AGENDA

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE

Meeting Date: October 17, 2013
Time: 10:00 AM
Location: 125 Worth Street, Room 532

BOARD OF DIRECTORS

CALL TO ORDER — **DR. STOCKER**

ADOPTION OF MINUTES
-September 12, 2013

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

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

METROPLUS HEALTH PLAN — **DR. SAPERSTEIN**

ACTION ITEM:

1. Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and enter into a contract with Dyntek Services, Inc., McAfee's authorized reseller and maintenance provider for security hardware, software licenses, related maintenance and professional services through a NYS Office of General Services ("NYS OGS") contract, for a term of 2 years and 9 months, in an amount not-to-exceed $11,360,499. — M**R. ROBLES/ MR. GUIDO**

INFORMATION ITEMS:

1. **Patient Safety Update** — **MS. JACOBS**

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

MINUTES

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE BOARD OF DIRECTORS

Meeting Date: September 12, 2013

ATTENDEES

COMMITTEE MEMBERS:

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

HHC CENTRAL OFFICE STAFF:

Louis Capponi, MD, Chief Medical Informatics Officer
Deborah Cates, Chief of Staff, Board Affairs
Paul Contino, Chief Technology Officer
Barbara Delorio, Senior Director, Internal Communications
Marisa Salamone-Greason, Assistant Vice President, EITS
Sal Guido, Assistant Vice President, Infrastructure 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
Susan Meehan, Assistant Vice President, HHC Office of Emergency Management
Andrea Mera, Director, Office of Healthcare Improvement
Bert Robles, Senior Vice President, Chief Information Officer
Salvatore Russo, Senior Vice President & General Counsel, Legal Affairs
David Stevens, MD, Senior Director, Office of Healthcare Improvement
Steven Van Schultz, Director, IT Audits
Joyce Wale, Senior Assistant Vice President, Office of Behavioral Health
Jaye Weisman, Ph.D., Assistant Vice President/COO, Accountable Care Organization
Manasses Williams, Assistant Vice President, Office of Affirmative Action/EEO
Ross Wilson, MD, Senior Vice President/Corporate Chief Medical Officer

FACILITY STAFF:

Ernest Baptiste, Executive Director, King County Hospital Center
Lynda D. Curtis, Senior Vice President, South Manhattan Network
Terry Mancher, Chief Nurse Executive, Coney Island Hospital
Arnold Saperstein, MD, Executive Director, MetroPlus Health Plan
Denise Soares, Executive Director, Harlem Hospital Center
Maurice Wright, Medical Director, Woodhull Medical and Mental Health Center

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
Deborah Terry, The Nash Group

**MEDICAL AND PROFESSIONAL AFFAIRS/
INFORMATION TECHNOLOGY COMMITTEE
Thursday, September 12, 2013**

Michael A. Stocker, MD, Chairman of the Board, called the meeting to order at 12:20 P.M. The minutes of the July 18, 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. HHC's Transfer Center

HHC is establishing a uniform process with a standard work with which patients are transferred from one hospital to another. The goals are to enhance patient care, improve the transfer process for the clinicians, and reduce leakage of patients outside the HHC. We are contracting with a vendor, DirectCall, who is experienced in communication, coordination, logistics and data tracking for individual hospitals and large systems.

DirectCall will provide the following support:

- One number for all transfers
- Based on protocols we provide the operator will
  - Locate the attending on call at either the specified transfer site or will assist in locating an accepting MD
  - An attending to attending call is initiated and recorded
  - Access existing ambulance services, also have an option to contract for an all-inclusive service for specialty care (eg, neonatal)
- Call is coordinated post-transfer to provide follow-up on the patient status
- Data will be provided regarding transfer process including destination, accepting service, MD and facility, timeliness of acceptance and actual transfer
- The service operates on algorithms provided by HHC, so leakage will initially be tracked, then prevented unless there is an acceptable reason for transfer outside of HHC (service not provided, patient request, possibly insurance requirement)

HHC will provide an Implementation Committee with representation from clinical and administrative stakeholders at sending and receiving facilities. Consistent messaging will be developed to encourage the use of the call center for all transfers within and into our acute facilities.

We anticipate a fall 2013 implementation. Please contact Lauren Johnston at 212-442-4065 or Lauren.Johnston@nychhc.org.

2. Nursing Excellence Awards

The 2013 Nursing Excellence awards will be held on October 28th. Six awards will be given to nurses from HHC in the following categories: Advancing and Leading the Profession; Home, Community or Ambulatory Care; Education and Mentorship; Inpatient Clinical Nursing; Management; or Volunteerism and Service.

There will be one winner in each category for the entire Corporation. We are looking forward to the opportunity to recognize some of our many nursing stars!

3. Emergency Preparedness

On October 3rd there will be a Corporate-wide functional exercise. This is a Training Exercise whose purpose is to test new equipment and systems that were purchased as part of a grant funded project to improve HHC's EM Program. Post Hurricane Sandy we are looking to improve inter-facility coordination, communication and cooperation. The systems to be tested are Send Word Now, an emergency alert notification system and N-C4 ETeam, an Incident Command Software system. These systems will allow for real time communication with sharing and collecting of data during emergency or planned events. As this is the first time we will be utilizing this system across the Corporation, we expect to find areas for improvement which we can build on to be ready for future events. The HHC Office of Emergency Management in conjunction with a Core Team of facility Emergency Preparedness Coordinators and Yale New Haven Center (YNH) for Emergency Preparedness and Response (YNH) developed this functional exercise.

4. Flu

The HHC policy for employee flu vaccination, in response to the New York state regulations, has been promulgated. Vaccination has commenced at many sites and vaccine supply has improved to a level that all sites are now able to commence. Vaccination is recorded in a system-wide registry for management and reporting purposes; and a sticker is affixed to the ID card of employees who have been vaccinated. For those not vaccinated at the date that the Commissioner determines that the flu season has commenced, the wearing of a surgical mask is mandatory and will continue until the Commissioner determines that the season has ended in 2014. In order to achieve the protection afforded by “herd immunity” more than 90% of our employees, affiliates, contractors and volunteers will need to be vaccinated. In order to maximize the protection of our patients, as well as vaccination the other key strategies are hand hygiene, covering your cough and staying home if you are sick.

METROPLUS HEALTH PLAN, INC.

Arnold Saperstein, MD, Executive Director presented to the Committee. Dr. Saperstein informed the Committee that the total plan enrollment as of August 26, 2013 was 424,789. Breakdown of plan enrollment by line of business is as follows:

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

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 experienced a decline of nearly 4,000 since his last report to the Committee. This month, MetroPlus lost members because of a State correction which removed approximately 1,500 MetroPlus members with presumed Third Party Health insurance coverage. MetroPlus also experienced a lower than usual new member enrollment for August. On the good news side, enrollment improved during August and recertification’s improved as well. The preliminary

membership numbers for September finally show much lower losses, a change from what MetroPlus has seen over the past five months.

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

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

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

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

Finally, OASAS, OMH, and DOH have announced a revised time line for implementing the transition of Behavioral Health services to Medicaid managed care. Implementation target dates have been delayed and

are now: January 1, 2015, for adults in New York City, July 1, 2015, for adults in the rest of the State, and January 1, 2016, for children Statewide.

ACTION ITEM:

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

Presenting to the Committee were Lauren Johnston, Senior Assistant Vice President/Chief Nursing Officer, Patient Centered Care and Deborah A. Terry, President, The Nash Group. Nursing is acutely aware of the ongoing financial pressure on HHC. The majority of personnel costs are nursing related. In FY 2012 HHC's expenditure for all nursing services was $818 million, of which $119 million was spent for "nursing" overtime and agency staffing. Several companies were found that could assist HHC in optimizing how staff is deployed. One of the companies were asked to conduct preliminary studies at two HHC sites which projected that using optimization would yield significant savings, while enhancing patient care in the most efficient manner at the lowest cost.

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

HHC will optimize nursing by using consulting services, technology and on-going support with the goal of reducing cost while maintaining or enhancing service and staff. Vendor will work closely with Corporate and facility leadership and staff to understand the needs and expectations. Patient placement algorithms will be used to match nursing staff competencies and supply. Better reporting at both the facility and Corporate level. The initial work will roll out over 18 months, with continued support over the life of contract.

The procurement methodology used was the Negotiated Acquisition (NA) process with an advertisement posted in the City Record. Four vendors were invited to submit proposals. Three major vendors in the field responded with written and verbal presentations. The NA Selection Committee was comprised of leaders from nursing, facilities, human resources, finance, business intelligence and applications management. The NA Selection Committee unanimously chose The Nash Group.

The contract is for a three year term with an option to renew for three additional years. Consulting costs are phased in over the first 3 years, as facilities begin the process. Licensing fees paid over life of engagement, commencing with on-site consulting. Payments for each site do not commence until assessment is complete – at least 6 months from each facility kick-off. The Nash Group is offering professional services via its GNYHA GPO contract.

	FY14*	FY15	FY16	FY17	FY18	FY19	FY20*	6yr Cost
Consulting	$34,697	$500,747	$916,307	$948,763	$948,763	$948,763	$237,191	$4,535,232
Technology	$16,798	$220,414	$494,451	$532,947	$532,947	$532,947	$133,237	$2,463,740
Total Cost	**$51,496**	**$72,161**	**$1,410,758**	**$1,481,710**	**$1,481,710**	**$1,481,710**	**$370,428**	**$6,998,972**

*Partial Years

The resolution was moved for the full Board of Directors consideration.

INFORMATION ITEM:

1. Windows 7 and Office 2010 Deployment Update

Presenting to the Committee was Sal Guido, Assistant Vice President, Infrastructure Services. Mr. Guido informed the Committee that EITS has created a Desktop Taskforce team comprising members all the hospital networks' IT departments. The taskforce was charged with standardizing the desktops in the Corporation as follows: upgrade all desktops that were 4 years and older; standardize desktop base image; desktop look and feel; hardware standardization; security (virus protection and disk encryption); and roles and responsibilities.

Project rationale was that most of the equipment currently in the infrastructure was at "end of life" both from a hardware and software standpoint, nor the proper encryption or virus software. Provided a table that outlined the migration results Corporate-wide. To date, 32,511 PCs (including the virus protection and encryption) across the Corporation have been deployed since this project began. Migration fell slightly behind at several sites, especially Bellevue Hospital Center due to Super Storm Sandy. However, both Bellevue and the full program will be completed by mid-October 2013.

Next steps include: Complete testing of Windows 8 for desktop deployment and evaluate Virtual Desktop Infrastructure (VDI) which means that all PCs and software updates will be centralized in one location.

2. ICIS Electronic Health Record Implementation Update

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

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

Accomplishments to date include: Epic Foundation Database has been loaded on HHC servers and is operational and accessible for HHC EITS staff members; 95 EITS Staff have been Epic Certified in their respective modules; and three of four work flow preview session weeks have been completed to review the Epic Foundation functionality by subject matter experts from all disciplines. Evaluation results from the 203 work flow preview sessions showed that 83.74% felt the sessions met the objectives.

Sequencing for EPIC roll out per site/facility is important for successful implementation. Criteria for selection of sites are:1) readiness assessment (staff readiness; major construction projects; and major surveys such as The Joint Commission); 2) complexity (lab; referral Network; and existing QD footprint); and technology infrastructure. In the current project plan the Queens Health Network will go live first followed by Jacobi Medical Center and North Central Bronx Hospital.

Action items for the next 90 days are: complete final round of Work Flow Preview Sessions; complete initial round of EPIC training and certification; define and operationalize business work groups for in-depth content and workflow design; and begin activation planning for first sites (Elmhurst and Queens). High complexity areas of focus over the next several months include: determining laboratory restructuring project impact on both business operations and software design; collaborating with Soarian team for Registration and Scheduling touch points to ensure Soarian is stabilized prior to Epic activation at Elmhurst and Queens; and coordinating the Enterprise Medical Person Index (eMPI): one patient- one record implementation with the Epic roll out schedule.

3. Meaningful Use Update

Presenting to the Committee was Louis Capponi, MD, Chief Medical Informatics Officer. Medicare EHR Incentive Program important milestone dates are: October 1, 2013 Stage 2 begins for eligible hospitals; eligible hospitals and critical access hospitals (CAHs) attest for a three-month reporting period; payments decrease for hospitals that start receiving payments in 2014 and later (attestation dates are October 1, January 1, April 1, and July 1 being the last day for eligible hospitals to begin their attestation); September 30, 2014 reporting year ends for eligible hospitals and CAHS; October 1, 2014 entire year for subsequent years of participation -eligible hospitals and CAHs that do not successfully demonstrate meaningful use of certified EHR technology will be subject to Medicare payment adjustments beginning in FY 2015.

Eligible hospitals and CAHs must meet 16 core objectives and 3 menu objectives. Thresholds have been raised and use of the electronic health record (EHR) for a larger portion of the patient population is required. Some new/complex objectives were introduced such as: automatically track medications from order to administration using assistive technologies (barcoding) in conjunction with an electronic medication administration record (eMAR/BCMA); requirement of patients to use health information technology; and requirement of providers who transition or refer a patient to another setting of care or provider of care to provide a summary of care record electronically.

Dr. Capponi discussed the following core objective timeline.

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

Dr. Capponi discussed the following table that outlines HHC status by Meaningful Use Phase 2 (MU2) objectives.

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

Dr. Capponi then discussed the QuadraMed QCPR upgrade timeline: North Bronx Health Network is currently beta testing QCPR v6.0 with upgrade scheduled to begin mid-November through April 2014 which is the first quarter required to begin MU2 attestation. All other Networks will begin beta testing QCPR v6.0 the remainder of 2013 with full upgrade beginning December 2013 through June 2014 in which all facilities will be ready for MU2 attestation.

There being no further business the meeting adjourned at 1:26 P.M.

Bert Robles
Senior Vice President, Information Technology Services
Report to the M&PA/IT Committee to the Board
Thursday, October 17, 2013 – 10:00 am

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

1. **ICIS Electronic Health Record (EHR) Program Update:**

I wanted to update the committee on EITS' activities regarding the Epic implementation. Since my last report to the Committee at the July meeting, the following activities have been achieved:

a. The Epic Foundation Database was loaded on HHC servers and is operational and accessible for HHC EITS staff members.

b. We achieved full EPIC certification for 102 EITS staff in their respective modules. In order to achieve certification, the collective group has taken and completed 781 scored projects and exams. HHC staff has achieved 43 perfect scores of 100 on first attempts and the team has 185 Epic certifications; with 44 people earning more than one certification and many earning 3 or more. This group should all be commended.

c. The fourth Workflow Preview session was held on September 23 and 24th at 160 Water Street, Bellevue and Harlem Hospitals. While there were hundreds of participants at 160 Water Street over the two days,

over 500 participants attended Bellevue Hospital on Day 1 and 210 at Harlem Hospital on Day 2. Included were sessions covering Medication Ordering and Administering, Consults in Long Term Care, Nuclear Stress Testing and Medication Dispensing.

d. There is one last set of sessions scheduled for Wednesday, October 16th for the Behavioral Health Emergency Department team. It will include four workflow sessions: Psych ED Provider Workflow/Documentation, Psych ED Nurse and Support Staff, Psych ED Patient Flow and Psych ED to Inpatient and Extended Observation Unit.

e. To date 250 Workflow Preview sessions have been held with more than 2,000 workflows previewed. Approximately 70% of the workflows have been approved.

f. An Operations ICIS EHR Kick-Off Meeting for HHC Senior Leadership was held on Tuesday, October 8th at Harlem Hospital Center. The purpose of this event was to provide a high level overview of the Electronic Health Record program as well as delineate the individual and departmental roles for HHC Leadership. The morning session provided a comprehensive review for all attendees with HHC leadership remaining in the afternoon for an in-depth hands-on demonstration by the Epic team on the reporting capabilities of the application.

g. Facility Sequencing: Elmhurst and Queens Hospital Centers will be the first two HHC sites to convert from Quadramed to Epic. Jacobi Medical Center and North Central Bronx Hospital will be the second go-live sites. The corporation is currently reviewing the sequence for remaining sites and will present a proposed rollout sequence to the leadership later this fall. Sequencing will be dependent upon several key initiatives and dependencies noted below:

h. There are several key dependencies which can impact HHC's anticipated scheduled November 2014 go-live. They are:
   - Soarian (Scheduling, EMPI, registration, interfaces & billing deployment must be stable at these sites for at least six (6) months after live activation .
   - North Shore-Long Island Jewish lab for rapid response and routine labs must be deployed with Epic.
   - ICD-10 implementation date is October 1, 2014. HHC's overall migration from ICD-9 to the new system must be reasonably stable.

These are all large projects. HHC will migrate to the new Joint Venture lab as the Epic Rollout progresses. Each facility will come up on EPIC and the new Joint Venture lab at the same time since lab results must flow into the core system on day one.

2. **Fire Department of New York and Wireless Access at HHC Facilities:**

Sal Guido, AVP for Infrastructure, recently met with the Deputy Commissioner and CIO of the New York City Fire Department to review wireless access at all HHC Facilities.

A plan has been put in place to install wireless access points at all HHC hospital facility emergency rooms over the next 30 days. Bellevue Hospital Center was completed on September 30th and Kings County Hospital underwent testing of its network during the week of October 7th.

The wireless access is being deployed throughout HHC facilities to allow for document transmissions for registration and vital information directly from the ambulance to the hospital facility, emergency room and eventually to HHC electronic medical record system to eliminate paper and increase patient care.

We are targeting completion by the end of October.

A press conference was held with the Mayor, FDNY leadership and HHC at Jacobi Medical Center to announce this initiative last week.

3. **SunGard Safeguards Following Superstorm Sandy**:

Superstorm Sandy did not negativity effect HHC's ability to provide computing services from our central data centers at Jacobi, located in the Bronx, or SunGard, located in NJ. HHC conducted a risk analysis on the SunGard facility and found that water levels around the building elevated to approximately 6 feet above normal conditions. SunGard has provided HHC engineering plans that will protect against a 500-year storm as defined by the Army Corps of Engineers. HHC contracted BASE Tactical, an

engineering company, to review SunGaurd's plan to protect against such a storm. We are awaiting the base tactical final report on the viability of SunGuard's plan.

This completes my report today. Thank you.

MetroPlus Health Plan, Inc.
Report to the
HHC Medical and Professional Affairs Committee
October 17th, 2013

Total plan enrollment as of September 2nd, 2013 was 424,708. Breakdown of plan enrollment by line of business is as follows:

Medicaid	362,294
Child Health Plus	12,283
Family Health Plus	33,843
MetroPlus Gold	3,268
Partnership in Care (HIV/SNP)	5,419
Medicare	7,232
MLTC	369

Attached are reports of members disenrolled from MetroPlus due to transfer to other health plans, as well as a report of new members transferred to MetroPlus from other plans.

Our membership numbers for this month are relatively stable.

On October 1st, the New York State Exchange went live, offering health insurance options on the NY State of Health, the Official Health Plan Marketplace. MetroPlus Health Plan is offering consumers the lowest cost products for three out of four metal levels in the individual market. MetroPlus has been working very closely with HHC to project the potential impact of our Exchange products on both the plan and HHC; as well as ensuring that we properly allocate resources for this new line of business. Also, this month, we are preparing for our Facilitated Enrollers (FE's) to serve as Certified Application Counselors (CACs). Our staff will play a crucial role in consumer enrollment as many regulations surrounding application submissions are changing. Only In Person Assistors (CACs, Navigators, Insurance Brokers and Agents) can assist potential members in enrollment into the Exchange. After November 20, 2013 all Child Health Plus applications will only be submitted through the Exchange. Beginning January 2014, all new Medicaid applications for Modified Adjusted Gross Income (MAGI) populations will be processed by the Exchange. MAGI populations include pregnant women, children, parents/caretaker relatives and adults under 65 that are not on Medicare. Single and childless adults enrolled in Family Health Plus (FHP), that are eligible for Medicaid will be automatically converted to Medicaid enrollment with the same plan January 1, 2014. The remaining members will be required to choose a Qualified Health Plan (QHP). By 2015, all other FHP enrollees will have been transitioned to Medicaid or a QHP on their date of renewal.

The Centers for Medicaid and Medicare Services (CMS) has begun readiness reviews of all Fully Integrated Duals Advantage (FIDA) plans. MetroPlus has been preparing for the readiness review and the CMS analysis of our policies and procedures. This will begin on October 18th, 2013.

This month, we have begun testing NotiFind®, an emergency and incident management system offered by SunGard as part of our business resumption contract. NotiFind® is a business continuity software that will keep MetroPlus team members informed with critical alerts and ongoing updates in the event of an interruption in normal business operations. We anticipate full implementation of the software by the end of this year.

The New York State Department of Health (NYSDOH) has released the final April 2013 premiums for mainstream Medicaid and FHP. Approximately $460 million was added to the draft premiums released in July 2013. In effect, these modifications will keep the MetroPlus Medicaid/FHP revenue stable, without cuts. Payment of final rates is contingent upon approval by the Division of Budget and CMS. An additional revised rate for July 2013 program changes will be completed in mid-late November. DOH and Mercer have already begun calculations for January 2014 rates, and is estimating they will be completed in late December.

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

September-2013

		Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13
Total Members	Prior Month	442,336	432,980	432,667	431,132	429,875	428,593	426,298
	New Member	13,312	15,429	14,606	14,529	15,638	12,929	15,270
	Voluntary Disenroll	2,695	3,094	2,547	2,549	2,897	2,273	2,866
	Involuntary Disenroll	19,973	12,648	13,594	13,237	14,023	12,951	13,994
	Adjusted	-80	-42	-61	-56	210	1,512	0
	Net Change	-9,356	-313	-1,535	-1,257	-1,282	-2,295	-1,590
	Current Month	432,980	432,667	431,132	429,875	428,593	426,298	424,708
Medicaid	Prior Month	378,240	370,334	370,081	368,979	368,025	366,454	364,296
	New Member	11,006	12,694	12,047	11,808	12,700	10,393	12,162
	Voluntary Disenroll	2,305	2,598	2,161	2,147	2,457	1,899	2,474
	Involuntary Disenroll	16,607	10,349	10,988	10,615	11,814	10,652	11,690
	Adjusted	-22	-30	-51	-46	215	1,455	0
	Net Change	-7,906	-253	-1,102	-954	-1,571	-2,158	-2,002
	Current Month	370,334	370,081	368,979	368,025	366,454	364,296	362,294
Child Health Plus	Prior Month	13,079	12,869	12,836	12,730	12,649	12,554	12,395
	New Member	410	450	447	462	393	350	436
	Voluntary Disenroll	56	43	31	26	20	36	49
	Involuntary Disenroll	564	440	522	517	468	473	499
	Adjusted	-59	-13	-15	-15	-12	-1	0
	Net Change	-210	-33	-106	-81	-95	-159	-112
	Current Month	12,869	12,836	12,730	12,649	12,554	12,395	12,283
Family Health Plus	Prior Month	35,719	34,338	34,200	33,740	33,453	33,603	33,549
	New Member	1,480	1,872	1,645	1,768	2,002	1,765	2,141
	Voluntary Disenroll	193	284	198	216	252	180	207
	Involuntary Disenroll	2,668	1,726	1,907	1,839	1,600	1,639	1,640
	Adjusted	1	1	2	5	2	39	0
	Net Change	-1,381	-138	-460	-287	150	-54	294
	Current Month	34,338	34,200	33,740	33,453	33,603	33,549	33,843

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

September-2013

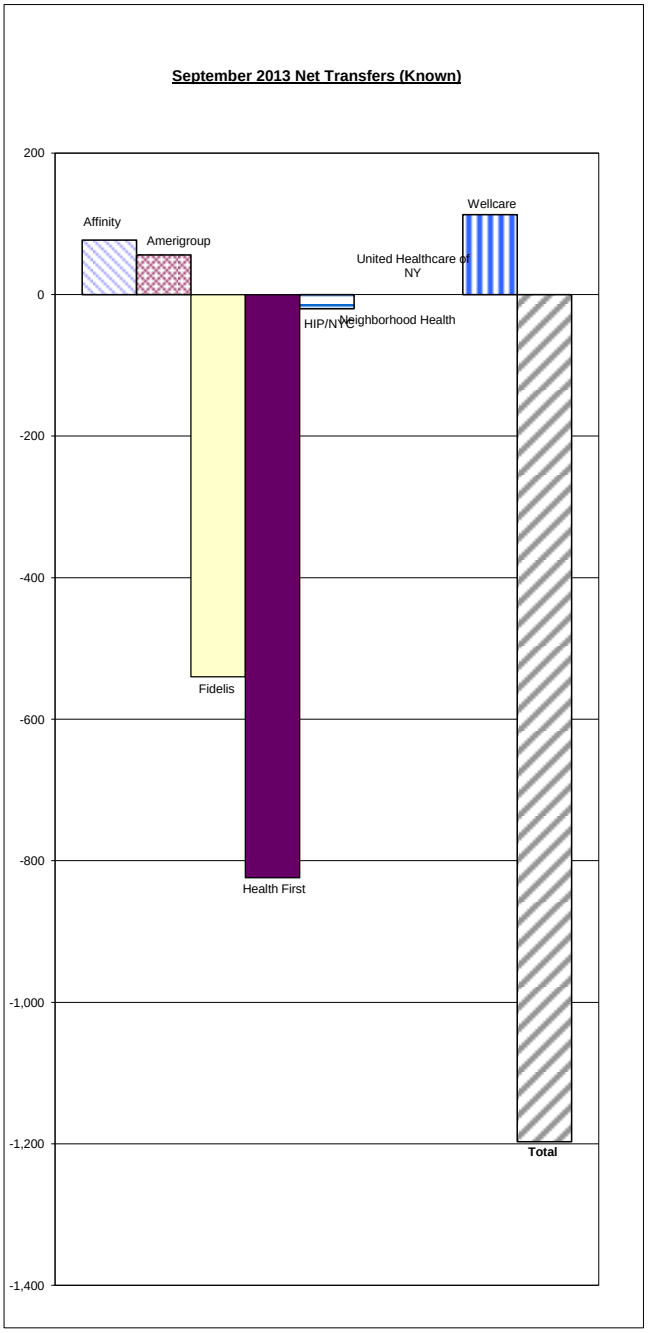
		Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13
HHC	Prior Month	3,217	3,230	3,253	3,264	3,298	3,334	3,280
	New Member	33	39	30	41	59	5	0
	Voluntary Disenroll	0	0	0	0	0	0	0
	Involuntary Disenroll	20	16	19	7	23	59	12
	Adjusted	0	0	3	3	9	11	0
	Net Change	13	23	11	34	36	-54	-12
	Current Month	3,230	3,253	3,264	3,298	3,334	3,280	3,268
SNP	Prior Month	5,578	5,541	5,511	5,495	5,456	5,455	5,449
	New Member	89	90	92	92	102	79	85
	Voluntary Disenroll	35	41	30	44	44	32	37
	Involuntary Disenroll	91	79	78	87	59	53	78
	Adjusted	0	0	0	-3	-4	2	0
	Net Change	-37	-30	-16	-39	-1	-6	-30
	Current Month	5,541	5,511	5,495	5,456	5,455	5,449	5,419
Medicare	Prior Month	6,481	6,614	6,687	6,780	6,795	6,936	7,040
	New Member	262	239	291	292	313	293	348
	Voluntary Disenroll	106	128	127	116	124	126	99
	Involuntary Disenroll	23	38	71	161	48	63	57
	Adjusted	0	0	0	0	0	-1	0
	Net Change	133	73	93	15	141	104	192
	Current Month	6,614	6,687	6,780	6,795	6,936	7,040	7,232
Managed Long Term Care	Prior Month	22	54	99	144	199	257	289
	New Member	32	45	54	66	69	44	98
	Voluntary Disenroll	0	0	0	0	0	0	0
	Involuntary Disenroll	0	0	9	11	11	12	18
	Adjusted	0	0	0	0	0	7	0
	Net Change	32	45	45	55	58	32	80
	Current Month	54	99	144	199	257	289	369

Disenrollments TO Other Plans		Sep-13			Oct-12 to Sep-13		
		FHP	MCAD	Total	FHP	MCAD	Total
	INVOL.	0	0	0	6	41	47
	VOL.	16	114	130	172	1,393	1,565
Affinity Health Plan	TOTAL	16	114	130	178	1,434	1,612
	INVOL.	0	3	3	14	109	123
	VOL.	17	221	238	227	2,421	2,648
Amerigroup/Health Plus/CarePlus	TOTAL	17	224	241	241	2,531	2,772
	INVOL.	0	0	0	16	137	153
	VOL.	56	674	730	870	7,794	8,664
Fidelis Care	TOTAL	56	675	731	886	7,933	8,819
	INVOL.	0	0	0	20	207	227
	VOL.	80	1,052	1,132	832	10,408	11,240
Health First	TOTAL	80	1,052	1,132	853	10,616	11,469
	INVOL.	0	0	0	0	23	23
	VOL.	8	88	96	97	906	1,003
HIP/NYC	TOTAL	8	88	96	97	929	1,026
	INVOL.	0	0	0	0	10	10
	VOL.	0	0	0	50	620	670
Neighborhood Health	TOTAL	0	0	0	50	630	680
	INVOL.	0	0	0	13	455	468
	VOL.	9	118	127	161	1,377	1,538
United Healthcare of NY	TOTAL	9	118	127	174	1,832	2,006
	INVOL.	0	0	0	16	91	107
	VOL.	0	29	29	40	348	388
Wellcare of NY	TOTAL	0	29	29	56	439	495
	INVOL.	1	7	8	118	2,566	2,684
	VOL.	205	2,331	2,536	2,577	25,575	28,152
Disenrolled Plan Transfers:	TOTAL	206	2,339	2,545	2,697	28,145	30,842
	INVOL.	1	22	23	32	674	706
	VOL.	0	51	51	7	821	828
Disenrolled Unknown Plan Transfers:	TOTAL	1	74	75	39	1,497	1,536
	INVOL.	1,014	10,756	11,770	11,940	115,530	127,470
	UNK.	3	3	6	24	49	73
	VOL.	2	90	92	16	1,014	1,030
Non-Transfer Disenroll Total:	TOTAL	1,019	10,849	11,868	11,980	116,593	128,573
	INVOL.	1,016	10,785	11,801	12,090	118,770	130,860
	UNK.	3	5	8	26	55	81
	VOL.	207	2,472	2,679	2,600	27,410	30,010
Total MetroPlus Disenrollment:	**TOTAL**	**1,226**	**13,262**	**14,488**	**14,716**	**146,235**	**160,951**

Disenrollments FROM Other Plans	Sep-13			Oct-12 to Sep-13		
	FHP	MCAD	Total	FHP	MCAD	Total
Affinity Health Plan	18	189	207	182	1,895	2,077
Amerigroup/Health Plus/CarePlus	35	262	297	296	2,834	3,130
Fidelis Care	15	176	191	183	2,435	2,618
Health First	26	282	308	203	2,226	2,429
HIP/NYC	3	73	76	60	983	1,043
Neighborhood Health	0	0	0	125	1,225	1,350
United Healthcare of NY	15	112	127	130	1,488	1,618
Wellcare of NY	6	136	142	181	1,133	1,314
Total	118	1,230	1,348	1,360	14,219	15,579
Unknown/Other (not in total)	2,047	10,985	13,032	19,637	120,664	140,301

Data Source: RDS Report 1268a&c Updated 09/17/2013

Net Difference	Sep-13			Oct-12 to Sep-13		
	FHP	MCAD	Total	FHP	MCAD	Total
Affinity Health Plan	2	75	77	4	461	465
Amerigroup/Health Plus/CarePlus	18	38	56	55	303	358
Fidelis Care	-41	-499	-540	-703	-5,498	-6,201
Health First	-54	-770	-824	-650	-8,390	-9,040
HIP/NYC	-5	-15	-20	-37	54	17
Neighborhood Health	0	0	0	75	595	670
United Healthcare of NY	6	-6	0	-44	-344	-388
Wellcare of NY	6	107	113	125	694	819
Total	-88	-1,109	-1,197	-1,337	-13,926	-15,263



MetroPlus Health Plan

New Member Transfer From Other Plans

	2012_10		2012_11		2012_12		2013_01		2013_02		2013_03		2013_04		2013_05		2013_06		2013_07		2013_08		2013_09		TOTAL
	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
AETNA	2	13	0	23	0	12	0	20	1	30	2	14	6	29	4	24	6	16	2	25	2	13	4	29	277
Affinity Health Plan	15	201	15	190	7	128	19	152	19	138	15	141	21	170	11	128	16	149	13	172	13	137	18	189	2,077
Amerigroup/Health Plus/CarePlus	20	263	36	280	22	188	24	211	21	204	22	236	28	271	21	259	17	217	29	251	21	192	35	262	3,130
BC/BS OF MNE	2	40	5	65	3	40	5	30	2	36	2	24	1	47	4	36	2	30	1	26	5	26	3	27	462
CIGNA	2	22	1	27	0	25	1	25	3	32	6	16	4	12	4	27	4	20	3	29	4	19	2	16	304
Fidelis Care	11	203	23	284	11	158	6	164	11	191	15	197	21	251	14	195	16	233	25	216	15	167	15	176	2,618
GROUP HEALTH INC.	2	22	2	32	3	17	2	22	2	30	1	25	5	19	0	20	3	19	3	32	1	13	3	29	307
Health First	13	165	18	190	5	117	14	147	11	148	18	162	15	182	14	150	13	171	32	288	24	224	26	282	2,429
HEALTH INS PLAN OF GREATER N	2	19	1	34	1	39	2	27	5	33	3	20	4	30	2	34	1	21	4	19	4	22	4	28	359
HIP/NYC	4	96	4	104	5	52	6	78	5	94	7	82	9	91	10	73	2	90	3	82	2	68	3	73	1,043
Neighborhood Health Provider PHPS	13	144	19	193	13	110	18	130	19	157	11	128	11	118	11	99	10	141	0	5	0	0	0	0	1,350
OXFORD INSURANCE CO.	0	7	1	19	0	8	3	17	2	18	3	17	2	10	0	10	0	8	2	13	1	14	0	23	178
UNION LOC. 1199	10	38	14	50	8	21	13	36	10	40	6	35	8	35	12	41	7	37	22	72	14	27	11	39	606
United Healthcare of NY	10	121	5	150	6	111	7	109	15	104	18	120	10	150	8	152	9	128	15	134	12	97	15	112	1,618
Unknown PLan	1,503	9,194	1,765	13,464	1,185	7,178	1,380	9,094	1,701	11,784	1,352	8,618	1,730	10,213	1,542	9,761	1,670	9,389	1,839	10,245	1,643	8,744	2,020	10,794	137,808
Wellcare of NY	16	77	18	82	8	70	5	91	16	107	18	90	18	102	13	51	16	101	22	117	25	109	6	136	1,314
TOTAL	1,625	10,625	1,927	15,187	1,277	8,274	1,505	10,353	1,843	13,146	1,499	9,925	1,893	11,730	1,670	11,060	1,792	10,770	2,015	11,726	1,786	9,872	2,165	12,215	155,880

Report ID: MHP1268C
Report Run Date: 9/15/2013

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 09/14/2013

Other Plan Name	Category	2012_10		2012_11		2012_12		2013_01		2013_02		2013_03		2013_04		2013_05		2013_06		2013_07		2013_08		2013_09		TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
AETNA	INVOLUNTARY	0	1	0	5	0	2	0	0	0	2	1	5	1	0	0	1	0	4	2	120	0	5	0	1	150
	VOLUNTARY	0	0	0	0	0	0	0	0	0	0	1	3	1	2	0	1	0	1	1	0	0	0	0	1	11
	TOTAL	0	1	0	5	0	2	0	0	0	2	2	8	2	2	0	2	0	5	3	120	0	5	0	2	161
Affinity Health Plan	INVOLUNTARY	0	0	1	2	2	0	0	3	1	5	0	6	0	8	1	5	1	10	0	1	0	1	0	0	47
	VOLUNTARY	11	93	21	152	7	88	9	85	24	123	13	156	17	155	18	129	12	108	11	113	13	77	16	114	1,565
	TOTAL	11	93	22	154	9	88	9	88	25	128	13	162	17	163	19	134	13	118	11	114	13	78	16	114	1,612
Amerigroup/ Health Plus/CarePlus	INVOLUNTARY	2	4	0	8	0	4	0	3	1	13	4	17	1	9	3	9	3	32	0	3	0	4	0	3	123
	UNKNOWN	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	VOLUNTARY	14	182	17	210	11	168	20	160	25	208	18	196	31	226	20	228	15	211	27	234	12	177	17	221	2,648
	TOTAL	16	186	17	218	11	172	20	164	26	221	22	213	32	235	23	237	18	243	27	237	12	181	17	224	2,772
BC/BS OF MNE	INVOLUNTARY	0	11	2	6	0	2	1	3	1	5	0	8	0	4	0	6	2	5	0	205	0	1	0	0	262
	VOLUNTARY	1	1	0	5	1	0	0	1	0	1	0	2	0	0	0	1	0	3	2	1	0	0	1	2	22
	TOTAL	1	12	2	11	1	2	1	4	1	6	0	10	0	4	0	7	2	8	2	206	0	1	1	2	284
CIGNA	INVOLUNTARY	1	4	2	2	1	5	0	2	0	5	1	3	0	2	1	6	0	3	0	323	1	4	0	0	366
	VOLUNTARY	1	1	0	0	0	0	0	1	0	1	0	1	3	2	0	0	1	1	0	0	0	0	0	0	12
	TOTAL	2	5	2	2	1	5	0	3	0	6	1	4	3	4	1	6	1	4	0	323	1	4	0	0	378
Fidelis Care	INVOLUNTARY	0	7	0	13	0	9	1	4	1	18	1	14	2	10	3	7	8	49	0	5	0	1	0	0	153
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	2
	VOLUNTARY	89	653	79	875	40	551	84	636	73	712	66	648	95	754	56	592	72	531	93	672	67	496	56	674	8,664
	TOTAL	89	660	79	888	40	560	85	640	74	730	67	662	97	764	59	599	80	580	93	678	67	497	56	675	8,819

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 09/14/2013

		2012_10		2012_11		2012_12		2013_01		2013_02		2013_03		2013_04		2013_05		2013_06		2013_07		2013_08		2013_09		TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
GROUP HEALTH INC.	INVOLUNTARY	2	3	1	4	0	7	0	1	1	4	0	4	1	1	0	3	0	4	0	133	0	0	0	1	170
	VOLUNTARY	1	3	1	3	0	1	0	1	1	1	0	1	1	2	0	1	1	2	0	0	1	1	1	0	23
	TOTAL	3	6	2	7	0	8	0	2	2	5	0	5	2	3	0	4	1	6	0	133	1	1	1	1	193
Health First	INVOLUNTARY	0	10	0	17	1	17	0	14	3	12	4	14	1	20	1	26	10	62	0	13	0	2	0	0	227
	UNKNOWN	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
	VOLUNTARY	59	832	76	934	63	662	58	776	61	844	64	855	83	1,007	68	815	70	812	92	1,050	58	769	80	1,052	11,240
	TOTAL	59	842	76	951	64	679	58	790	65	857	68	869	84	1,027	69	841	80	874	92	1,063	58	771	80	1,052	11,469
HEALTH INS PLAN OF GREATER NY	INVOLUNTARY	0	1	2	4	0	9	0	3	0	10	0	7	0	3	0	3	0	5	0	162	0	0	0	1	210
	VOLUNTARY	0	1	0	1	0	1	0	1	2	1	0	2	0	1	0	1	1	2	0	0	1	0	0	3	18
	TOTAL	0	2	2	5	0	10	0	4	2	11	0	9	0	4	0	4	1	7	0	162	1	0	0	4	228
HIP/NYC	INVOLUNTARY	0	0	0	2	0	1	0	0	0	3	0	8	0	3	0	0	0	4	0	2	0	0	0	0	23
	VOLUNTARY	13	52	17	90	6	68	5	82	12	80	4	84	10	83	3	69	10	72	4	67	5	71	8	88	1,003
	TOTAL	13	52	17	92	6	69	5	82	12	83	4	92	10	86	3	69	10	76	4	69	5	71	8	88	1,026
Neighborhood Health Provider PHPS	INVOLUNTARY	0	1	0	7	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	10
	VOLUNTARY	10	122	14	169	5	60	4	115	17	121	0	33	0	0	0	0	0	0	0	0	0	0	0	0	670
	TOTAL	10	123	14	176	5	60	4	117	17	121	0	33	0	0	0	0	0	0	0	0	0	0	0	0	680
OXFORD INSURANCE CO.	INVOLUNTARY	0	2	0	0	0	1	0	3	0	7	0	5	0	0	0	1	0	2	0	44	0	0	0	0	65
	VOLUNTARY	0	1	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	1	1	0	1	1	7
	TOTAL	0	3	0	0	0	1	0	3	0	7	0	6	1	0	0	1	0	2	0	45	1	0	1	1	72
UNION LOC.	INVOLUNTARY	0	7	1	7	0	2	0	5	3	6	1	7	2	11	0	7	0	3	0	234	1	4	1	1	303

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 09/14/2013

		2012_10		2012_11		2012_12		2013_01		2013_02		2013_03		2013_04		2013_05		2013_06		2013_07		2013_08		2013_09		TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
UNION LOC. 1199	UNKNOWN	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	VOLUNTARY	5	22	11	29	4	24	3	24	8	27	6	12	11	15	12	16	5	11	10	14	10	20	16	28	343
	TOTAL	5	29	12	36	4	26	3	29	11	33	8	19	13	26	12	23	5	14	10	248	11	24	17	29	647
United Healthcare of NY	INVOLUNTARY	0	6	3	9	0	5	0	10	2	10	1	17	2	7	1	13	2	28	1	345	1	5	0	0	468
	VOLUNTARY	7	86	21	142	12	74	17	85	13	137	17	113	18	150	14	111	19	111	5	139	9	111	9	118	1,538
	TOTAL	7	92	24	151	12	79	17	95	15	147	18	130	20	157	15	124	21	139	6	484	10	116	9	118	2,006
Wellcare of NY	INVOLUNTARY	0	10	4	12	0	5	0	0	2	8	2	6	1	12	0	6	7	31	0	1	0	0	0	0	107
	VOLUNTARY	4	31	3	45	2	24	4	25	3	38	3	21	9	26	4	33	2	28	3	30	3	18	0	29	388
	TOTAL	4	41	7	57	2	29	4	25	5	46	5	27	10	38	4	39	9	59	3	31	3	18	0	29	495
Disenrolled Plan Transfers	INVOLUNTARY	5	67	16	98	4	69	2	53	15	108	15	121	11	90	10	93	33	242	3	1,591	3	27	1	7	2,684
	UNKNOWN	0	0	0	0	0	0	0	1	1	1	1	0	0	0	0	0	0	0	0	1	0	0	0	1	6
	VOLUNTARY	215	2,080	260	2,655	151	1,721	204	1,992	239	2,294	192	2,128	280	2,423	195	1,997	208	1,893	248	2,321	180	1,740	205	2,331	28,152
	TOTAL	220	2,147	276	2,753	155	1,790	206	2,046	255	2,403	208	2,249	291	2,513	205	2,090	241	2,135	251	3,913	183	1,767	206	2,339	30,842
Disenrolled Unknown Plan Transfers	INVOLUNTARY	0	84	2	28	0	73	2	50	9	26	1	50	5	22	2	17	3	91	5	193	2	18	1	22	706
	UNKNOWN	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2
	VOLUNTARY	0	55	0	92	0	53	1	28	0	68	1	91	2	92	1	93	0	71	2	68	0	59	0	51	828
	TOTAL	0	139	2	120	0	126	3	78	9	95	2	141	7	114	3	110	3	162	7	261	2	77	1	74	1,536
Non-Transfer Disenroll Total	INVOLUNTARY	884	8,836	1,214	10,459	152	5,486	132	3,776	1,625	12,368	1,902	15,760	925	9,485	1,088	10,177	1,067	9,468	922	9,209	1,015	9,750	1,014	10,756	127,470
	UNKNOWN	4	15	2	2	0	5	0	2	6	7	1	2	0	5	2	3	4	1	2	1	0	3	3	3	73
	VOLUNTARY	0	55	0	82	0	53	0	56	0	88	0	86	2	83	2	71	8	183	2	68	0	99	2	90	1,030

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 09/14/2013

		2012_10		2012_11		2012_12		2013_01		2013_02		2013_03		2013_04		2013_05		2013_06		2013_07		2013_08		2013_09		TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
Non-Transfer	**TOTAL**	888	8,906	1,216	10,543	152	5,544	132	3,834	1,631	12,463	1,903	15,848	927	9,573	1,092	10,251	1,079	9,652	926	9,278	1,015	9,852	1,019	10,849	128,573
Total MetroPlus Disenrollment	INVOLUNTARY	889	8,987	1,232	10,585	156	5,628	136	3,879	1,649	12,502	1,918	15,931	941	9,597	1,100	10,287	1,103	9,801	930	10,993	1,020	9,795	1,016	10,785	130,860
	UNKNOWN	4	15	2	2	0	5	0	3	7	9	2	2	0	5	2	3	4	1	2	2	0	3	3	5	81
	VOLUNTARY	215	2,190	260	2,829	151	1,827	205	2,076	239	2,450	193	2,305	284	2,598	198	2,161	216	2,147	252	2,457	180	1,898	207	2,472	30,010
	TOTAL	1,108	11,192	1,494	13,416	307	7,460	341	5,958	1,895	14,961	2,113	18,238	1,225	12,200	1,300	12,451	1,323	11,949	1,184	13,452	1,200	11,696	1,226	13,262	160,951

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and enter into a contract with Dyntek Services, Inc., McAfee's authorized reseller and maintenance provider for security hardware, software licenses, related maintenance and professional services through a NYS Office of General Services ("NYS OGS") **contract, for a term of 2 years and 9 months, in an amount not-to-exceed $11,360,499.**

WHEREAS, the Corporation will be able to better protect its assets including electronic patient health information (ePHI) and raise the level of regulatory compliance including HIPAA; and

WHEREAS, the Corporation requires security solutions and services to safeguard mission critical business and clinical applications used for patient care and allow HHC to prevent and respond to security incidents in an efficient and cost effective manner; and

WHEREAS, the Corporation issued a Solicitation on August 30, 2013 to obtain responses from authorized vendors of McAfee products and services in accordance with the Corporation's operating procedures for purposes of entering into a consolidated enterprise agreement to effectively and efficiently address the Corporation's needs; and

WHEREAS, the NYS OGS contract prices for such services and maintenance are discounted from market price; and

WHEREAS, the accountable person for this procurement is the Senior Vice President/Corporate Chief Information Officer.

NOW, THEREFORE, BE IT:

RESOLVED, THAT the President of the New York City Health and Hospitals Corporation be and hereby is authorized to negotiate and enter into a contract with Dyntek Services, Inc., McAfee's authorized reseller and maintenance provider for security hardware, software licenses, related maintenance and professional services through a NYS Office of General Services ("NYS OGS") contract, for a term of 2 years and 9 months, in an amount not-to-exceed $11,360,499.

Executive Summary –
McAfee Enterprise Licensing Agreement

The accompanying resolution requests approval to negotiate and enter into a contract with Dyntek Services, Inc. to purchase hardware, software, related maintenance and professional services on an on-going basis in an amount not to exceed $11,360,499 for 2 years and 9 months.

Through this program (McAfee's Enterprise License Agreement or "ELA"), HHC is undertaking an important initiative to protect its critical assets including ePHI (electronic patient health information), comply with regulatory requirements and improve the operational efficiency of its security and risk management operations while reducing its security expenditures. HHC is facing an overwhelming task of dealing with complex security issues, targeted attacks, more stringent regulatory requirements (HIPAA/HITECH) and increased risk of data breaches. In addition, as HHC continues with the consolidation of its data centers and prepares for EMR/EPIC, it is extremely important that the correct security controls are in place at the hospitals as well as the data centers.

HHC spent almost $3.4 million for the GRM data breach in FY 2011. Most recent statistics by the Ponemon Institute put data breaches at $214 per record and on average $7.2 million per data breach. For the amount of patient data HHC deals with, this could have a detrimental impact to the Corporation. The Encryption, Intrusion Prevention System (IPS), and Data Loss Prevention (DLP) projects were undertaken to reduce the likelihood of such breaches, provide protection against new threats and safeguard our data centers from the outside as well as inside. The encryption project has been completed as of 9/15/2013, the IPS project is 7.6% complete (2 out of the 26 facilities) and the DLP proof of concept has been kicked off as of 8/1/13. As part of the ELA, HHC can complete these projects and avoid almost $27.6 million in costs

The Enterprise License Agreement will allow HHC to procure, implement and manage security controls in a cost effective manner. The agreement provides approximately 70% discount over list price and provides payments for the hardware, software, services and support in a fixed annual payment schedule. In addition, the program will (i) improve HHC's ability to prevent and respond to cyber security incidents, (ii) pass on to Dyntek the responsibility for hiring and retention of skilled security staff and (iii) provide access to McAfee's (Intel) state of the art technology and research. Having access to the right information and resources at the right time can make all the difference when dealing with a cyber-attack.

Over the past three fiscal years (FY 11, 12 and 13), HHC spent on an average $2.88 million per year with McAfee for software, hardware and maintenance. As part of the ELA, HHC will be spending approximately $4.1 million per year for the duration of the contract. The additional $2.7 million over 2 year and 9 months will allow HHC to avoid $27.6 million in costs for approved and in progress security projects, reduce the risk of data breaches, provide security assurance to the business and elevate its overall security

posture. Below is a cost comparison with and without the ELA for finishing currently approved projects, maintenance, professional services and new security solutions:

	With ELA	Without ELA	Cost Avoidance
Intrusion Prevention System Deployment; Data Loss Prevention; Maintenance; Services; New Security Solutions	$11,360,499.34	$39,048,134.79	$27,628,631.61

A solicitation was sent out and Dyntek Services, Inc. was selected as the winner based on lowest pricing.

CONTRACT FACT SHEET

New York City Health and Hospitals Corporation

Contract Title: McAfee Enterprise Licensing Agreement

Project Title & Number: McAfee Enterprise Licensing Agreement

Project Location: Enterprise Wide

Requesting Dept.: EITS/ Infrastructure Services

Number of Respondents: 3
(If Sole Source, explain in Background section)

Successful Respondent: Dyntek Services, Inc.

Contract Amount: $11,360,499.34

Contract Term: 2 years and 9 months

Range of Proposals: $ 11,360,499.34 to $12,224,444.37

Minority Business Enterprise Invited: **x** Yes If no, please explain:

Funding Source: **x** General Care Capital
Grant: explain
Other: explain

Method of Payment: Lump Sum Per Diem Time and Rate
Other: explain Annual payment schedule

EEO Analysis: N/A

Compliance with HHC's McBride Principles? **x** Yes No

Vendex Clearance Yes No **X** N/A (TPC, Caution Check completed)

(Required for contracts in the amount of $100,000 or more awarded pursuant to an RFP, NA or as a Sole Source, or $100,000 or more if awarded pursuant to an RFB.)

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

Through this program (McAfee's Enterprise License Agreement or "ELA"), HHC is undertaking an important initiative to protect its critical assets including ePHI (electronic patient health information), comply with regulatory requirements and improve the operational efficiency of its security and risk management operations while reducing its security expenditures. HHC is facing an overwhelming task of dealing with complex security issues, targeted attacks, more stringent regulatory requirements (HIPAA/HITECH) and increased risk of data breaches. In addition, as HHC continues with the consolidation of its data centers and prepares for EMR/EPIC, it is extremely important that the correct security controls are in place at the hospitals as well as the data centers.

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

Scheduled to present at Sept 26th, 2013 CRC meeting.

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

N/A

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

McAfee, Inc. has a NYS OGS Contract (#PT65091). A solicitation to purchase hardware, software, maintenance and services was issued to 13 vendors, who were listed as McAfee value-added resellers on this contract.

There were 3 proposals received. All 3 proposals were reviewed by HHC IT Infrastructure Services staff to determine whether they met the solicitation requirements. The award was based on lowest proposed price.

List of Firms Considered/Responding to Solicitation

1. McAfee
2. Dyntek
3. Jim Krantz & Associates dba Krantz Secure Technologies
4. Tailwind Associates
5. AMR Networks
6. Nexus Consortium, Inc.
7. SHI (Software House International)
8. CDW Government LLC
9. Sure Technology
10. Dimension Data
11. NH&A, LLC
12. Source It Technologies, LLC
13. Horizon Systems

Scope of work and timetable:

As part of the McAfee Enterprise Licensing Agreement (ELA) the HHC security team will procure and deploy 18 Intrusion Prevention Systems (IPS) in FY 14, 27 IPSs in FY 15 and 13 IPSs in FY 16. This project will significantly reduce the impact on the data center or any other facility of any unauthorized or malicious activity.

The HHC security team will also procure and deploy Data Loss Prevention (DLP) in FY 14 and FY 15. This project will significantly limit intentional or unintentional disclosure of ePHI and other sensitive information in an unauthorized manner.

In addition to IPS and DLP rollouts, the HHC Security Team and the HHC Clinical Information Systems (CIS) team will collaborate to deploy McAfee Antivirus for the HHC SharePoint environment.

Also, in FY 14 and FY 15, HHC security team will upgrade the vulnerability management infrastructure to increase security and regulatory compliance.

In addition to these projects, HHC will leverage McAfee professional services and resident security engineers throughout the duration of the contract, to improve its security and risk management processes, including, but not limited to better prevention and response to cyber security incidents. The Term of the contract is 2 years and 9 months.

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

Dyntek, Inc. offered the lowest price for the requested products and services as indicated above. This request is for an Enterprise Licensing Agreement with Dyntek, Inc. for a cost of $11,360,499.34 for a 2 year and 9 month term. As shown below, through discounted pricing via the NYS OGS Contract, this agreement results in a savings for the Corporation.

Total Spend without an Enterprise Licensing Agreement (2 Year 9 months) = $39.04M

Total Spend with the Enterprise Licensing Agreement (2 year 9 months) = $11.36M

Cost Avoidance (2 year 9 months) = $27.6M

	With ELA	Without ELA	Cost Avoidance
Intrusion Prevention System Deployment; Data Loss Prevention; Maintenance; Services; New Security Solutions	$11,360,499.34	$39,048,134.79	$27,628,631.61

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

Fiscal Year	**Total Spend**
2011	$3,232,513 (Software, Hardware and Support)
2012	$3,237,974 (Software, Hardware and Support)
2013	$2,191,041 (Software and Support)

Average annual spend: $2.88 million

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

HHC does not have the appropriate staff to complete the services included in this contract. In order to attain the same capabilities as the vendor, HHC would require staff certified in the multiple technologies and would need to provide for on-going training in order to make recommendations to improve operations, services and reduce cost.
The discounts included in the Enterprise Licensing Agreement keep the cost of solutions and professional services lower than the cost of solutions alone without the Enterprise Licensing Agreement.

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 artistic/creative/intellectual property will be produced from this contract

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

This contract will be administered by Bert Robles, Senior VP / Corporate CIO

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):*

N/A.

Received By E.E.O. _____
Date

Analysis Completed By E.E.O._____
Date

_____
Name

Application to enter into contract for McAfee Enterprise Licensing Agreement with Dyntek Services, Inc.

M&PA/IT Committee Meeting

October 17, 2103

Presenter: Sal Guido

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

nyc.gov/hhc

Background Summary

Current Industry Threat Landscape

- In 2011, NYCHHC spent **$3.4M** as a result of the GRM (Vendor) data breach
- Sutter Health is facing anywhere **from 9.25M-$4.25** billion in class action lawsuits.
- Stolen medical records can bring **$50** apiece on the underground market.
- **$214 -** Per capita cost for a breached medical record
- Average cost of a breach - **$5.4M** (2013 Ponemon Breach report)*

- **94%**of healthcare organizations suffered at least one data breach during the past 2 years (2012 Ponemon Breach report)*

- Post breach preventative action taken by victims (4 year average based on 2009-12 Ponemon Breach reports)*

  - **44.75%** companies implemented Data Loss Prevention
  - **57%** expanded the use of encryption, tokenization and other cryptographic techniques
  - **22.5%** companies strengthened their perimter controls
  - **39.75%** companies implemented endpoint security solutions

- *** Note**: Ponemon is an annual study amongst approx. 50 companies across 14 sectors including healthcare

Background Summary

HHC Requirements

- Significantly reduce or prevent hacking attempts
- Protect against cyberattacks and data breaches
- Avoid/reduce harm caused by a virus outbreak
- HIPAA security compliance
- Reduce security expenditure
- Skilled security personnel
- Improve security processes
- Vendor support

Current State

- Resource constraints (financial & personnel)
- Breach driven security strategy
- Vendor support does not fully meet our needs in emergent situations

In Scope with Contract Solution

- Confidentiality, Integrity and Availability of Electronic Personal Health Information (ePHI)

McAfee Enterprise Licensing Agreement - New Capabilities

Network Security

- Network Intrusion Prevention Devices for all HHC facilities
- Network Data Loss Prevention Devices
- eMail Protection Technologies for the HHC Corporation

Endpoint Protection

- Advanced Anti-Malware Technologies
- Application Control
- Hardware Assisted Security Technologies
- Advanced Remote Desktop Management
- Endpoint Security for Virtual Environments
- Real-time collection of Endpoint data
- Advanced Root-kit detection

Data Protection

- Sharepoint Security
- Virtual Server Security
- Endpoint Encryption (Existing)
- Host Data Loss Prevention

Risk & Compliance

- Vulnerability scanning
- Asset Discovery and monitoring
- Database monitoring and protection
- Network Policy and Configuration Auditing
- Risk Advisory Services

Services from ELA:

- Highest Level Premium support

Financial Analysis

Historical Spend

Description	FY11	FY12	FY13	Total Spend
New Products and Support	$3.23M	$3.23M	$2.19M	$8.65M

Future Spend

Description	FY14(9mos)	FY15	FY16	Total Spend
New Products, Support & Pro. Services	$3.04M	$4.05M	$4.25M	$11.36M

Benefits

- Comply with regulatory requirements and improve security postures while reducing potential security expenditures.
- HHC will avoid $27.6 M in product costs with the ELA; cost without ELA $39 M .
- Information & Transactions remain trustworthy
- Systems are available with minimal downtime
- Protect personal & senstive corporate information
- Enable new application or infrastructure

Procurement Approach

- **13 vendors were solicited via NYS OGS contract**
- **3 bids received**
- **<u>Recommendation</u>: Direct agreement with Dyntek Services, Inc. based on lowest responsive bid**

Vendor Information	Contract #	Bid Amount	No Bid	No Reply
Dyntek Services, Inc.	NYS OGS PT65091	$11,360,499.34		
Source IT Technologies	NYS OGS PT65091	$12,224,444.37		
SHI	NYS OGS PT65091	$12,005,250.61		
McAfee	NYS OGS PT65091		X	
Dimension Data	NYS OGS PT65091		X	
Sure Technology	NYS OGS PT65091			X
CDW	NYS OGS PT65091			X
NH&A, LLC	NYS OGS PT65091			X
Jim Krantz & Assoc	NYS OGS PT65091			X
Horizon Systems	NYS OGS PT65091			X
Nexus Consortium	NYS OGS PT65091			X
Tailwind Associates	NYS OGS PT65091			X
AMR Networks	NYS OGS PT65091			X

Questions

Questions?

Patient Safety Update 2013

Caroline M. Jacobs, MPH, MS.Ed.

M&PA IT Committee

Thursday, October 17, 2013

Items for Discussion

- Enterprise-wide strategic priority
  - Workforce development
    - Increase TeamSTEPPS® engagement by 20% or 4,692 employees in FY 13 (in the aggregate)
- Medication safety
- The NYS Partnership for Patients (NYSPFP)
  - Preventing hospital acquired conditions
  - Reducing preventable readmissions
- Snapshot of other patient safety activities and products

TeamSTEPPS®

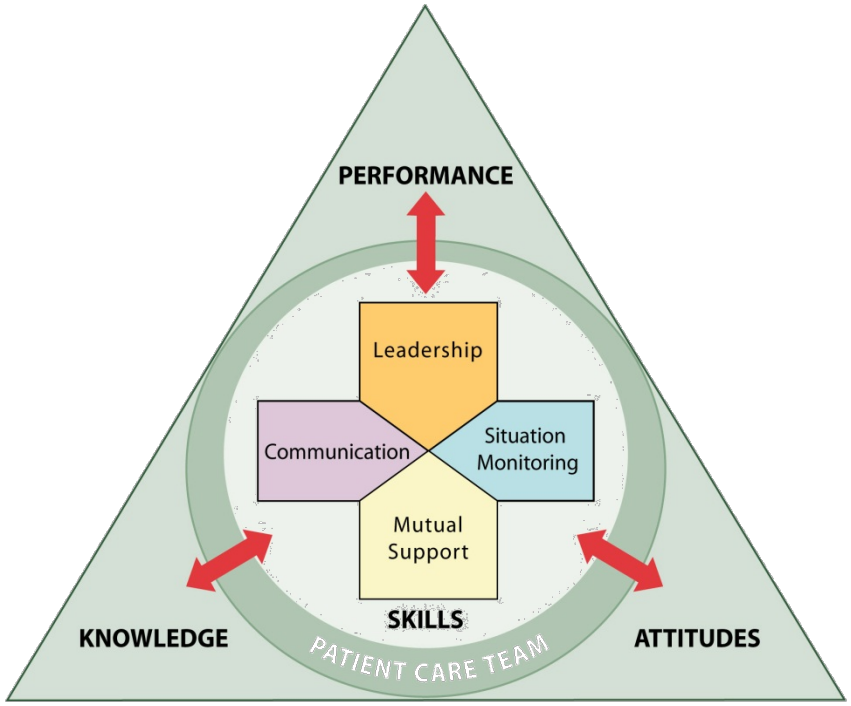
- **TeamSTEPPS** – **T**eam **S**trategies and **T**ools to **E**nhance **P**erformance and **P**atient **S**afety

- An evidence-based framework and toolkit designed by the Agency for Healthcare Quality and Research (AHRQ) in collaboration with the Department of Defense (DoD) to optimize team performance in healthcare settings.

- Increasing staff engagement in TeamSTEPPS continues to be a Corporate strategic priority and performance metric

Key TeamSTEPPS Principles

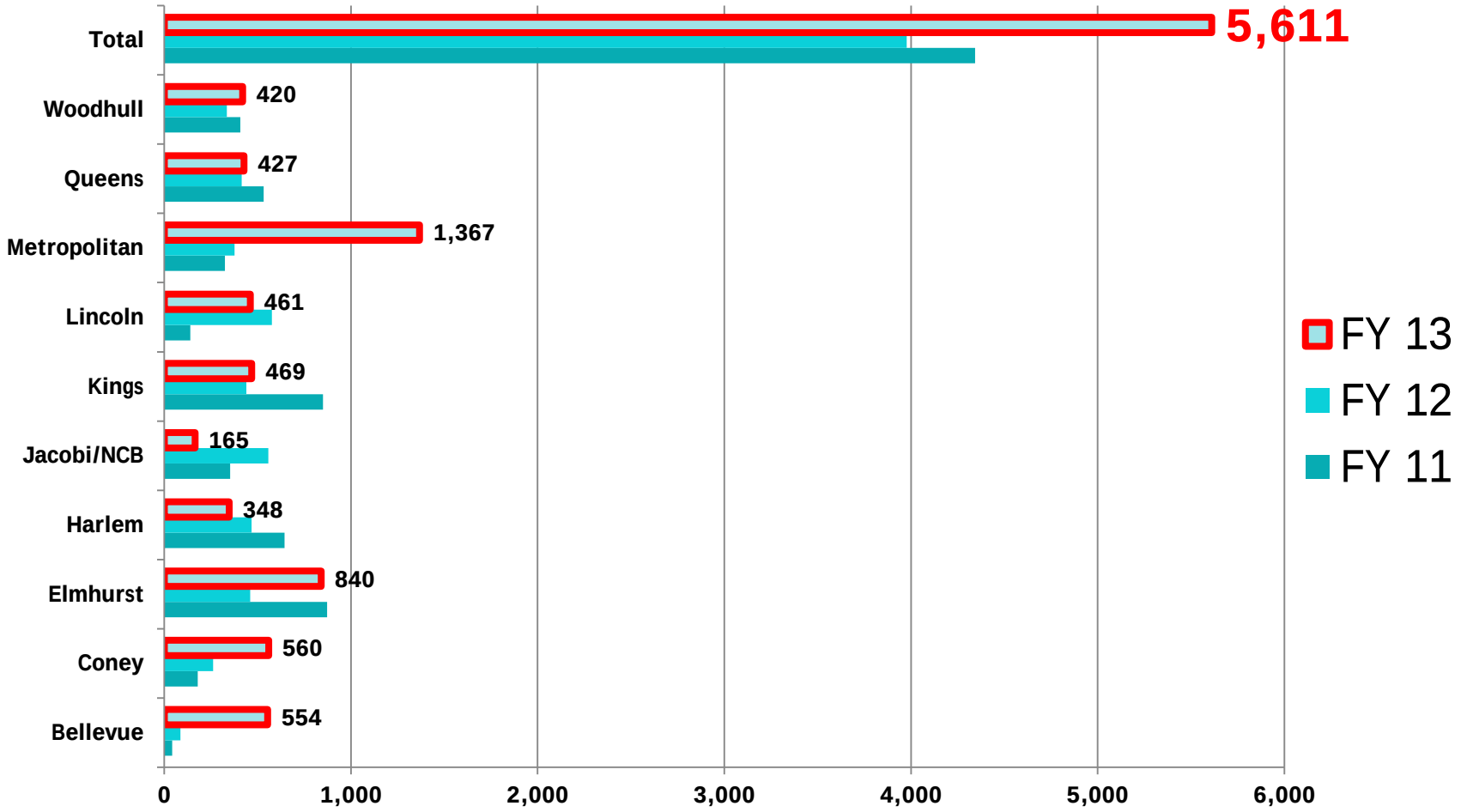
Four teachable-learnable skills



Team Competency Outcomes

- Knowledge
  - Shared mental model
- Attitudes
  - Mutual trust
  - Team orientation
- Performance
  - Adaptability
  - Accuracy
  - Productivity
  - Efficiency
  - Safety

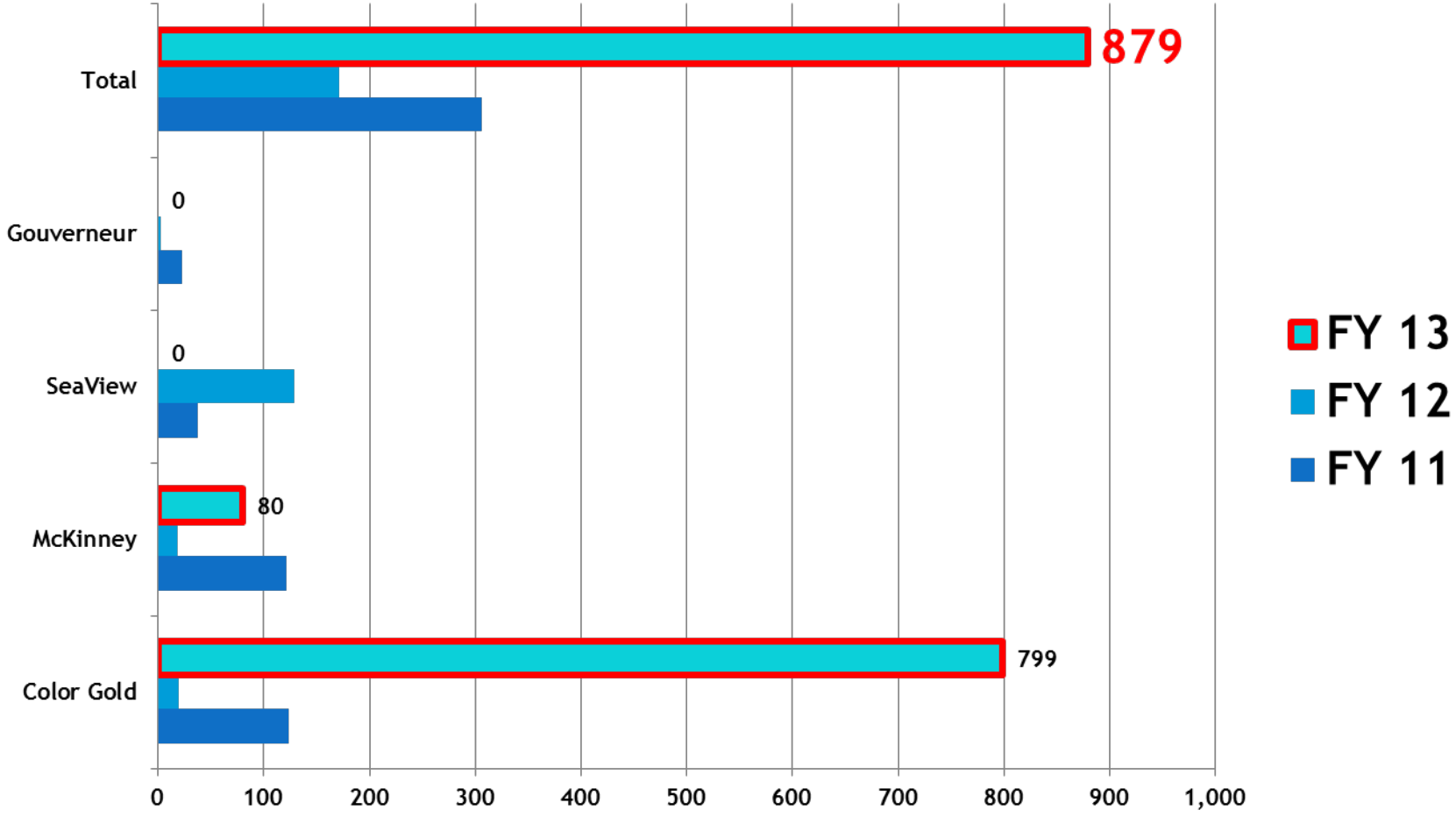
TeamSTEPPS Engagement FY'11* - FY'13
Number of Staff Engaged: Acute Care Hospitals



Engagement = participation in full half day, 4 core modules, or two day Master Training.

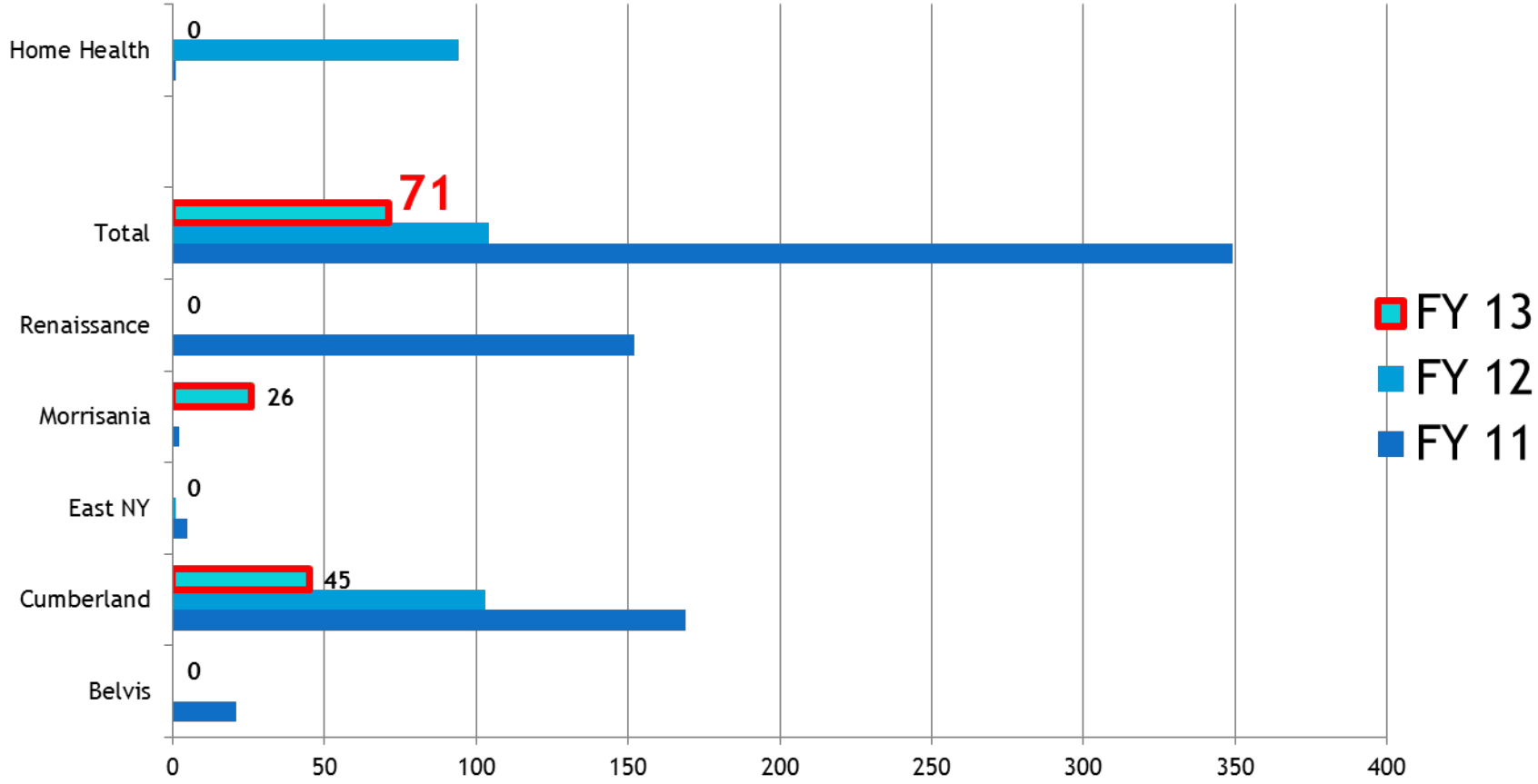
* FY 11 reflects baseline data collected between FY 07 through FY 11

TeamSTEPPS Engagement FY'11* - FY'13
Number of Staff Engaged: LTC Facilities



Engagement = participation in full half day, 4 core modules, or two day Master Training.
* FY 11 reflects baseline data collected between FY 07 through FY 11

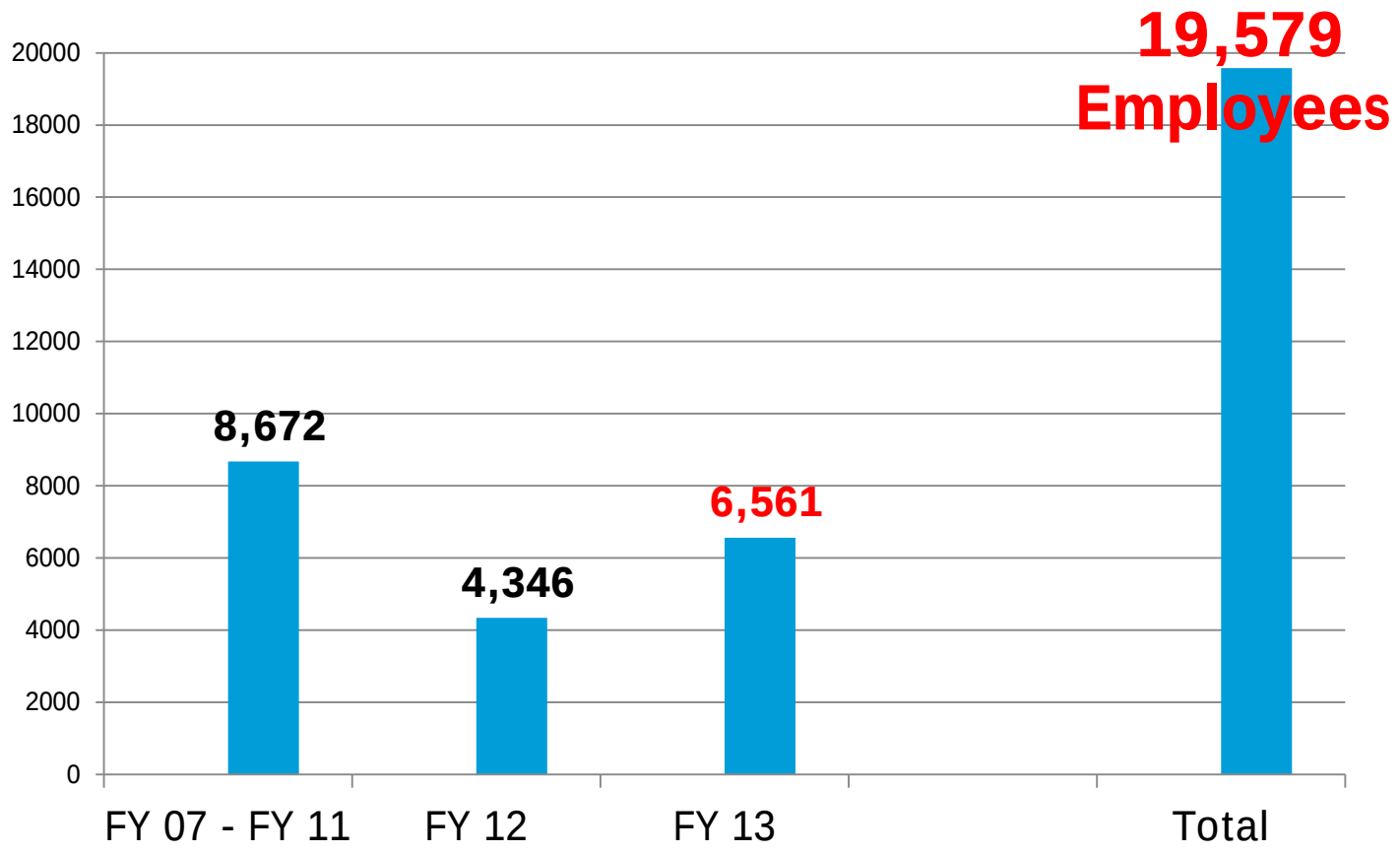
TeamSTEPPS Engagement FY'11* - FY'13
Number of Staff Engaged: D&TC and Home Health



Engagement = participation in full half day, 4 core modules, or two day Master Training.

* FY 11 reflects baseline data collected between FY 07 through FY 11

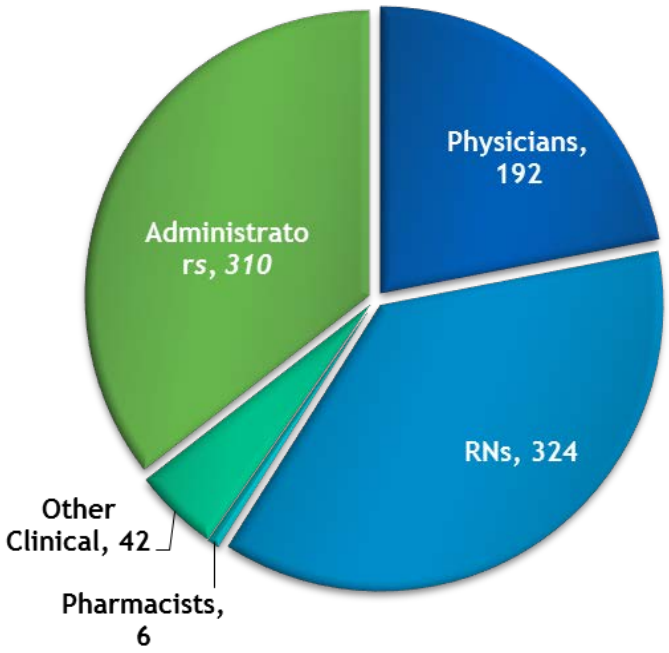
Total TeamSTEPPS Engagement FY 07 - 13



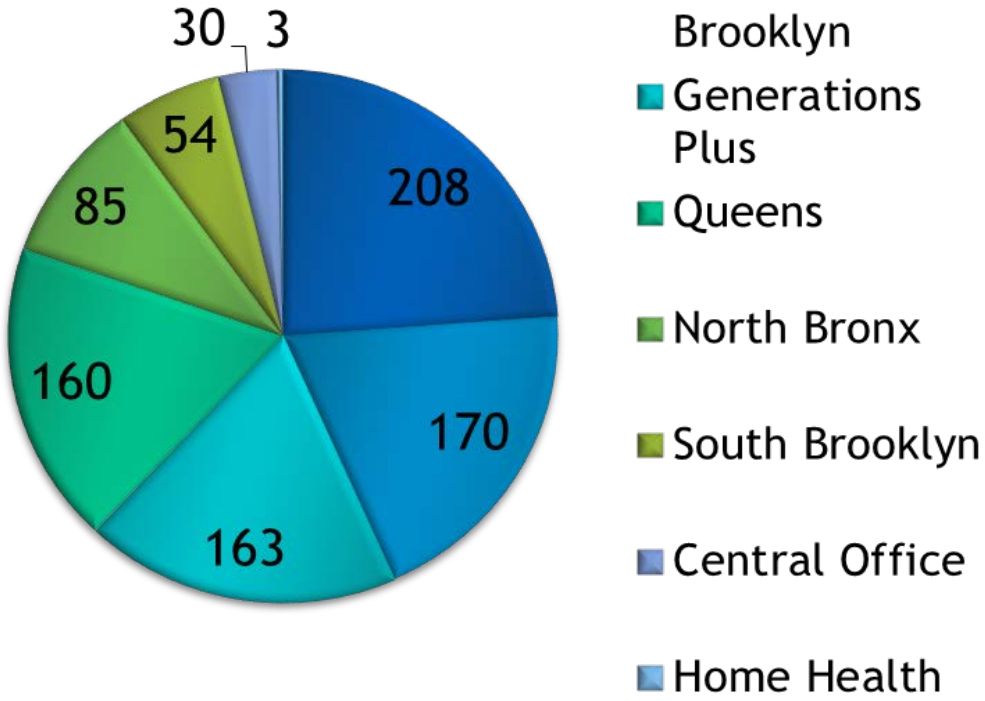
Engagement = participation in full half day, 4 core modules, or two day Master Training.

TeamSTEPPS Master Trainers (as of August 2013)

Number By Discipline



Number By Network



Requires two-day certificate training with “teach-back”

Effectiveness

- Lincoln Hospital implemented an interdisciplinary program on one med-surg unit that focused on embedding TeamSTEPPS communication tools and techniques in combination with targeted quality improvement interventions
  - Over 98% decrease in rate of catheter associated urinary tract infections
  - Sustained rate of 0 ventilator associated pneumonias (VAPS)
  - Decrease in unplanned extubations

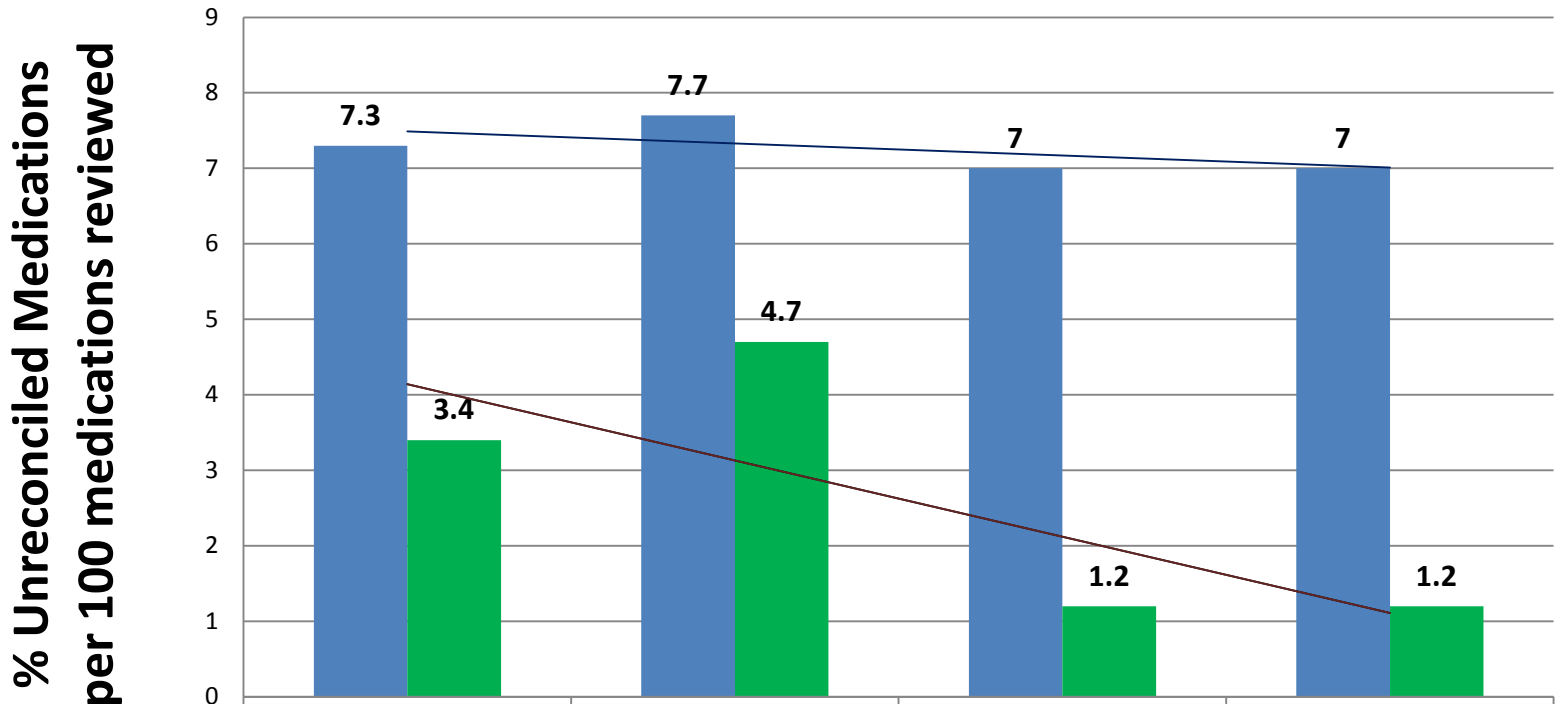
- Significant increased awareness across the system of staff application of TeamSTEPPS tools and techniques
  - Bellevue Hospital - Conducted a "return on investment" study of TeamSTEPPS with 57 staff six weeks post training
    - Nine of 12 tools were used appropriately approximately 90% of the time
    - Staff rated a positive change in on-the-job teamwork scores (4.2 out of 5)

- Planning study with IMSAL

Medication Safety

- Enterprise Medication Safety Council
  - Focusing on improving
    - Rate of medication reconciliation
    - Use of “high-alert” medications
      - Anticoagulants
      - Opioids
    - Automating collection, analysis and reporting of medication intervention data

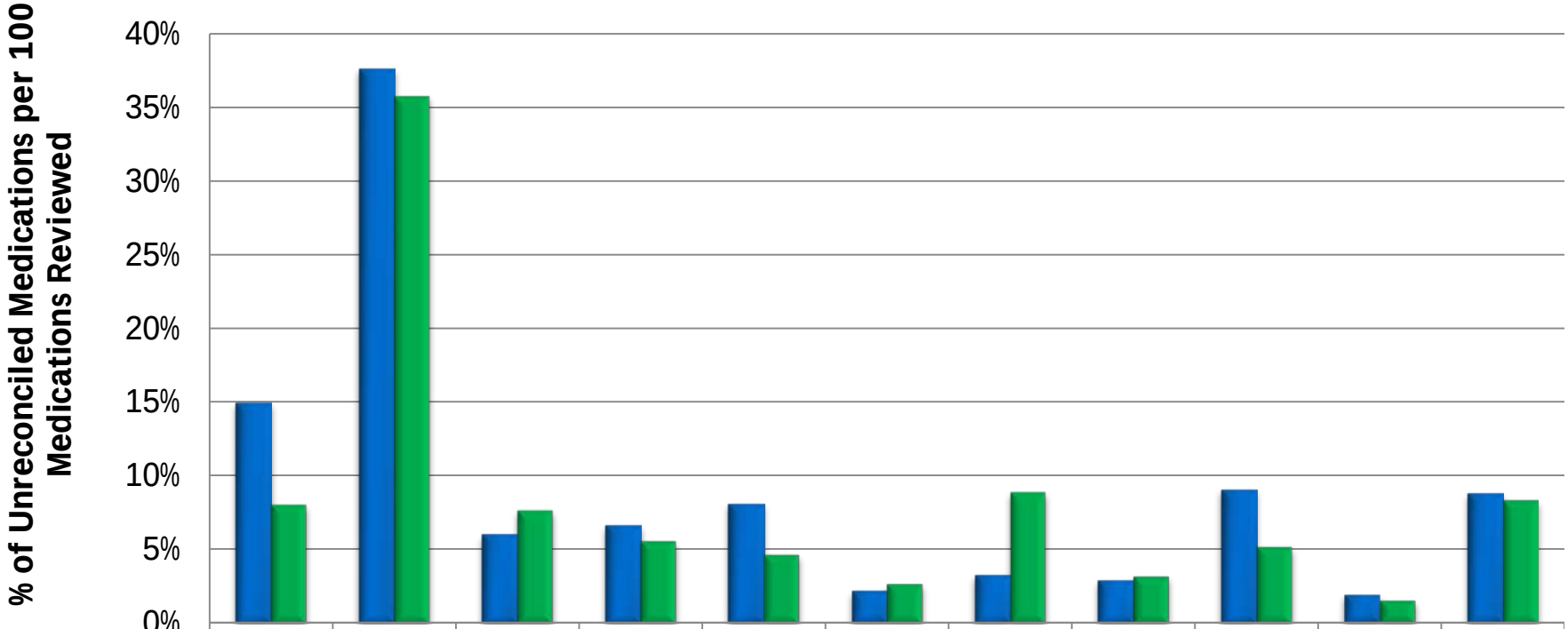
Aggregate Medication Reconciliation Data



	2009	2010	2011	2012
Acute (% unreconciled meds)	7.3	7.7	7	7
LTC (% unreconciled meds)	3.4	4.7	1.2	1.2

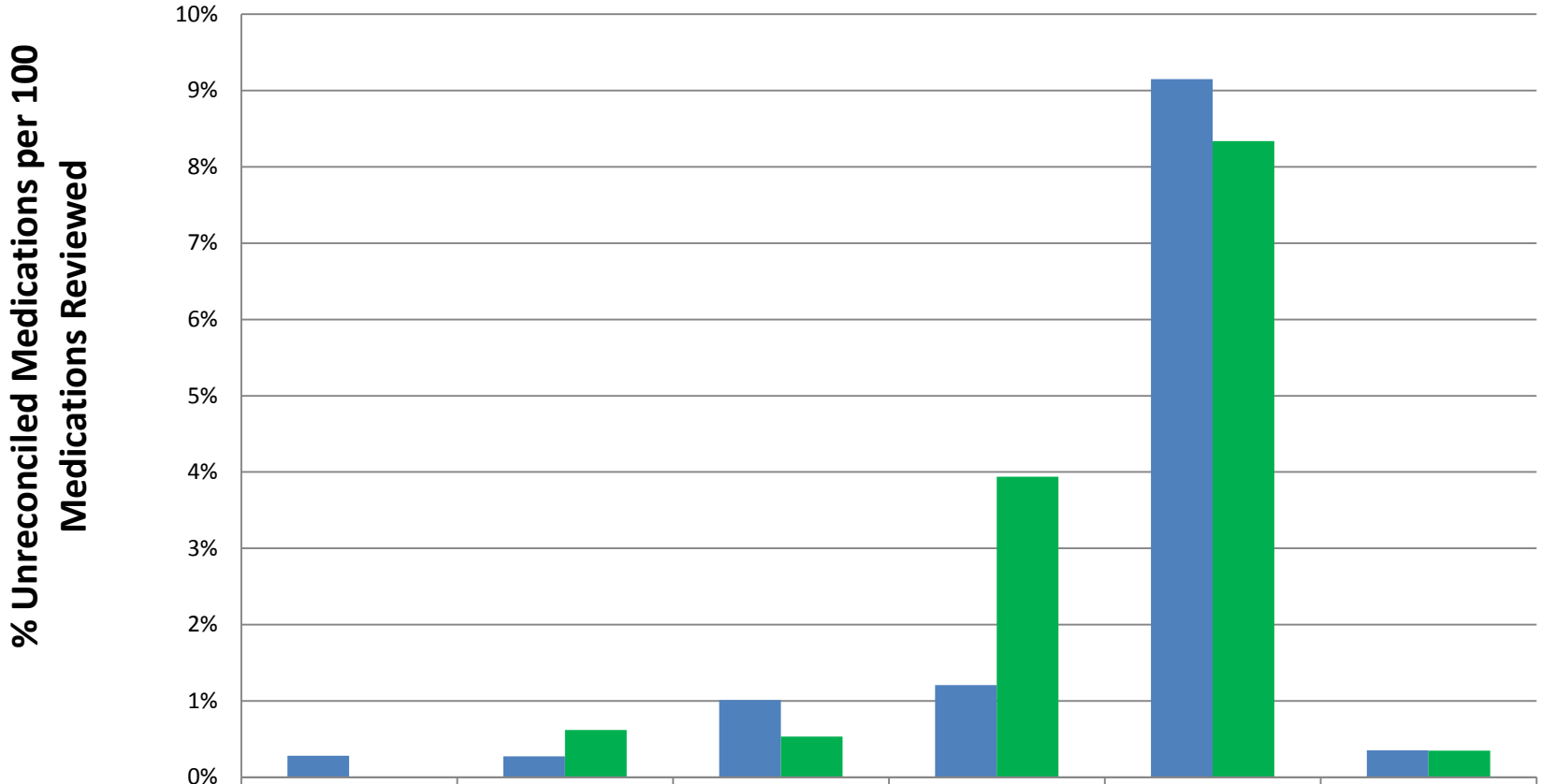
Medication Reconciliation = Process of identifying the medications currently being taken by an individual and comparing them against newly ordered medications to identify and resolve any discrepancies.

Medication Reconciliation (Acute Care facilities 2011 - 2012)



	Bellevue	Coney Island	Elmhurst	Harlem	Jacobi	Kings County	Lincoln	Met	NCB	Queens	Woodhull
% of Unrecon. Meds 2011	15%	38%	6%	7%	8%	2%	3%	3%	9%	2%	9%
% of Unrecon. Meds 2012	8%	36%	8%	6%	5%	3%	9%	3%	5%	2%	8%

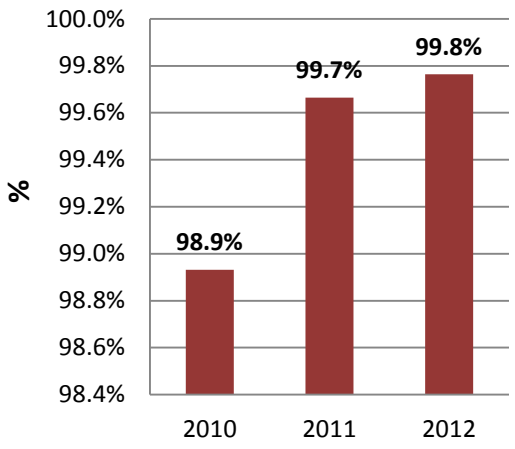
Medication Reconciliation (Long Term Care facilities 2011 - 2012)



	Coler-Hospital	Coler-Nursing	Goldwater-Hospital	Goldwater-Nursing	Gouverneur	Sea View
% of Unrecon. Meds 2011	0%	0%	1%	1%	9%	0%
% of Unrecon. Meds 2012		1%	1%	4%	8%	0%

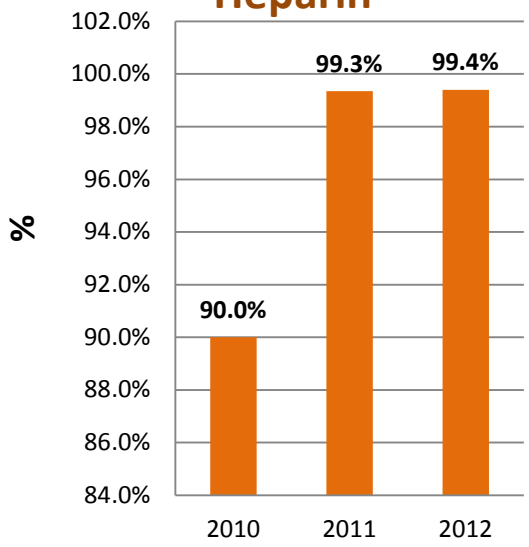
Improving Anticoagulation Therapy

Percent of Patients for Whom an INR* is Available Prior to Administering or Adjusting Warfarin Dose



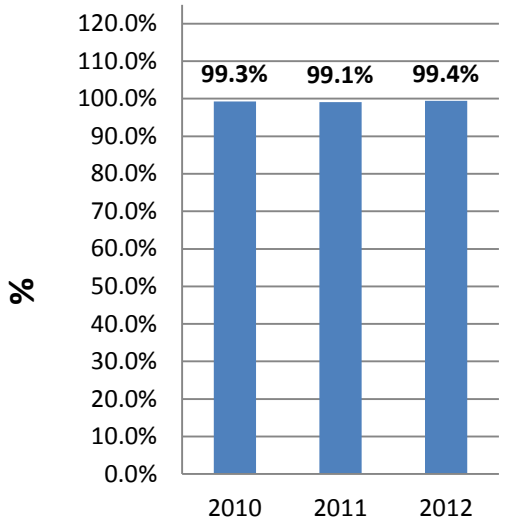
	2010	2011	2012
Number of Patients	78,378	79,242	84,090

CBC Testing Prior to Administration of Low Molecular Weight Heparin



	2010	2011	2012
Number of Patients	230	767	670

Monitoring INR for Warfarin



	2010	2011	2012
Number of Patients	275	764	864

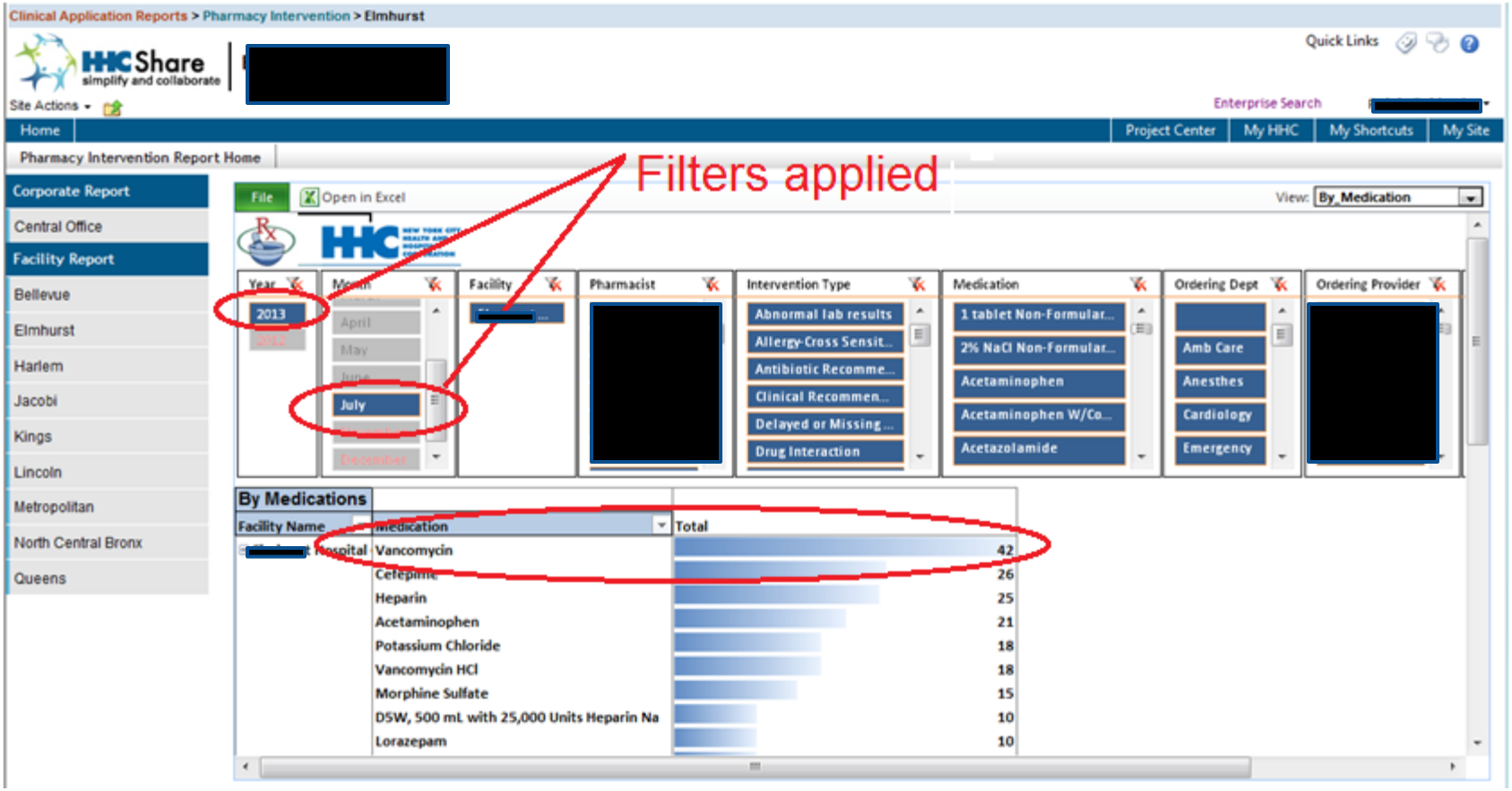
*International Normalized Ratio (INR)

Electronic Medication Interventions

- Standardized medication intervention categories across all facilities
- Export report runs automatically each month for the previous month
- Automated import of the facility medication intervention data
- Reporting tool is now operational for all facilities

Medication Interventions

Example of New Reporting Tool



Pain Management and Opioid Use

- **Developed Opioid Handbook for Clinicians**
- **Medication Safety Newsletter – *"Patient Controlled Analgesia Safety"***

Medication Safety Council

Medication Safety Council Newsletter

New York City Health and Hospitals Corporation

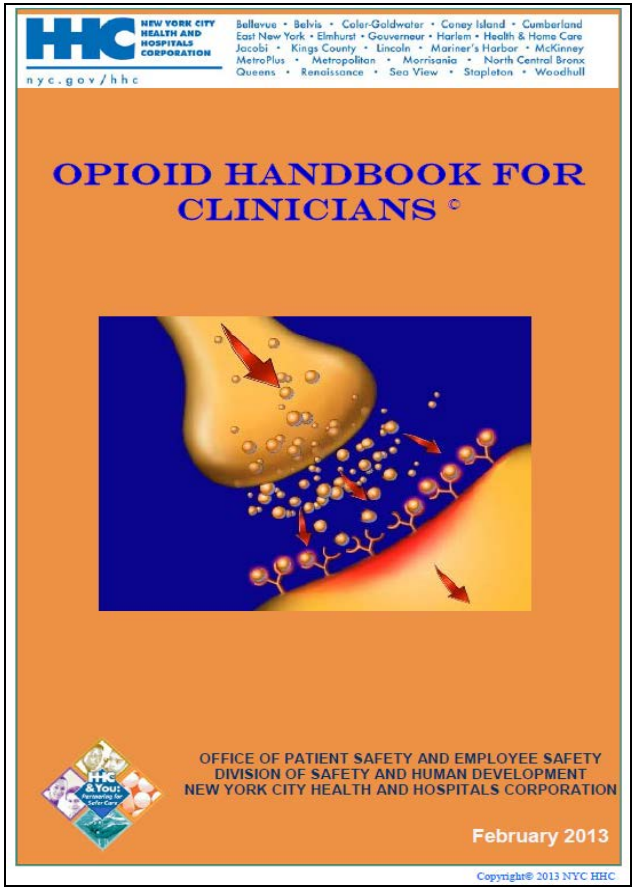
Volume 2, Issue 2 May 2012

Patient Controlled Analgesia Safety

Patient controlled analgesia (PCA) is a process where patients have the control to determine when and how much pain medication they receive. This method allows the patient to self-administer pain medication, usually an intravenous opioid with a push of a button via a computerized pump. PCA is most commonly used for post-operative pain management and research has shown that it provides better patient satisfaction than conventional methods of administration. Patients are able to ambulate earlier which leads to

needed for pain. The prescriber chooses a PCA dose and interval that may be set at every 10 minutes. Therefore, the patient can press the button every 10 minutes to administer one dose. The pump will not deliver a dose if the patient presses more frequently than the specified time interval.

- *Lockout*—controls the number of doses a patient can receive in a specified time period which is usually one hour. For example, a patient can only receive 6 doses per hour.



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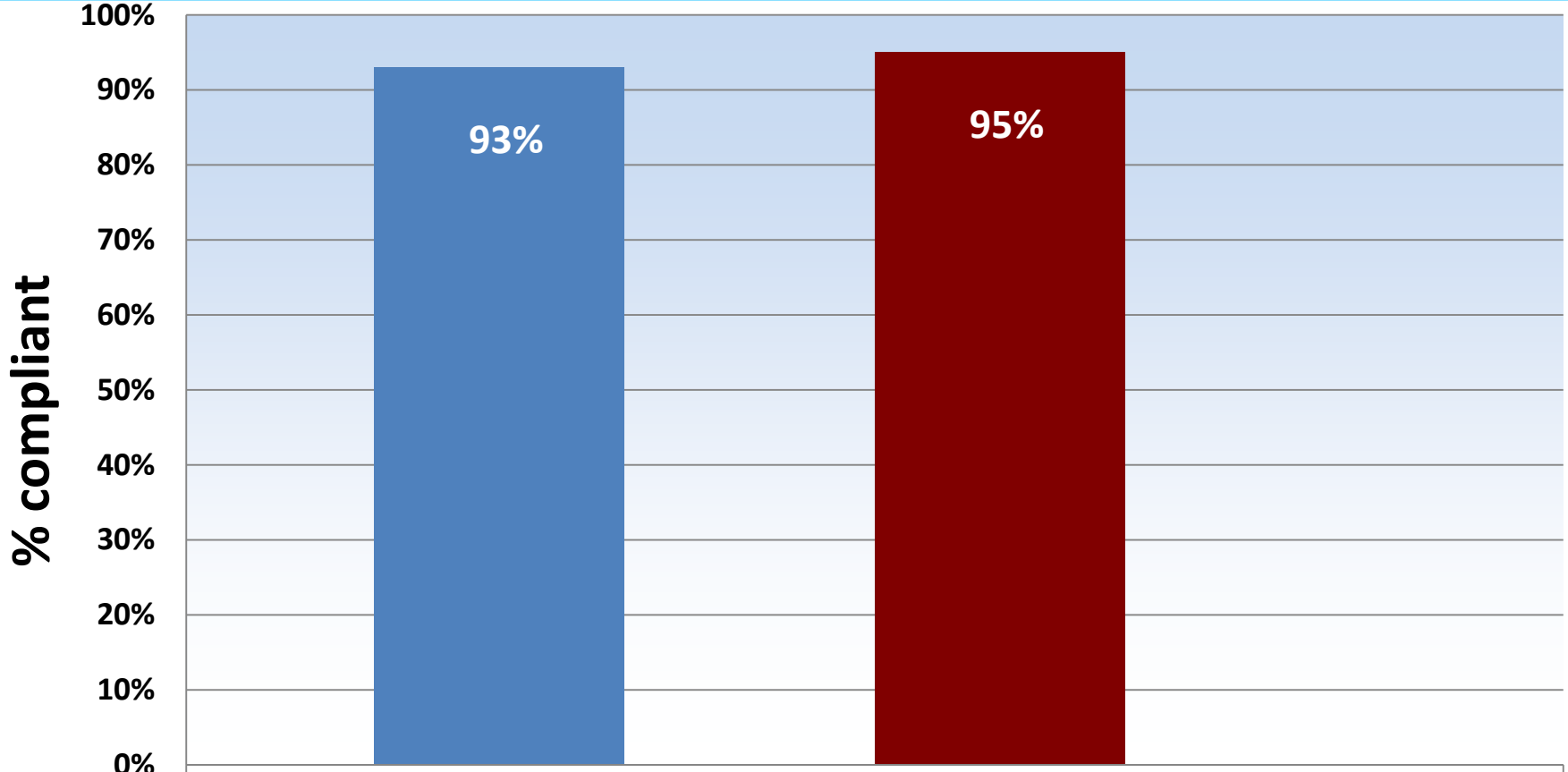
OFFICE OF PATIENT SAFETY AND EMPLOYEE SAFETY
DIVISION OF SAFETY AND HUMAN DEVELOPMENT
NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

February 2013

The Joint Commission National Patient Safety Goal on Use of Two Patient Identifiers, 2011-2012

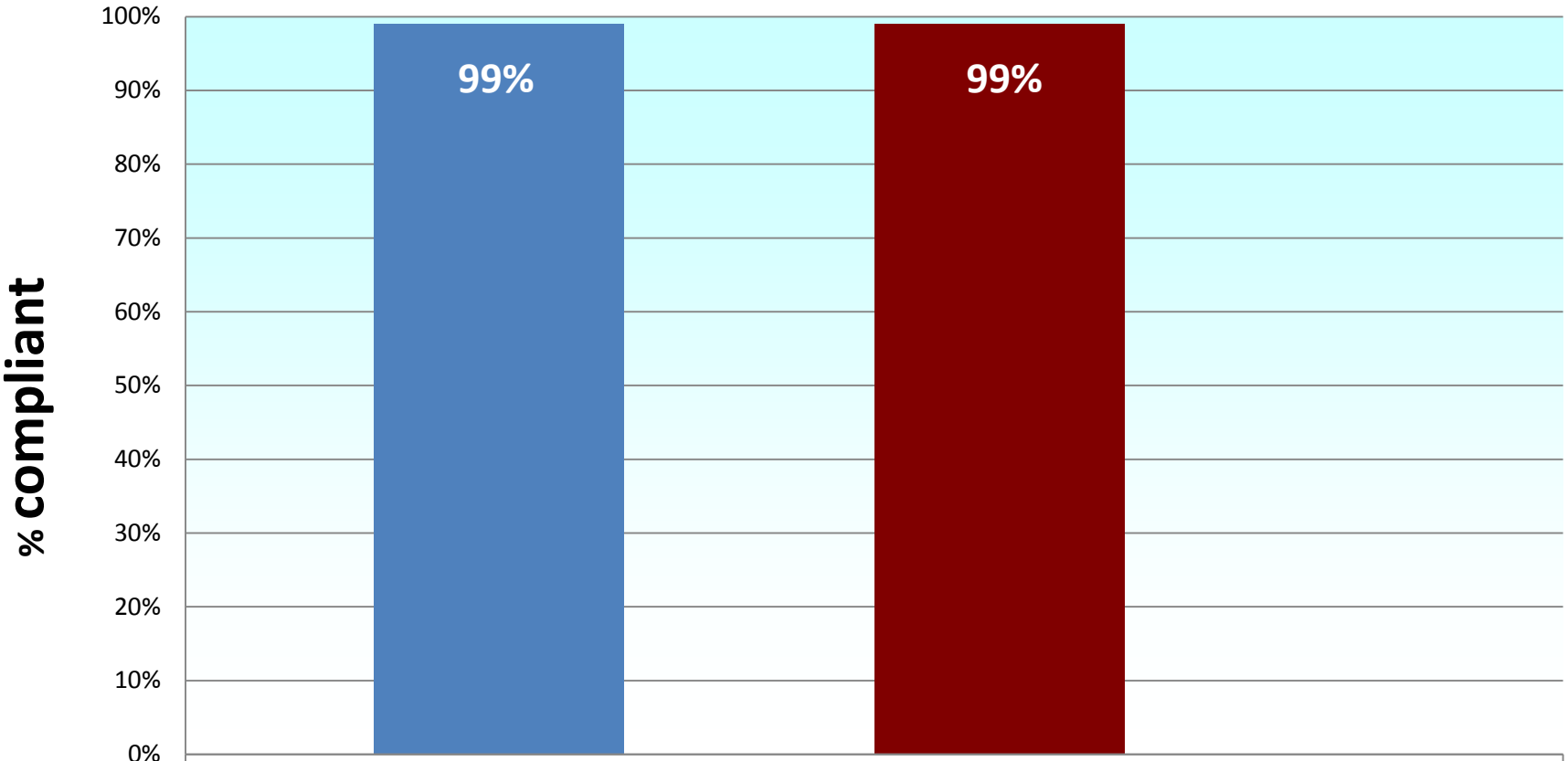
NPSG.01.01.01: Use at least two patient identifiers when providing care, treatment and services



	NPSG.01.01.01: Two Pt ID	
% Compliant 2011	93%	
# Non-compliant 2011	5730	(n=75,265)
% Compliant 2012	95%	
# Non-compliant 2012	3418	(n=61,976)

The Joint Commission National Patient Safety Goal on Use of the Universal Protocol, 2011-2012

UP.01.01.01: Conduct a pre-procedure verification process



	UP 01.01.01 Pre-Proc Verification	
% Compliant 2011	99%	
# Non-compliant 2011	220	(N =11,154)
% Compliant 2012	99%	
# Non-compliant 2012	89	(N = 9,765)

NYS Partnership for Patients (NYSPFP)

Collaboration between GNYHA and HANYS - Funded by HHS/CMS

170 Participating Hospitals in NYS

- Goals to Achieve by December 2014:
  - Reduce preventable harm (hospital-acquired conditions) in the aggregate **by 40%**
  - Reduce preventable readmissions in the aggregate **by 20%**

Source: NYSPFP

Ten NYSPFP Focus Areas

Preventable Readmissions	Catheter-Associated Urinary Tract Infections (CAUTI)	Central Line Associated Blood Stream Infections (CLABSI)	Injuries from Falls and Immobility
Ventilator-Associated Pneumonia (VAP)	Pressure Ulcers	Surgical Site Infections	Venous Thromboembolism (VTE)
	Adverse Drug Events (ADEs)	Obstetrical Safety	

HHC Performing better than the NYSPFP Mean

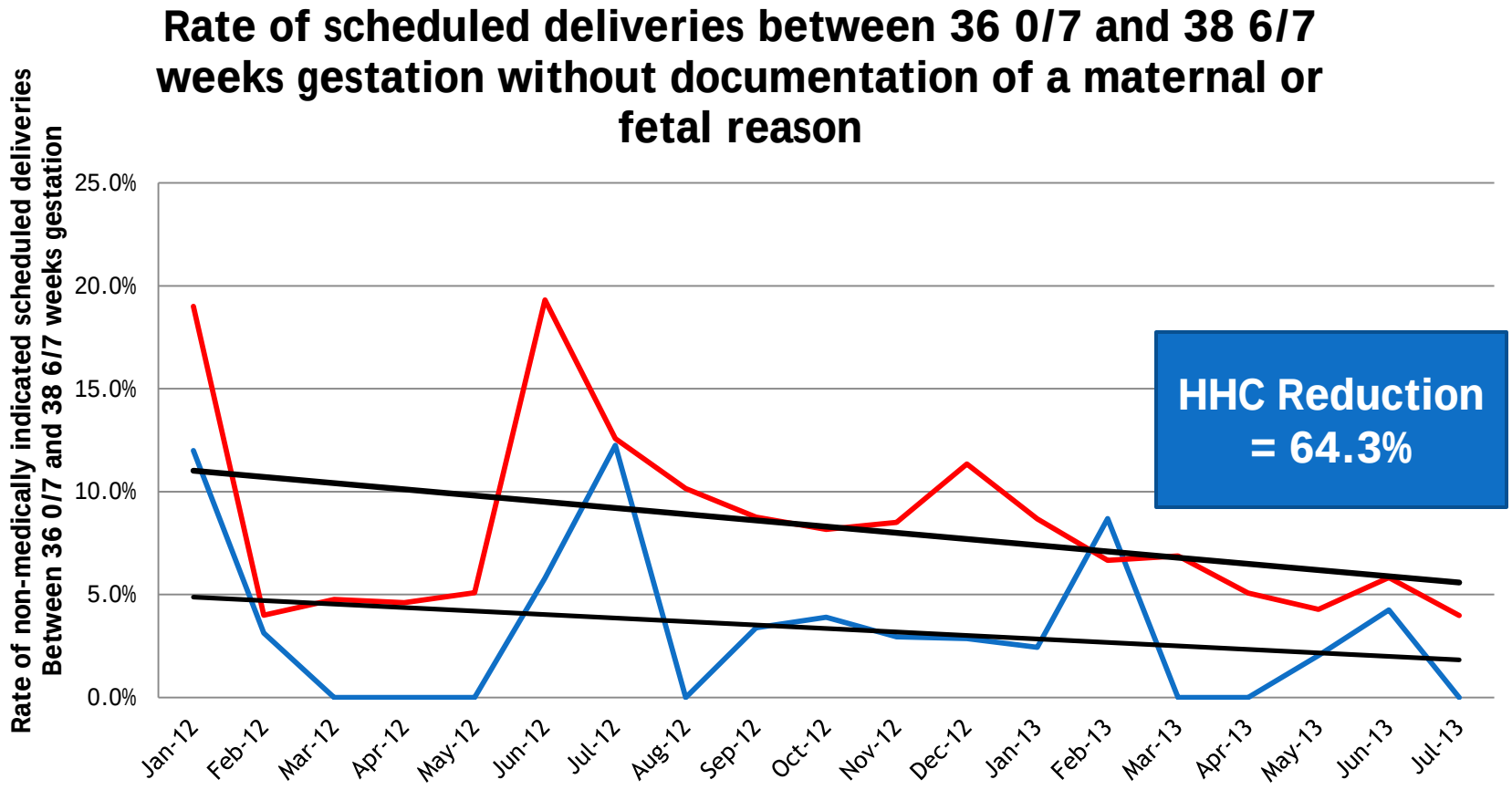
HHC performing equal to the NYSPFP Mean

Building Culture and Leadership

PARTNERSHIP FOR PATIENTS

Source: NYSPFP

Obstetrical Safety – Early Elective Delivery HHC Rate Compared to NYSPFP Rate



	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13
HHC rate	12.0%	3.1%	0.0%	0.0%	0.0%	5.8%	12.2%	0.0%	3.4%	3.9%	2.9%	2.9%	2.4%	8.7%	0.0%	0.0%	2.0%	4.3%	0.0%
NYSPFP rate	19.0%	4.0%	4.8%	4.6%	5.1%	19.3%	12.6%	10.2%	8.8%	8.2%	8.5%	11.3%	8.7%	6.7%	6.9%	5.1%	4.3%	5.8%	4.0%

Other Capacity Building Patient Safety Activities

- **Large scale patient safety forums and events**
  - Medical Decision Making Errors (Diagnostic Errors)
  - Advancing Patient Safety Through the Understanding of Human Factors
  - Hardwiring TeamSTEPPS and Just Culture for the C-Suite
  - Partnering with Patients: A Bird's Eye View of Safety
  - Annual Patient Safety Champions Awards
- **Annual Patient Safety EXPO**
- **Developing and disseminating patient safety resources and tools**
- **Patient Engagement – *"No Decisions About Me Without Me"* booklet and "just-in-time" patient involvement surveys**
- **Continued Labor-Management collaboration with the Committee of Interns and Residents, engaging residents in patient safety**
- **Policy on Communication of Adverse Events to Patients and Families**
- **Continue to share successes locally and nationally**
  - **Nine posters in the Annual National Patient Safety Foundation Congress**
  - **Faculty to AHRQ TeamSTEPPS Collaborative, NYSPFP, and America's Essential Hospitals (formerly NAPH)**

http://patientsafety.nychhc.org/