital will need to electronically transmit sixteen Quality measures to CMS.

As was the case in preparing for Meaningful Use Stage 1, Stage 2 will require several major software upgrades. These include moving from the current QuadraMed software version of 5.2, first to version 5.4 and ultimately to version 6.0. QuadraMed has advised HHC that the 6.0 version will not be generally available until the third quarter of calendar year 2013. However, it is anticipated that several HHC facilities will participate in the Beta release of this version which will give HHC an opportunity to test the system and test the features and functions in the release. All facilities are expected to be on version 5.4 by June 30, 2013. In addition to these software upgrades, there is also a database upgrade for the Cache database as well as updates to the MediSpan drug database.

As was the case for attestation in Stage 1, the first year of Stage 2 is allows for a 90 day compliance period as opposed to 365 days in subsequent years. However, unlike stage 1, which allowed hospitals to choose any 90 day period, Stage 2 requires the period to coincide with a quarter within the Federal Fiscal year. HHC plans to have all software upgrades completed by the fall of 2013, thus permitting hospitals to attest in one of the three remaining quarters of the fiscal year: January – March 2014; April – June 2014; or July – September 2014 (last chance).

**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 January 31, 2013 was 443,173. Breakdown of plan enrollment by line of business is as follows:

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>377,914</td>
</tr>
<tr>
<td>Child Health Plus</td>
<td>13,466</td>
</tr>
<tr>
<td>Family Health Plus</td>
<td>36,467</td>
</tr>
<tr>
<td>MetroPlus Gold</td>
<td>3,287</td>
</tr>
<tr>
<td>Partnership in Care (HIV/SNP)</td>
<td>5,679</td>
</tr>
<tr>
<td>Medicare</td>
<td>6,354</td>
</tr>
<tr>
<td>MLTC</td>
<td>6</td>
</tr>
</tbody>
</table>

From December to January, MetroPlus gained 4,630 members. MetroPlus experienced a positive gain in Medicare, gaining 160 enrollees.

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

Dr. Saperstein informed the Committee that MetroPlus’ membership losses to Health First and Fidelis are holding steady at 1,200 per month. MetroPlus continues to reevaluate their marketing and retention efforts to address these losses. The losses due to the dental plan change have tapered off, and MetroPlus is working with Healthplex to continually improve their dental network’s satisfaction.

MetroPlus was informed this month that 160 Water Street will be open and available for occupancy on February 15, 2013. Their move back to 160 Water Street is dependent on air quality safety, as well as full availability of phone and data services. MetroPlus is working on their plan for relocating all areas and anticipate having all operations back at 160 Water Street by mid-March 2013.
This month, MetroPlus completed an analysis of their Medicare disenrollments and found that the majority of their losses were because members voluntarily disenrolled to join another plan. The largest segment of the members surveyed left MetroPlus’ Platinum product to join Healthfirst Medicare.

Enrollment for MetroPlus’ new Managed Long Term Care product began on January 1, 2013. MetroPlus currently has six members and are expecting 22 new members in February, including 13 new auto assignments.

MetroPlus is in the process of preparing to submit an application for the Fully Integrated Duals Advantage (FIDA) program. FIDA is a three-year demonstration project designed to test new service delivery and capitated payment models for beneficiaries dually eligible for Medicaid and Medicare. These beneficiaries must require more than 120 days of long term support and services. The demonstration project will be effective in January 2014 and will service eight New York counties, including Bronx, Kings, New York, Queens, Nassau, Suffolk, Richmond and Westchester. The total number of beneficiaries eligible for the demonstration is estimated at 123,000. Beneficiaries currently enrolled in the MetroPlus MLTC program will be passively enrolled in the FIDA program, with an option to opt-out. All Medicare Advantage plans will transition to a product line to provide FIDA. Otherwise, plans that do not transition to FIDA will only serve duals that opt-out or dis-enroll from FIDA. The initial application is due to CMS February 15, 2013.

On January 31, 2013 the New York Health Benefit Exchange issued its invitation to health insurers and dental plans to participate in the New York Health Benefit Exchange. The letter of interest is due on February 15, 2013, and the submission of a participation form is required by April 5, 2013. NYS Health Benefit Exchange will go live in October 2013. Qualified Health Plans (QHPs) are classified into 4 types of product levels, Platinum, Gold, Silver, and Bronze; with progressively increased copayments and deductibles. Within each plan there will be an additional pediatric option and within the Silver plan there are three additional levels of coverage based on a member’s income as compared to the federal poverty level. Given these requirements, MetroPlus must offer a minimum of 16 products in the NYS Health Benefit Exchange, which will also include a Catastrophic Plan.

Governor Cuomo released his Executive Budget on Tuesday January 22, 2013. The Executive Budget proposes to revise existing Medicaid categories and convert eligibility levels to a Modified Adjusted Gross Income (MAGI) equivalent standard. The Executive’s proposal establishes a new adult category for individuals ages 19 to 64 with incomes below 133 percent of the Federal Poverty Level (FPL) and provides that these beneficiaries receive a Benchmark benefit package. There will also be unique eligibility levels for pregnant women, parents, infants and children. The Executive Budget also defines the Medicaid eligibility categories that will not be subject to MAGI financial methodologies and adds a new mandatory eligibility category for former foster care children, up to age 26 years old, who were receiving Medicaid when they aged out of foster care. The Executive Budget establishes 12 month continuous eligibility for individuals whose Medicaid eligibility is based on MAGI methodologies, except for individuals whose eligibility changes due to citizenship, residency or failure to provide a valid social security number.

Other changes in the Executive Budget include:
- Medicaid global cap (3.9%) remains in place and the 2% across-the-board payment cut, which was scheduled to expire at the end of this fiscal year, is extended through March of 2015;
- A repeal of “prescriber prevails” authority for atypical antipsychotics in Medicaid managed care and in the entire Medicaid fee-for-service (FFS) pharmacy program;
- Institutes a new $20 million quality incentive program for the Managed Long Term Care program;
- Eliminates statutory impediments to enrolling excluded FFS populations into Medicaid managed care;
- Amends the autism mandate to replace the $45,000 annual benefit cap with 680 hours of treatment per policy or calendar year;
- Enacts numerous provisions that will enable New York to align and conform with the federal Affordable Care Act (ACA) and move forward with the New York Health Exchange including:
  - Beginning a phase out of the Family Health Plus (FHP) and FHP buy-in programs;
  - Eliminating the standardized individual direct pay products, effective October 2013, and establishing a new individual market product outside of the Exchange that must conform to Exchange requirements;
  - Eliminating the Healthy New York program, effective December 31, 2013.

INFORMATION ITEM:

1. Meaningful Use Update – Stage 2

Presenting to the Committee was Louis Capponi, MD, Chief Medical Informatics Officer. Starting in 2014, providers participating in the EHR Incentive Programs who have met Stage 1 for two or three years will need to meet meaningful use Stage 2 criteria. Stage 2 includes new objectives to improve patient care through better clinical decision support, care coordination and patient engagement. With this next stage, EHRs will further save our health care system money, save time for doctors and hospitals, and save lives.

Dr. Capponi reviewed the core objectives and menu objectives comparing the changes from Stage 1 to Stage 2 (see attached table for details). Highlights of the changes are below.

More than 50 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH have their information available online within 36 hours of discharge (Stage 1 was 10%, menu set). More than 5 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH view, download or transmit to a third party their information during the reporting period (new). Clinical summaries provided to patients within 24 hours for more than 50 percent of office visits (Stage 1 was 3 days).

More than 10 percent of all unique patients admitted to the eligible hospital’s or CAH’s inpatient or emergency departments (POS 21 or 23) are provided patient-specific education resources identified by Certified EHR Technology (Stage 1 was menu set). A secure message was sent using the electronic messaging function of Certified EHR Technology by more than 10 percent of unique patients seen during the EHR reporting period (New – Eligible Provider).

The eligible hospital or CAH performs medication reconciliation for more than 65 percent of transitions of care in which the patient is admitted to the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23) (Stage 1 was 50%, menu set). The eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals. The eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care electronically transmits a summary of care record using certified EHR technology to a recipient with no organizational affiliation and using a different Certified EHR Technology vendor than the sender for more than 10 percent of transitions of care and referrals (Stage 1 was one test of transmission).

Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider’s risk management process (added data at rest).
In summary, there are a total of 22 Meaningful Use objectives of which 16 are core items required for Stage 2 and 3 of 6 menu items required for Stage 2. In Stage 2, Stage 1 menu items are now required, seven new objectives added and some related Stage 1 objectives combined. In addition, quality reporting now separate element of meaningful use. Hospitals now must report on 16 measures. Quality measures include the following 29 measures in six domains: Patient and Family Engagement (5); Patient Safety (6); Care Coordination (2); Population and Public Health (0); Efficient Use of Healthcare Resources (2); and Clinical Processes/Effectiveness (14).

There being no further business the meeting adjourned at 11:04 A.M.
# Core Objectives

<table>
<thead>
<tr>
<th>Core Objective</th>
<th>Measure Stage 1</th>
<th>Measure Stage 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CPOE</td>
<td>30% medication</td>
<td>Use CPOE for more than 60% of medication, 30% of laboratory, and 30% of radiology</td>
</tr>
<tr>
<td>2. Demographics</td>
<td>50% demographics</td>
<td>Record demographics for more than 80%</td>
</tr>
<tr>
<td>3. Vital Signs</td>
<td>50% vital signs over age 2</td>
<td>Record vital signs for more than 80%, blood pressure over age 3.</td>
</tr>
<tr>
<td>4. Smoking Status</td>
<td>50% smoking status</td>
<td>Record smoking status for more than 80%</td>
</tr>
<tr>
<td>5. Interventions</td>
<td>1 clinical support</td>
<td>Implement 5 clinical decision support interventions + drug/drug and drug/allergy</td>
</tr>
<tr>
<td>6. Labs</td>
<td>40% lab results</td>
<td>Incorporate lab results for more than 55%</td>
</tr>
<tr>
<td>7. Patient List</td>
<td>Same</td>
<td>Generate patient list by specific condition</td>
</tr>
<tr>
<td>8. eMAR</td>
<td>NEW</td>
<td>eMAR is implemented and used for more than 10% of medication orders</td>
</tr>
<tr>
<td>9 Transitions of Care</td>
<td>50% patients who request electronic</td>
<td>Provided for more than 50% of transitions of care or referrals (does not have to</td>
</tr>
<tr>
<td>Record</td>
<td>copy are provided within 3 days.</td>
<td>be electronic)</td>
</tr>
<tr>
<td>10. Education Resources</td>
<td>Provide education resources. (previously a menu item)</td>
<td>More than 10% are transmitted electronically</td>
</tr>
<tr>
<td>11. Rx Reconciliation</td>
<td>Same (previously a menu item)</td>
<td>• Care plan, including goals and instructions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• List of team members, including PCP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provide education resources more than 10% by certified EHR technology</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medication reconciliation at more than 50% of transitions of care</td>
</tr>
</tbody>
</table>
## Core Objectives

<table>
<thead>
<tr>
<th>Core Objective</th>
<th>Measure Stage 1</th>
<th>Measure Stage 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Summary of Care Record for Patient</td>
<td><em>(New)</em></td>
<td>Updated measure. Patients can View, Download, and transmit to a Third Party a summary of care document within 36 hours. 50% of the time and 5% of patients actually do so.</td>
</tr>
<tr>
<td>13. Immunizations</td>
<td>Perform 1 test on EHR to submit data (previously a menu item)</td>
<td>Successful ongoing transmission of immunization data</td>
</tr>
<tr>
<td>14. Reportable Labs</td>
<td>Perform 1 test on EHR to submit data (previously a menu item)</td>
<td>Successful ongoing submission of reportable laboratory results</td>
</tr>
<tr>
<td>15. Syndromic Surveillance</td>
<td>Perform 1 test on EHR to submit data (previously a menu item)</td>
<td>Successful ongoing submission of electronic syndromic surveillance data</td>
</tr>
<tr>
<td>16. Security Analysis</td>
<td>Conduct or review security analysis</td>
<td>Conduct or review security analysis and incorporate in risk management process addressing encryption of data</td>
</tr>
</tbody>
</table>
# Menu Objectives (choose 3)

<table>
<thead>
<tr>
<th>Menu Objective</th>
<th>Measure Stage 1</th>
<th>Measure Stage 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Advanced Directives</td>
<td>50% of transactions of care.</td>
<td>Record advanced directives for more than 50% of patients 65 years or older</td>
</tr>
<tr>
<td>2. Progress Notes</td>
<td>NEW</td>
<td>Enter an electronic progress note for more than 30% of unique patients</td>
</tr>
<tr>
<td>3. Imaging Results</td>
<td>NEW</td>
<td>More than 20% of imaging results are accessible through Certified EHR Technology</td>
</tr>
<tr>
<td>4. Family History</td>
<td>NEW</td>
<td>Record family health history for more than 20%</td>
</tr>
<tr>
<td>5. E-Rx</td>
<td>NEW</td>
<td>More than 10% electronic prescribing (eRx) of discharge medication orders</td>
</tr>
<tr>
<td>6. Labs</td>
<td>NEW</td>
<td>Provide structured electronic lab results to EPs for more than 20%</td>
</tr>
</tbody>
</table>
Thank you and good afternoon. I would like to provide the Committee with the following updates:

1. **HHC’s Response to the February 21st Cyber-Attacks:**

   On Thursday, February 21st, China according to "The Washington Post" hacked computers of virtually every institute in Washington. Additionally on the same day, Froedhert Hospital in Milwaukee, Wisconsin announced that it encountered one massive security hack that caused 43,000 patient records to be exposed. It was estimated that this security breach could cost Froedhert hospital close to $8.3m in damages.

   Following these developments, the EITS Security Team became extra vigilant in monitoring intrusion attempts on our corporate assets especially from outside HHC. On February 22nd, the EITS Security Team proactively engaged the “US Computer Emergency Readiness Team" (US-CERT) and received specific IP addresses and websites that were involved in attacks against US government and private entities. This was non-public information and was received over a secure channel. In addition, the Security Team engaged and alerted its security partners/vendors and sister agencies. Based on historical institutional knowledge and information received from the Department of Homeland Security, the FBI and other
entities contacted, the EITS Security Team elevated HHC’s security status which included re-calibrating our perimeter security devices (Intrusion Prevention Systems, Anti-Virus, DNS, Firewalls etc..) within a matter of 4 hours to cover all known as well as unknown but expected intrusions. In addition, the monitoring which is usually from 8am-6pm was extended to 24 by 7 from Friday, February 22\textsuperscript{nd} through Monday, February 25\textsuperscript{th}.

As a result of these proactive measures and collaboration with internal and external entities, HHC managed to block all malicious attempts. At this point, there is no reported or detected compromise of any HHC asset due to the alleged Chinese cyber-attacks. We continue to operate our security devices at increased sensitivity but have resumed normal security monitoring.

2. \textbf{ICIS Electronic Health Record (EHR) Program Update:}

I wanted to update the committee on EITS’ activities regarding the Epic implementation. Since my last update to the committee at the January meeting, I am pleased to report that our planning phase for this program is well underway.

\textbf{Staffing:}

As you all know, our first major deadline with the project was to have identified 80\% of the project team members by March 1\textsuperscript{st} in order for HHC to begin the first wave of Epic training on March 25\textsuperscript{th}. Depending on their identified roles, EHR staff may need to attend multiple trainings at the Epic campus in order to receive their certification on specific application modules. It was critical for the program team to recruit and identify those
key staff members who would be attending the first trainings scheduled for
the week of March 25th. I am happy to report that the team has met this
challenge and we will be sending our first wave of trainees to EPIC in late
March.

**Current Program Activities:**
I am also pleased to report that the Infrastructure and Operations team has
ordered the necessary hardware for the program and it is being staged for
initial review of the EPIC application.

The program team continues to work on and prioritize workflows for
standardization across the enterprise. We are in the process of developing a
plan for application review sessions which will start in late June of this year
and go through August. We anticipate some 200+ sessions for this review
by HHC clinical and non-clinical staff over a 6-8 week period. Planning for
this large scale event is underway and the team is currently exploring venues
where this event could be held.

We are also in the process of finalizing the program plan which includes
establishing a governance model, refining baseline timelines and milestones,
as well as creating a risk plan. With Epic, we are also in the process of
looking at key criteria that will be used in discussions with Senior HHC
leadership to identify which facility/network will be the initial site for our
implementation strategy.

Going forward, I will continue to provide a monthly update to the committee
members on our progress.
This completes my report today. Thank you.
Total plan enrollment as of February 28th, 2013 was 440,352. Breakdown of plan enrollment by line of business is as follows:

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<th>Line of Business</th>
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<td>MLTC</td>
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This month, we had a net loss of 4,339 members. We experienced a positive gain in Medicare, gaining 346 enrollees.

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.

This month, we analyzed disenrollments from our plan. In February, we had 19,978 disenrollments from MetroPlus, and 15,639 new applications. The majority of the losses were due to loss of Medicaid eligibility, likely a catch-up after Superstorm Sandy.

Our membership losses to Health First and Fidelis continue to be a significant part of our monthly losses. In February, we lost 899 members to Healthfirst and we lost 783 members to Fidelis Care. As I have reported in the past, approximately 80% of the members that transfer from MetroPlus to Healthfirst leave the HHC system as well. This trend began this summer, after our dental transition to Healthplex. We have completed further disenrollment surveys beyond the dental transition period and the overwhelming number of members surveyed stated that they wish to see doctors that are not a part of the MetroPlus network.

This month, MetroPlus successfully completed the submission of the initial Centers for Medicaid and Medicare Services (CMS) FIDA application on February 21st, 2013. The FIDA program is a demonstration project between CMS and the State of New York and is focused on long term care. MetroPlus is currently waiting for guidance from the State on any next steps that may be required.

In February, MetroPlus implemented an authorization program for outpatient high tech radiology services (PT, MRI, MRA, CT) and nuclear cardiology services. Due to the volume of requests, and expertise required, MetroPlus will be partnering with MedSolutions to issue the authorizations for these services. All HHC facilities are excluded from this authorization requirement.
The HHC Health Home initiative has entered into its second phase of enrollment. At the end of January, the State sent HHC a new list of members for outreach to join the HHC Health Home. The current outreach strategy includes a target outreach population of 50% of HHC FFS patients and 50% MetroPlus members. A mailing of 1,300 letters was sent this month and the response is favorable. The current enrollment in the HHC Health Home is 640 patients, 348 of which are MetroPlus members. In addition, the NYSDOH notified health plans that the plans must diversify their contracts beyond HHC. MetroPlus has entered into negotiations with other Health Homes that are not considered direct competitors.

This month, the state has announced the Phase II Medicaid Redesign Team rate adjustments for health plans. There will be an overall increase of 0.6% to Medicaid rates and 0.7% to Family Health Plus rates. In the future, there will also be a rate increase for our Managed Long Term product line. The calculation for reimbursement was made on the assumption that 80% of members in the program would be nursing home certifiable. The actual number has proven to be 98% of members that are nursing home certifiable- generating the rate increase.

There will be a .7% shift in dollars due to the transportation carve-out; these dollars will be used to support the primary care rate increase required by the Affordable Care Act. For dates of service starting January 1st, 2013, the statute specifies that higher payment applies to primary care services delivered by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine. The regulation specifies that specialists and subspecialists within those designations as recognized by the American Board of Medical Specialties (ABMS) the American Osteopathic Association (AOA) or the American Board of Physician Specialties (ABPS) also qualify for the enhanced payment. In order to be eligible for higher payment physicians must first self-attest to a covered specialty or subspecialty designation. It was recently announced that the State will collect attestations from providers and will provide plans with an eligibility file to aid in the reimbursement process.

As the New York State Medicaid Redesign Team continues their work to cut costs, the focus is now on the Behavioral Health population. The latest recommendation for NYC will be full benefit integrated SNPs (affiliated with existing plan or freestanding) for high need populations to be called Health and Recovery Plans (HARPs). HARPs eligibility criteria and specialized benefits will be developed by DOH, OASAS, OMH and NYC with stakeholder input. The state has issued a draft BH benefit redesign proposal timeline which shows that applicants will need to be prepared to respond to serve as a HARP in the Summer of 2013 with a 30-day response time to an RFP. HARPs will begin operation in Fall/Winter 2014.
### Membership Summary by LOB Last 7 Months
**February-2013**

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### Data Source:
RDS Report 1268a&c Updated 02/18/2013
## New Member Transfer From Other Plans

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| Affinity Health Plan        | 20   | 254  | 38   | 296  | 26   | 239  | 21   | 180  | 23   | 199  | 22   | 212  | 15   | 202  | 15   | 190  | 7    | 128  | 19   | 152  | 19   | 139  | 2,688 |
| Amerigroup/Health Plus/Care Plus | 55   | 555  | 77   | 614  | 74   | 549  | 44   | 372  | 47   | 342  | 30   | 333  | 20   | 263  | 36   | 281  | 22   | 188  | 24   | 211  | 21   | 205  | 4,920 |
| Fidelis Care                | 16   | 207  | 27   | 224  | 11   | 199  | 5    | 159  | 22   | 220  | 14   | 215  | 11   | 206  | 24   | 208  | 12   | 159  | 6    | 164  | 11   | 192  | 2,596 |
| Health First                | 17   | 250  | 19   | 253  | 25   | 212  | 13   | 212  | 20   | 244  | 22   | 177  | 13   | 165  | 18   | 192  | 5    | 117  | 14   | 147  | 11   | 152  | 2,531 |
| HIP/NYC                     | 10   | 128  | 5    | 130  | 7    | 130  | 9    | 95   | 7    | 112  | 8    | 128  | 4    | 96   | 4    | 106  | 5    | 53   | 6    | 78   | 5    | 94   | 1,544 |
| Neighborhood Health Provider PHPS | 18   | 233  | 30   | 250  | 32   | 208  | 15   | 140  | 16   | 184  | 13   | 186  | 13   | 144  | 19   | 195  | 13   | 110  | 18   | 131  | 19   | 157  | 2,548 |
| United Healthcare of NY     | 10   | 125  | 11   | 161  | 10   | 144  | 10   | 96   | 6    | 95   | 14   | 92   | 9    | 98   | 5    | 115  | 4    | 90   | 5    | 80   | 9    | 81   | 1,569 |
| Unknown Plan                | 2,066| 11,417| 1,914| 18,656| 2,476| 14,769| 2,180| 12,021| 1,950| 11,514| 2,029| 13,344| 1,692| 10,659| 1,524| 9,757| 1,789| 13,737| 1,261| 7,359| 1,408| 9,293| 1,732| 12,009| 158,114|
| Wellcare of NY              | 31   | 121  | 15   | 185  | 27   | 146  | 19   | 84   | 32   | 137  | 13   | 91   | 16   | 79   | 18   | 86   | 8    | 70   | 5    | 91   | 16   | 109  | 1,566 |
| **TOTAL**                   | 2,243| 13,290| 2,106| 19,335| 2,698| 16,882| 2,392| 13,840| 2,086| 12,882| 2,242| 14,777| 2,028| 12,093| 1,625| 10,628| 1,928| 12,187| 5,277| 8,274| 1,565| 10,347| 1,843| 15,138| 177,476|
## Disenrolled Member Plan Transfer Distribution

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Report ID: MHP1268A
Report Run Date: 2/15/2013
### Disenrolled Member Plan Transfer Distribution

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**Report Run Date:** 2/15/2013
# Disenrolled Member Plan Transfer Distribution

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<td>1,564</td>
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Report ID: MHP1268A
Report Run Date: 2/15/2013
RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate a contract with CyraCom International, Inc., Language Line Services, and Pacific Interpreters, Inc. to provide over-the-phone-medical interpreting (OPI) services to the Corporation to meet the patient care needs of its limited English proficient patient population and comply with external review agency requirements for a term of three years with two-one year options to renew, solely exercisable by the Corporation, for an amount not to exceed $30,853,396.

WHEREAS, the Corporation is committed to providing equitable, safe, timely, efficient patient centered care in the languages spoken by its patient populations; and

WHEREAS, in fiscal year 2012 over twenty-five percent of the Corporation’s patient population was deemed limited English proficient; and

WHEREAS, in fiscal year 2012, over 190 languages and dialects were spoken by the patients receiving care by the Corporation; and

WHEREAS, the Corporation requires the assistance of firms specializing in over-the-phone medical interpreting services to support the provision of patient care services in the languages spoken by the populations served by the Corporation’s acute care hospitals, long term care facilities, diagnostic and treatment centers, certified home health agency and, community based clinics.

WHEREAS, CyraCom International, Inc., Language Line Services, and Pacific Interpreters, Inc. are recognized leaders in the provision of over-the-phone medical interpreting services; and

WHEREAS, the Corporation will benefit from the provision of over-the-phone medical interpreting services to its patients requiring such services; and

WHEREAS, the provision of over-the-phone medical interpreting services will enable compliance with external review agency regulations, standards and law; and

WHEREAS, the responsibility for monitoring these contracts shall reside with the Senior Vice President for Safety and Human Development.

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 a contract with CyraCom International, Inc.,
Language Line Services, and Pacific Interpreters, Inc. to provide over-the-phone-medical interpreting (OPI) services to the Corporation to meet the patient care needs of its limited English proficient patient population and comply with external review agency requirements for a term of three years with two-one year options to renew, solely exercisable by the Corporation, for an amount not to exceed $30,853,396.
EXECUTIVE SUMMARY

The accompanying resolution requests authorization to negotiate a three year contract with two-one year options to renew with CyraCom International, Inc., Language Line Services, and Pacific Interpreters, Inc. for the provision of over-the-phone medical interpreting services for the HHC acute care hospitals, long term care facilities, community based clinics and certified home health agency.

Contracts with these Vendors are required to enable HHC to provide culturally competent care, meet the patient care needs of its diverse limited English proficient patient population, and comply with federal law, and external review agency requirements/standards. To assure patient care quality and safety, under these contracts, CyraCom, Language Line, and Pacific will provide medically qualified interpreters for 100% of interpretation calls requested by any HHC facility or program. Each Vendor will provide the equipment to enable over-the-phone interpretations. Each Vendor will also provide on-demand and monthly reports detailing duration of each interpreting assignment, language requested, hospital unit, provider name, medical record number, or any other information the specific facility requests be collected for reporting purposes. Reports of all languages requested by an HHC facility that was unavailable at the time of the request and the action(s) taken, including response time to provide the language will be standard.

CyraCom, Language Line, and Pacific have been providing OPI services at the HHC facilities since 2002, 2006 and 2009, respectively. The existing agreements with the three (3) Vendors were entered into in 2009. The contracts with the three Vendors expire on March 31, 2013, May 6, 2013, and May 9, 2013.

Consistent with Operating Procedure 100-5, a competitive request for proposals process was initiated in October 2012. Subsequent to a robust evaluation process, CyraCom International, Inc., Language Line Services, and Pacific Interpreters, Inc. were selected to provide medical interpreting services because they each met the requirements as set forth in the RFP, offered a competitive rate of $0.75 per minute of medical interpreting services, and, had positive references. HHC currently pays $0.90 per minute of medical interpreting services. The proposed contracts are for a term of three years with two-one year options to renew, solely exercisable by the Corporation, for an amount not to exceed $30,853,396.
CONTRACT FACT SHEET
New York City Health and Hospitals Corporation

Contract Title: Over-the-Phone Medical Interpreting Services
Project Title & Number: Over-the-Phone Medical Interpreting Services DCN#: 2014
Project Location: HHC Acute Hospitals, Community-based Clinics, LTC Facilities, Certified Home Health Agency

Successful Respondents:
CyraCom International, Inc., Pacific Interpreters, Inc., and Language Line Services

Contract Amount: $30,853,396.00
Contract Term: 3 years with 2 additional one year options to renew solely exercisable by the Corporation

Requesting Dept.: Division of Safety and Human Development, Office of CLAS/LEP

Number of Respondents: Ten

Range of Proposals: $0.67/minute to $0.99/minute

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

Funding Source: X General Care Grant: explain Capital Other: explain ____________________________

Method of Payment: X Lump Sum Per Diem XX Time and Rate Payable upon invoice based on utilization Other: explain ____________________________

EEO Analysis: Complete

Compliance with HHC's McBride Principles? X Yes No Vendex Clearance Yes No N/A PENDING

(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.)
CONTRACT FACT SHEET (continued)

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

The Division of Safety and Human Development is seeking authorization to contract with three vendors to provide over-the-phone medical interpreting services (OPI) to enable HHC to meet the patient care needs of its diverse patient population and comply with external review agency requirements. The selected Vendors are CyraCom International, Inc., Language Line Services, and Pacific Interpreters, Inc.

The provision of effective, timely and medically accurate interpreter services is a patient's right that is essential to the provision of patient-centered care, and foundational to assuring patient safety. Regulatory and accreditation agencies (Centers for Medicare and Medicaid Services, New York State Department of Health, The Joint Commission), federal law (Title VI of the Civil Rights Act), and national standards (National Standards for Culturally and Linguistically Appropriate Services) mandate the provision of healthcare services in a manner understood by patients. This includes providing an interpreter for those patients who are not proficient in English. The Joint Commission explicitly requires the following: “The hospital respects the patient's right to and need for effective communication”; “The hospital provides information in a manner tailored to the patient's age, language, and ability to understand”; and “The hospital provides language interpretation and translation services.”

Historically, HHC has contracted with external vendors to provide OPI services. Given the volume of services required, it is necessary for HHC to contract with multiple vendors. In FY 12, over 25% of HHC's patient population was deemed limited English proficient. In FY 12, OPI services were utilized enterprise-wide for over 680,000 interpretation requests in over 190 different languages and dialects for a total of more than 7 million minutes of interpreting services at a cost of $6,665,000 to the HHC acute hospitals, long term care facilities, diagnostic and treatment centers, community health clinics, and certified home health agency. The need for OPI services will not diminish.

OPI services are currently being provided to HHC by three (3) vendors: Pacific Interpreters, Inc., Language Line Services, and CyraCom International, Inc. HHC entered into the existing agreements with the three (3) vendors in 2009 and the contracts expire on March 31, 2013, May 6, 2013, and May 9, 2013, respectively. The agreement with Language Line and CyraCom were extensions to a prior contract. The agreement with Pacific was new in 2009. The current negotiated rate per minute of medical interpreting is $0.90. Each vendor invoices the HHC facilities that utilize their service; payments are remitted to the vendor by each facility.

Consistent with HHC Operating Procedure 100-5, a request for proposals for OPI services was issued on October 12, 2012. Ten (10) proposals were received of which three (3) vendors were selected. The selected vendor(s) have the capacity to meet HHC's current and potential increasing demand for OPI services. The proposed term of the new contracts with each of the three vendors will be for a period of three years, with two additional one-year options to renew, solely exercisable by the Corporation. The anticipated total cost of the contract over 5 years is $30,853,396.00 which includes a 10% contingency of $2,804,854.00.
Contract Review Committee
Was the proposed contract presented at the Contract Review Committee (CRC)? (include date):

Yes. October 3, 2012

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

No
Selection Process (attach list of selection committee members, list of firms responding to RFP, list of firms considered, describe here the process used to select the proposed contractor, the selection criteria, and the justification for the selection):

List of Selection Committee Members

Chairperson: Aleksandra Sas, Associate Director, CLAS
Patricia Banks, Assistant Director, Language Coordinator, Coney Island Hospital
Melanie Colon, Assistant Director, Bellevue Hospital Center
Joanne Grimes, Director of Patient Relations, Jacobi Medical Center
Lucia Jimenez, Associate Director, Language Assistance Program, Lincoln Medical and Mental Health Center
Fernando Lee, Assistant Director, Volunteer Public Department, Elmhurst Hospital Center
Irene Quinones, Associate Director, Metropolitan Hospital Center
Frederick Covino, Assistant Vice President, Corporate Budget
Mark Walter, Senior Counsel, Legal Affairs

List of Firms Responding to RFP

Certified Languages International
CyraCom International, Inc.
Language Line Services
Language Select
Linguistica International, Inc.
Optimal Phone Interpreters
Pacific Interpreters, Inc.
Teledia, Inc.
Translation Plus, Inc.
TransPerfect Remote Interpreting

Process used to Select the Proposed Contractors

Proposals were received from ten (10) Vendors. Each proposal received by close of business November 13, 2012 was reviewed to determine if it met the minimum qualifications as specified in the RFP. Vendor must have a minimum of 10 years of experience working with hospitals and healthcare organizations to provide over-the-phone medical interpreting; Vendor must adopt the National Standards of Practice for Interpreting in Healthcare and the National Code of Ethics for Interpreters in Healthcare. Vendor must be capable of providing exclusively medically qualified interpreters, and, Minimum of three non-HHC healthcare facility or healthcare system client references, for services provided within the past three years. None of the proposals were eliminated and all 10 were considered for evaluation by the Selection Committee.

The proposals were sent to the members of the Selection Committee for review along with the evaluation criteria. The Selection Criteria included points for:

A. Technical Qualifications (40%)
   - Evaluation of the Vendor Qualification Requirements delineated in the Scope of Services
   - Evaluation of the Medical Interpreter Qualification Requirements delineated in the Scope of Services
   - Clear description of emergency back-up process for providing medically qualified interpreters
   - Capacity to provide services compatible with standard/vendor/brand neutral phone equipment
   - Adequacy of currently provided capacity/volume of OPI medical interpreting, in minutes
   - Documented proof of languages provided (including lesser diffusion languages)

B. Previous Client References (10%)
   - Minimum of three non-HHC healthcare facility or healthcare system client references for services provided within the last 3 years.
   - List of current/recent clients for similar scope of work as delineated in this RFP (volume, languages, etc.)

C. Company Organization and Qualification (15%)
• 10 years of experience working with hospitals and healthcare organizations in OPI medical interpreting
• Evidence that the Vendor has adopted the National Standards of Practice for Interpreting in Healthcare and the National Code of Ethics for Interpreters in Healthcare
• Description of Company and its organizational structure
D. Cost of Proposal ((25%))
• Reasonable flat fee cost per minute for the three year contract term and for each one year renewable option
E. Other (10%)
• Capacity and willingness to meet the performance requirements as indicated in the RFP:
  Response time to provide qualification data on each interpreter when requested within 24 hours;
  and, Evidence of connection time within an average of 40 seconds

Selection Committee Members reviewed and scored each vendor proposal and submitted their completed evaluation forms to the Associate Director CLAS/LEP. Total score per bidder ranged from 40.34 to 69.61. Price per minute per vendor ranged from $0.67 to $0.99 per minute of interpretation. The Associate Director CLAS/LEP aggregated the scores.

Selection Committee members met to discuss and agree on the potential finalists. Subsequent to the meeting, a Selection Committee member re-tabulated the scores given to each proposal to validate the accuracy of the initial aggregated scores.

The three vendors with the highest evaluation scores were selected as finalists pending reference checks.

Three references were contacted for each of the 3 proposed finalists.

After review of references, Committee Members re-confirmed the selection of the 3 vendors. A “best and final offer” was requested from each of the three vendors.

On December 26, 2012 correspondence was sent to CyraCom International, Inc, Language Line Services, and Pacific Interpreters, Inc. via e-mail and postal service notifying each that they had been selected as a potential vendor pending approval by the HHC Board of Directors.

Correspondence was sent to the remaining 7 vendors via e-mail that they had not been selected.

All original materials submitted in response to this solicitation are maintained in the Office of CLAS/LEP.

Justification for the Selection

Of the 10 proposals received, the Selection Committee determined that CyraCom International, Inc., Pacific Interpreters, and Language Line Services met the RFP requirements, received the highest evaluation scores, received positive references, and offered a competitive rate of $0.75/minute of medical interpretation. Based on a review of the proposals, the 3 vendors combined can meet the current and future OPI volume requirements of the Corporation.

Scope of work and timetable:

The selected vendor(s) have demonstrated expertise and extensive experience in over-the-phone medical interpreting for healthcare agencies and are capable of meeting HHC’s volume and language requirements. Each vendor will provide medically qualified interpreters for 100% of interpretation calls requested by any HHC facility or program, within an average of 40 seconds. Each Vendor will provide monthly reports detailing duration of each interpreting assignment, language requested, hospital unit, provider name, medical record number or other information the specific facility ask to be collected for reporting purposes. Each Vendor will also provide monthly reports of all languages requested by an HHC facility that was unavailable at the time of the request and the action(s) taken, including response time to provide the language. The contracts will be effective April 1, 2013 pending Board approval.
CONTRACT FACT SHEET (continued)

Costs/Benefits:

Given the extensive range of languages and dialects spoken by HHC's patient population, particularly lesser diffusion languages, it would be impossible and cost-prohibitive for HHC to internally staff the provision of medically qualified interpreter services, across 21 facilities plus home health services, 24/7/365. Qualified medical interpreters have extensive training to accurately interpret complex medical terminology and convey this information between members of the healthcare team and the patient and his/her family. Qualified medical interpreters allay the concerns of both patients and providers by effectively communicating with the patient and minimizing opportunity for error. OPI is a high quality, cost effective vehicle for providing critically essential, high-volume patient care services.

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

The Corporation does not have staff at each facility on all tours who speak over 190 languages and dialects and who are expert in providing highly specialized medical interpreter services. Given HHC's diverse limited English proficient population, it would be prohibitively expensive, inefficient and a risk to patient care quality and safety to in-source this work.

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?

No

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

Aleksandra Sas, Associate Director, HHC's Office of CLAS/LEP will have daily responsibility for contract monitoring with oversight by Caroline M. Jacobs, Senior Vice President for Safety and Human Development.
CONTRACT FACT SHEET (continued)

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. ______________________

Date

Analysis Completed By E.E.O. ______________________

Date

Name

Waiver of NYS Executive Law Article 15-A M/WBE Goals received on September 18, 2013. (See Attached)
TO: Aleksandra Sas
   Associate Director,
   Center for Culturally and Linguistically Appropriate Services (CLAS)

FROM: Manasses C. Williams

DATE: February 20, 2013

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor CyraCom LLC has submitted to the Affirmative Action Office a completed Contract Compliance Questionnaire and the appropriate EEO documents.

This company is a:

Project Location(s): Central Office

Contract Number: ________ Project: Interpretation/Translation services

Submitted by: Center for Culturally and Linguistically Appropriate Services (CLAS)

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:

MCW:gsp
TO: Aleksandra Sas  
Associate Director  
Central Office – CLAS 

FROM: Manasses C. Williams  

DATE: February 25, 2013  

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION  

The proposed contractor/consultant, Language Line Services Inc., has submitted to the Affirmative Action Office a completed Contract Compliance Questionnaire and the appropriate EEO documents.  
This company is a:  

Project Location(s): HHC – Corporate Wide  

Contract Number: _______________  Project Number: _____________  

Submitted by: Central Office – CLAS  

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:
TO: Aleksandra Sas, M.A.
Associate Director
Center for Culturally and Linguistically Appropriate Services

FROM: Manasses Williams

DATE: February 12, 2013

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor/consultant, Pacific Interpreters, Inc, has submitted to the Affirmative Action Office a completed Contract Compliance Questionnaire and the appropriate EEO documents.

This company is a:


Project Location(s): HHC’s Corporate Wide

Contract Number: ____________ Project: Language Interpreting Services

Submitted by: Center for Culturally and Linguistically Appropriate Services

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: pt
TO: Caroline M. Jacobs  
Senior Vice President  
Office of Patient Safety, Accreditation & Regulatory Services  

FROM: Manasses C. Williams  

DATE: September 18, 2012  

SUBJECT: Waiver of NYS Executive Law Article 15-A M/WBE Goals  

The New York City Health & Hospitals Corporation is in receipt of your email request dated 9/18/2012 for goals for the RFP for Over-the-Phone Medical Interpreting Services (OPI) for the New York City Health and Hospitals Corporation.

A review of the submitted data indicated that a waiver of the (M and/or WBE) goals for this RFP, is appropriate. A review of the scope of work required for this contract indicates that no Article 15A goals are required. The scope of work and method of negotiating the contract did not meet the requirements of Article 15A for establishing M/WBE goals. The Office of Affirmative Action/Equal Employment Opportunity will grant a waiver for the (MBE / WBE) goals on this contract.

Thank you for your cooperation. If you have any further questions, you may contact Martin Everette. He can be reached at (212) 788-3374.

MCW:moe  
c: Martin O. Everette

Waiver Approval
Over-the-Phone (OPI) Medical Interpreting Services

CyraCom International, Inc.
Language Line Services
Pacific Interpreters, Inc.

Caroline M. Jacobs
Chief Patient Safety Officer
Senior Vice President
Safety and Human Development
What are Over-the-Phone Interpreting Services (OPI)?

• A technique that uses telephones to connect professional human interpreters to individuals who need to speak to each other but who do not share a common language.

• Connect remotely via telephone to professionals who are proficient in the languages of both the speaker and receiver and who may also have some knowledge or familiarity with both cultures.

• In the healthcare environment, medical OPI services facilitate and support:
  ▫ Patient’s ability to converse with their health care providers
  ▫ Health care providers ability to converse with patients and their family
Why are Medical OPI Services Necessary?

• 25% of HHC’s patient population is limited English proficient

• Critical to patient safety and the provision of culturally competent, patient-centered care
  ▫ Clearly and concisely transfers complex, sensitive medical information in a manner understood by patients
  ▫ Increases patient satisfaction
  ▫ May reduce length of stay and, potentially, readmissions

• Enables compliance with external review agency requirements and federal laws and mandates for the provision of healthcare in a manner understood by patients (e.g., the Centers for Medicare and Medicaid Services, The Joint Commission, NYS Department of Health, Title VI of the Federal Civil Rights Act, local executive directives)
Over-the-Phone Medical Interpreting Service Usage at HHC (FY 12)

- OPI services used for approximately **700,000** interpreter requests in over **190** languages and dialects ranging from over **450,000** requests for Spanish to 1 request for Kanjobal (Mayan dialect)

- Over **7,000,000** minutes of medical OPI services requested and provided enterprise-wide at a total cost of **$6,670,000**
HHC Language Interpretation Statistics

Requested Interpretations by Language FY 12

- Spanish
- Mandarin
- Bengali
- Polish
- French
- Cantonese
- Arabic
- Haitian
- Russian
- Korean
- Albanian
- Other

“Other” category included up to 180 languages or dialects
Current State - Growing Volume; Growing Expenditure FY 10 - FY 12
Current State


- Current flat fee rate is $0.90 per minute of medical interpreting services.

- Determined that we needed to scan the medical OPI market to assure the Corporation was receiving the best value and quality for the expenditure.
Selection Process

- RFP issued October 12, 2012
- Non-mandatory bidders conference October 31, 2012 – 13 vendors participated
- Proposal due date – November 13, 2012
  - Proposals received from ten (10) Vendors
- Selection Committee deliberations and clarifications from Vendors
  - November - December
- Vendor notification, December 26, 2012
  - CyraCom International, Inc.
  - Language Line Services
  - Pacific Interpreters, Inc.
Key Contract Deliverables

- Provision of services by exclusively qualified medical interpreters for 100% of requests

- A 24/7 live operator to respond to HHC interpretation requests and connect each call within an average of 40 seconds, including lesser diffusion languages

- A 24/7 live operator to address HHC customer service concerns and an efficient complaint resolution process

- Monthly and on-demand reports of vendor performance

- Equipment (e.g., corded dual handset and cordless phones)
Contract

• Three years with 2-one year options to renew solely exercisable by the Corporation at a flat fee of $0.75 per minute of interpretation, irrespective of language, day of week, or time of day at an amount not to exceed $30,853,396 for the 5 years.

• New rate is a $0.15 per minute decrease over the current rate of $0.90 per minute of interpretation.

• Facilities will determine the vendor they wish to receive services from; facilities may choose to receive services from more than one vendor.
Contract Monitoring

- Responsibility rests with the Senior Vice President for Safety and Human Development through the HHC Office of Cultural and Linguistically Appropriate Services/Limited English Proficiency (CLAS/LEP)
RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate and execute a contract and related agreements with North Shore-Long Island Jewish Health Systems, Inc. ("NSLIJ") (i) to establish a jointly controlled not-for-profit hospital cooperative ("CoOpLab") that will provide laboratory services at cost to NSLIJ’s and the Corporation’s respective health systems in a new cooperative laboratory facility to be located within the City of New York for this purpose; (ii) for the period prior to CoOpLab obtaining the requisite licenses to provide such laboratory services, to have NSLIJ’s existing not-for-profit corporation, which operates its core laboratory perform the Corporation’s reference laboratory work that is now sent to commercial vendors at cost and have the Corporation join such not-for-profit corporation as a member; and (iii) to provide for NSLIJ to indemnify the Corporation for any cost, damage or liability arising out of its laboratory activities prior to the launch of the cooperative venture and out of any ongoing laboratory activities unrelated to the cooperative venture and for CoOpLab to purchase liability insurance to cover any claims that may arise in the conduct of CoOpLab’s cooperative business.

AND

Authorizing the President of the Corporation to effectuate the establishment of CoOpLab and take such other actions as he/she deems appropriate to establish the cooperative laboratory structure described below consistent with these Resolutions.

WHEREAS, the Corporation’s internal studies as augmented by independent consultants lead to the determination that the best way to assure high quality laboratory services and achieve savings is to collaborate with another large health system to establish a shared core laboratory to process clinical lab work for the Corporation’s health system; and

WHEREAS, not-for-profit NSLIJ, the biggest integrated healthcare network in the New York metropolitan area, currently operates an efficient, high quality consolidated core laboratory to serve the needs of its member hospitals, and wishes to establish a new, larger consolidated core laboratory in collaboration with the Corporation to achieve even greater efficiencies; and

WHEREAS, a core laboratory shared by HHC and NSLIJ is expected to benefit the Corporation by achieving economies of scale, improved quality of services, lower prices and savings, and data sharing of best practices; and

WHEREAS, NSLIJ will be solely responsible to finance the purchase or lease of the selected site for the new laboratory facility, its improvements and outfitting; and

WHEREAS, the amount charged to CoOpLab by NSLIJ shall be capped at an amount based on a maximum agreed upon capital project cost; and

WHEREAS, both NSLIJ and the Corporation will appoint members of the board of directors of CoOpLab under an agreement providing that the following actions of CoOpLab will require the consent of the Corporation in its capacity as a founding member: (i) any sale, relocation or dissolution of the laboratory or of CoOpLab and any action that terminates the Corporation’s membership status; (ii) any capital call; and (iii) the establishment of the level of reserves to be maintained by CoOpLab; and

WHEREAS, the governing documents of CoOpLab shall clearly establish that the Board of
CoOpLab shall act in the interest of all of its members and that any action that is proposed to be taken that will benefit NSLIJ and will impose any significant risks or costs on HHC will require the consent of HHC; and

WHEREAS, the Corporation will be indemnified by CoOpLab for any costs, damages or liability that arise from NSLIJ’s activities conducted within the cooperative structure or prior to its establishment and CoOpLab will purchase liability insurance to cover any claims that may arise in the conduct of CoOpLab’s cooperative business; and

WHEREAS, a CoOpLab joint standards committee with representatives of NSLIJ and the Corporation will develop the laboratory quality assurance standards and other methods and metrics for the laboratory operations of CoOpLab; and

WHEREAS, current employees of NSLIJ and the Corporation will be provided to CoOpLab to provide the needed laboratory services with all associated costs paid by CoOpLab; and

WHEREAS, through the cooperative structure, the Corporation will benefit from volume discounts on its purchases of laboratory equipment, blood products, systems and supplies;

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 and related agreements with North Shore-Long Island Jewish Health Systems, Inc. ("NSLIJ") (i) to establish a jointly controlled not-for-profit hospital cooperative ("CoOpLab") that will provide laboratory services at cost to NSLIJ’s and the Corporation’s respective health systems in a new cooperative laboratory facility to be located within the City of New York for this purpose; (ii) for the period prior to CoOpLab obtaining the requisite licenses to provide such laboratory services, to have NSLIJ’s existing not-for-profit corporation, which operates its core laboratory perform the Corporation’s reference laboratory work that is now sent to commercial vendors at cost and have the Corporation join such not-for-profit corporation as a member; and (iii) to provide for NSLIJ to indemnify the Corporation for any cost, damage or liability arising out of its laboratory activities prior to the launch of the cooperative venture and out of any ongoing laboratory activities unrelated to the cooperative venture and for CoOpLab to purchase liability insurance to cover any claims that may arise in the conduct of CoOpLab’s cooperative business; and

BE IT FURTHER RESOLVED, that the President of the Corporation be, and hereby is, authorized to effectuate the establishment of CoOpLab and take such other actions as he/she deems appropriate to establish the cooperative laboratory structure described consistent with these Resolutions.
HHC Laboratory Restructuring Project

March 12, 2013
Finance Committee
Agenda

- Overview
- Vision of the Cooperative
- Structure of the Cooperative
- Governance
- Business Model
- Staffing Changes
- Five Year Cost Savings Projections
- Implementation
Overview

- Current HHC lab operations
  - 4 Core Labs serving entire system
  - 12 Rapid Response Laboratories at each of the hospitals

- Restructuring project:
  - Efforts and savings to date
  - Review of options for restructuring
  - Identification of opportunity to achieve greater efficiencies through a shared core lab with another large health system

- Process to identify potential partners

- Cooperative with North Shore Long Island Jewish (NSLIJ)
Vision of the Cooperative

• Standard test menus for local hospital clinical tests

• Hospital labs provide:
  • Clinical lab results needed in less than four hours on behalf of Emergency Departments and Inpatient Units
  • Surgical and Anatomical Pathology
  • Blood Bank

• NSLIJ and HHC will cooperate to create one Shared Core Laboratory to process:
  • Clinical lab work on behalf of nursing homes, diagnostic and treatment centers and hospital clinics
  • Micro and Molecular Biology tests
  • Tests on behalf of community physicians and/or other outside business

• Through collaboration will achieve economies of scale, better pricing, savings for both entities, improved quality and data sharing of best practices
Structure of the Cooperative

“CoOpLab”
- Not for profit corporation
- NSLIJ and HHC will have joint membership and operate shared core lab
- Board of Directors from NSLIJ and HHC
- CEO and management
- Maintain NSLIJ outreach business and support HHC commercial insurance collection

NSLIJ and HHC
- Collaborate on lab methods but independently operate hospital rapid response labs
- Share information technology
- Same test menus
- Group purchasing of equipment, reagents, and Blood products
Governance

- NSLIJ will have majority seats on the Board of Directors of “CoOpLab”
  - 15 years building the Core Lab
  - NSLIJ will be providing all of the initial capital
  - Given the phase in of HHC over 4 years and NSLIJ test growth rate it is almost certain that NSLIJ will always have the plurality of test volume

- HHC receives founding member status, which guarantees that if new members join, HHC’s rights and benefits shall not be diminished

- Critical decisions will require HHC’s consent as a founding member
Governance

- Decisions requiring HHC’s consent as a founding member include:
  - Sale, closing, or relocation of core lab
  - Requirement that HHC contribute capital
  - The addition of any new member with the same rights as HHC
  - Termination of HHC’s membership
  - Increases to the level of reserves of CoOpLab requiring increases to the cost per test
  - Any action taken to benefit NSLIJ at the expense of HHC
Governance

"CoOpLab" Board of Directors
HHC/NSLIJ

CEO and Management Team

Joint Standards Committees
HHC/NSLIJ
- System Interoperability
- Equipment and reagents
- Policy and Procedures
- Test Menu
- Research

Shared Core Lab

Shared Suppliers
- Vendors (Best Pricing)
  - Reference Test and Blood products
  - Equipment
  - Reagents
  - Information Technology

Rapid Response Laboratories

HHC Hospitals

NSLIJ Hospitals
# Business Model

## HHC
- Staff and operate hospital labs
- Provide staff to “CoOpLab”
- Pay “CoOpLab” per test

## “CoOpLab”
- Sell tests to HHC and NSLIJ at actual cost
- Pay HHC and NSLIJ for staff
- Pay NSLIJ rent
- Bill Commercial Insurers
- Group purchasing
- Methods best practice sharing

## NSLIJ
- Staff and operate hospital labs
- Provide staff to “CoOpLab”
- Pay “CoOpLab” per test
# Staffing Changes

<table>
<thead>
<tr>
<th>Staff at HHC facilities</th>
<th>Base</th>
<th>FY2014</th>
<th>FY2015</th>
<th>FY2016</th>
<th>FY2017</th>
<th>FY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical*</td>
<td>636</td>
<td>591</td>
<td>545</td>
<td>487</td>
<td>455</td>
<td>446</td>
</tr>
<tr>
<td>Microbiology**</td>
<td>162</td>
<td>162</td>
<td>132</td>
<td>71</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pathology and Blood Bank</td>
<td>607</td>
<td>607</td>
<td>607</td>
<td>607</td>
<td>607</td>
<td>607</td>
</tr>
<tr>
<td>HHC staff at HHC</td>
<td>1405</td>
<td>1360</td>
<td>1285</td>
<td>1165</td>
<td>1062</td>
<td>1053</td>
</tr>
<tr>
<td>HHC staff at the Core**</td>
<td>0</td>
<td>0</td>
<td>30</td>
<td>91</td>
<td>162</td>
<td>162</td>
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<tr>
<td><strong>Total</strong></td>
<td>1405</td>
<td>1360</td>
<td>1315</td>
<td>1256</td>
<td>1224</td>
<td>1215</td>
</tr>
</tbody>
</table>

*Clinical staff will not be replaced as they leave and will be redeployed across HHC

**Microbiology staff move to the core as we transition our hospitals
## Five Year Cost Projections – Current State ($s in millions)

<table>
<thead>
<tr>
<th>Current State</th>
<th>Base</th>
<th>FY2014</th>
<th>FY2015</th>
<th>FY2016</th>
<th>FY2017</th>
<th>FY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Testing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Services</td>
<td>$130.4</td>
<td>$132.4</td>
<td>$134.4</td>
<td>$136.6</td>
<td>$138.9</td>
<td>$141.3</td>
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<tr>
<td>Other Than Personal Services</td>
<td>$59.5</td>
<td>$63.0</td>
<td>$70.0</td>
<td>$69.9</td>
<td>$72.2</td>
<td>$74.5</td>
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<tr>
<td>Capital</td>
<td>$3.0</td>
<td>$6.5</td>
<td>$6.6</td>
<td>$6.7</td>
<td>$6.8</td>
<td>$6.9</td>
</tr>
<tr>
<td>Indirect</td>
<td>$23.4</td>
<td>$23.4</td>
<td>$23.4</td>
<td>$23.4</td>
<td>$23.4</td>
<td>$23.4</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>$216.2</td>
<td>$225.3</td>
<td>$234.4</td>
<td>$236.6</td>
<td>$241.3</td>
<td>$246.1</td>
</tr>
<tr>
<td><strong>Blood Bank</strong></td>
<td>$17.1</td>
<td>$17.6</td>
<td>$18.1</td>
<td>$18.6</td>
<td>$19.2</td>
<td>$19.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$233.3</td>
<td>$242.9</td>
<td>$252.5</td>
<td>$255.3</td>
<td>$260.5</td>
<td>$265.9</td>
</tr>
</tbody>
</table>
### Five Year Cost “CoOpLab” model Projections ($s in millions)

<table>
<thead>
<tr>
<th>“CoOpLab”</th>
<th>Base</th>
<th>FY2014</th>
<th>FY2015</th>
<th>FY2016</th>
<th>FY2017</th>
<th>FY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Testing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Services</td>
<td>$ 130.4</td>
<td>$ 128.5</td>
<td>$ 124.0</td>
<td>$ 115.9</td>
<td>$ 107.9</td>
<td>$ 108.9</td>
</tr>
<tr>
<td>Other Than Personal Services</td>
<td>$ 59.5</td>
<td>$ 44.6</td>
<td>$ 48.5</td>
<td>$ 40.6</td>
<td>$ 35.6</td>
<td>$ 33.0</td>
</tr>
<tr>
<td>Capital</td>
<td>$ 3.0</td>
<td>$ 3.9</td>
<td>$ 3.7</td>
<td>$ 3.2</td>
<td>$ 2.8</td>
<td>$ 2.5</td>
</tr>
<tr>
<td>Indirect</td>
<td>$ 23.4</td>
<td>$ 23.4</td>
<td>$ 23.4</td>
<td>$ 23.4</td>
<td>$ 23.4</td>
<td>$ 23.4</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>$ 216.2</td>
<td>200.3</td>
<td>199.6</td>
<td>183.1</td>
<td>169.5</td>
<td>167.8</td>
</tr>
<tr>
<td>Blood Bank</td>
<td>$ 17.1</td>
<td>$ 16.2</td>
<td>$ 16.4</td>
<td>$ 16.7</td>
<td>$ 17.0</td>
<td>$ 17.4</td>
</tr>
<tr>
<td>“CoOpLab”</td>
<td>$ -</td>
<td>$ 15.3</td>
<td>$ 22.8</td>
<td>$ 41.1</td>
<td>$ 59.3</td>
<td>$ 62.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$ 233.3</td>
<td>$ 231.8</td>
<td>$ 238.7</td>
<td>$ 240.9</td>
<td>$ 245.9</td>
<td>$ 247.4</td>
</tr>
</tbody>
</table>
# Five Year Cost Savings Projections ($s in millions)

<table>
<thead>
<tr>
<th>Change</th>
<th>Base</th>
<th>FY2014</th>
<th>FY2015</th>
<th>FY2016</th>
<th>FY2017</th>
<th>FY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cost Current State</td>
<td>$ 233.3</td>
<td>$ 242.9</td>
<td>$252.5</td>
<td>$255.3</td>
<td>$260.5</td>
<td>$265.9</td>
</tr>
<tr>
<td>Total Cost Future State</td>
<td>$ 233.3</td>
<td>$ 231.8</td>
<td>$238.7</td>
<td>$240.9</td>
<td>$245.9</td>
<td>$247.4</td>
</tr>
<tr>
<td>Savings</td>
<td>$ 11.1</td>
<td>$ 13.9</td>
<td>$ 14.4</td>
<td>$ 14.6</td>
<td>$ 18.5</td>
<td></td>
</tr>
<tr>
<td>Additional Revenue</td>
<td>$ 0.3</td>
<td>$ 1.9</td>
<td>$ 2.6</td>
<td>$ 4.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Benefit</td>
<td>$ 11.1</td>
<td>$ 14.1</td>
<td>$ 16.3</td>
<td>$ 17.1</td>
<td>$ 23.1</td>
<td></td>
</tr>
</tbody>
</table>
Implementation

• NSLIJ may immediately offer membership to HHC in its existing 501 C-3 which will allow HHC to send reference tests to the lab at cost for a savings of $1.7 million.

• NSLIJ would enter into a real estate lease and pay build out costs and pass actual rental and debt service costs down to the Core lab

• NSLIJ and HHC must agree to the allowable costs for the build out

• HHC and NSLIJ shall seek 501 C-3 status. If it is not awarded within nine months we will ask the IRS for 501 E status.
Implementation

• CoOpLab will need:
  • Liability and Insurance
    • Shared Core Lab must obtain
      • Commercial insurance
      • Malpractice insurance
    • NSLIJ must indemnify the new entity against prior claims
    • Each party must assume responsibility for claims arising out of non-member business
  • Regulatory/Certifications
    • Shared Core Lab must maintain all requirements
  • Disaster Plan
    • Shared Core Lab must have a plan to maintain business operations in the event of a disaster
North Shore LIJ Health System Laboratories
Presentation to HHC Medical and Professional Affairs Committee

James Crawford, MD, PhD – SVP, Chairman of Pathology and Laboratory Medicine
Bob Stallone - Vice President North Shore LIJ Health System Laboratories
Overview

• Strategically Located Core Laboratory
  – 15 years of continuous integration and growth
  – Current space limitations

• 11 Rapid Response Laboratories
  – Unified Management
  – Standardized Information Systems and Equipment
  – All testing capabilities available on site for patient management
  – Highly developed logistics service and infrastructure

• Goals:
  – Strategically partner with another non-for-profit organization who shares similar public/community/teaching mission
  – Increase volume to reduce cost and improve quality and depth of service
  – Develop additional value opportunities through the relationship
NSLIJ Centralized Laboratory Network
Current (CLN)

Core Lab

Outreach
Hospital Lab
RRL

Plainview
Southside
Huntington
Forest Hills
SI UH North
SI UH South
Clinical Trials BARC
Non-System Hospital Reference Testing

LHH
Manhasset
LIJ
Glen Cove
Franklin
Physician's Offices
Nursing Homes

North Shore LIJ Laboratories
North Shore-Long Island Jewish Health System
# Performance Metrics

## Core Lab Key Indicators

<table>
<thead>
<tr>
<th>Metric</th>
<th>Performance Area</th>
<th>Goal</th>
<th>Current</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stat Turn Around Time (call to call)</td>
<td>Service Excellence</td>
<td>240 min</td>
<td>186 min</td>
</tr>
<tr>
<td>Routine Turn Around Time</td>
<td>Service Excellence</td>
<td>95%- less than 4 hours</td>
<td>99.6%</td>
</tr>
<tr>
<td>Laboratory Error Rates</td>
<td>Operational Performance</td>
<td>275 DPMO (.03%)</td>
<td>229 DPMO (.02%)</td>
</tr>
<tr>
<td>“Likelihood to Recommend” (patient)</td>
<td>Customer Service</td>
<td>95%</td>
<td>99.7%</td>
</tr>
<tr>
<td>“Likelihood to Recommend” (physician)</td>
<td>Customer Service</td>
<td>95.8%</td>
<td>97.5%</td>
</tr>
<tr>
<td>Abandoned Call Rates</td>
<td>Customer Service</td>
<td>4.4%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Live Voice in 20 Sec.</td>
<td>Customer Service</td>
<td>70%</td>
<td>71%</td>
</tr>
<tr>
<td>Critical Value Notification</td>
<td>Patient Safety</td>
<td>98% in 15 min</td>
<td>98%</td>
</tr>
</tbody>
</table>
Joint Standards Committee Process

Requests
- Resources
- Analysis
- Recommendations
- Approval

Information
- Direction
- Decisions
- Requests
- Communication

Methods Committees

Medical Board

Hospital Admin

Executive Committee

PICG

Senior Leadership

Customers

Vendors

Laboratories
Improving Hypertension Control at HHC

March 14, 2013

David Stevens, MD
Office of Healthcare Improvement
Medical & Professional Affairs
Hypertension at HHC

• **#2 Threat** to Population Health in US
  – 120,000 in Primary Care at HHC
    • 43% are controlled (<140/90) (46% nationally)

• **HHC Quality Gap**: Target is 75% Controlled
  – Meeting this target would mean 38,400 additional patients controlled, resulting in:
    • 1920 fewer Heart Attacks every year
    • 768 fewer Strokes every year

*Each 1% improvement across HHC prevents 60 MIs and 24 strokes*
Percentage of Primary Care patients with BP controlled at <140/90 – January 2013

Bell
Jacobi
Harlem
QHC
Kings
NCB
WoodH
Ren
EHC
ENY
CIH
Cumb
Met
Linc
Morr
Belvis
Gouv
BP Control at HHC

January 2010:  44%
January 2011:  43%
January 2012:  43%
January 2013:  43%

... No Improvement
Factors Contributing to Uncontrolled Hypertension

Physician Barriers
• Accepting ‘close enough’ (‘therapeutic inertia’)
• Ineffective counseling
• Unaware of own performance (compared w/ others)

Patient Barriers
• Insufficient engagement (awareness, commitment)
• Time and Cost involved in appointments

System Barriers
• Access to primary care appointments
Strategies for Hypertension Improvement at HHC

- Feedback to PCPs on Performance
- Identify Uncontrolled Patients in Registry
- Engage Patients as Partners in their Care:
  - Home BP monitors
  - Collaborative goal setting
  - Close relationship with RN care manager:
    - Uncover patients’ barriers
    - Support patients’ motivation for better BP control
1. PCP:
   • Determines & negotiates goal with patient
   • Directs RN in BP target and medication adjustments

2. RN:
   • Evaluates pt frequently: *Reaching target? Adhering?*
   • Counsels and adjusts treatment plan as needed
   • Consults with PCP as needed, documents (PCP cosigns)

3. Oversight of Progress
   • Review program performance, provide feedback
Key Strategy: RN-Led Treat-to-Target Pathway

*Implemented in 6 facilities beginning May ‘13*

- **Focused**
  - Patients seen frequently by RN until BP is at target
  - “They get the message—this is about controlling BP”

- **Supportive**
  - Relationship building with RN
  - Patients talk about their concerns about treatments
  - “Patients feel they have a team caring for them”

- **Convenient**
  - “In and out” — patients appreciate minimal wait time
Percentage Change in BP Control: 12 months*

*TARGET

Bellevue and CIH data is Jan 12 vs Oct 12
Next Steps

• Spread T-t-T Model to all facilities

• Integrate new conditions:
  – Phase 2:
    • Hyperlipidemia
    • Depression in hypertensive patients
  – Phase 3:
    • Diabetes

• Innovations to promote engagement
  – Community-based self-management groups
  – Pedometers and other devices
  – Digital social networks

• Payment Models that align with better outcomes

• Registry that integrates all population health concerns