AGENDA

INFORMATION TECHNOLOGY
COMMITTEE

Meeting Date: __October 11, 2017__
Time: __11:00 AM__
Location: __125 Worth Street, Room 532__

BOARD OF DIRECTORS

CALL TO ORDER   **MS. YOUSSOUF**

ADOPTION OF MINUTES
   June 13, 2017

CHIEF INFORMATION OFFICER REPORT   **MR. GUIDO**

INFORMATION TECHNOLOGY COMMITTEE REPORT OUT   **MR. GUIDO**

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

NEW YORK CITY HEALTH + HOSPITALS

Meeting Date: June 13, 2017

INFORMATION TECHNOLOGY COMMITTEE

ATTENDEES

COMMITTEE MEMBERS
Emily Youssouf, Chair
Josephine Bolus, RN
Stanley Brezenoff, Interim President & CEO
Gordon Campbell
Karen Lane (for Steven Banks)
Barbara Lowe

NYC HEALTH + HOSPITALS CENTRAL OFFICE STAFF:
PV Anantharam, Senior Vice President and Chief Financial Officer
Donald Ashkenase, Assistant Vice President, Office of Medical & Professional Affairs
Kamal Bhermani, Technical Advisor, NYC Health + Hospitals
Dr. Rosa Colon-Kolacko, Chief People Officer, NYC Health + Hospitals
Bob De Luna, Communications and Marketing
Olga Deshchenko, Director, Communications and Marketing
Suzanne Fathi, Director, Enterprise Information Technology Services
Dr. Alfred Garofalo, Senior Assistant Vice President, Enterprise Information Technology Services
Sal Guido, Senior Vice President and Chief Information Officer, Enterprise Information Technology Services
Colicia Hercules, Chief of Staff, Office of the Chairperson
Dr. Christina Jenkins, Chief Executive Officer, OneCity Health Services
Michael Keil, Assistant Vice President, Enterprise Information Technology Services
Barbara Lederman, Senior Director, Enterprise Information Technology Services
Patricia Lockhart, Secretary to the Corporation
Jeffrey Lutz, Senior Director, Enterprise Information Technology Services
Salvatore Russo, Senior Vice President & General Counsel, Legal Affairs
Pamela Saechow, Senior Assistant Vice President, EMR Build and Implementation
Barry Schechter, Assistant Director, Enterprise Information Technology Services
Brenda Schultz, Senior Assistant Vice President, Finance
Barry Shapiro, EMR IT Financial Administration
Erika Soiman, Chief Financial Officer, NYC Health + Hospitals
Devon Wilson, Senior Director, Internal Audits
Dr. Ross Wilson, Senior Vice President and Chief Medical Officer, Corporate Medical & Professional Affairs

OTHERS PRESENT:
James Cassidy, Analyst, Office of Management and Budget
Steve Novis, ViiV Healthcare

INFORMATION TECHNOLOGY COMMITTEE
Tuesday, June 13, 2017

Emily Youssouf called the meeting to order at 12:05 PM. The minutes of the May 15, 2017 meeting were adopted.

Stanley Brezenoff introduced Kamal Barwani, who will serve as a volunteer advisor for NYC Health + Hospitals. He has a wealth of experience in both public and private sector in information technology. He said we are fortunate to have him.

Mr. Barwani thanked Mr. Brezenoff and the Board.

CHIEF INFORMATION OFFICER REPORT

Sal Guido welcomed Mr. Barwani and presented the Chief Information Officer Report. He said for today's meeting, Enterprise IT Services would be presenting two (2) action items associated with DSRIP (Delivery System Reform Incentive Payment) for the Committee's consideration: Digital Health and Population Health.

He then gave the following brief updates:

ENTERPRISE RESOURCE PLANNING (PROJECT EVOLVE)

Mr. Guido said this project continues to be on budget and on time, with go-live for Wave I sites targeted for July 1, 2017. He said cutovers and dress rehearsals have all been completed. He said we have successfully completed User Acceptance Testing. We will have "war rooms" at 55 Water Street and 160 Water Street. There will be support on site throughout that weekend as well as having extra support available the first couple of weeks after go-live.

As a reminder, he said on July 1, the following modules will go live for all NYC Health + Hospitals facilities: General Ledger, Treasury – Cash Management, Asset Management, Project Costing – Grants, and Budget.

Mr. Guido said the following modules will be rolled out in five (5) Waves across the enterprise, with Wave 1 going live July 1 at NYC Health + Hospitals/Queens, NYC Health + Hospitals/Lincoln, Central Office, and Correctional Health: Purchasing, Procurement, Materials Management, Accounts Payable, Project Costing – Capital Projects, and Tagging of Assets for Asset Management. We are doing this in phases, he said, because we are so large and we want to avoid disruption. By this time next year, everyone will be on the system.

Emily Youssouf asked that Mr. Guido keep the Committee informed of the progress of this project and any issues.

Mr. Guido said he would. He said they are expecting issues, but the support is in place to deal with them as they arise. This happens with all projects. He said the testing has been positive, so we are prepared. We will keep the Board up to date of this.

Ms. Youssouf asked if there will be any pleasant surprises from the tagging of assets.

Mr. Guido said he thinks there will be pleasant surprises throughout the implementation process. He said we are going from six different systems into one integrated system. He said that will build efficiencies with

a complete view of inventory and supply chain. Also, from a maintenance and ease of operation it will help. He said it will provide the Finance team with information they need.

Josephine Bolus asked how many classes we will need to get people ready.

Mr. Guido said training has been going on for 30 days and we have people in the facilities who helped us to design the system. He said there will be support for the users as well.

DENTRIX CONSOLIDATION

Mr. Guido said this is the EMR (electronic medical record) for dentistry. He said we are consolidating 23 dental systems into one. He said we had a very successful go-live at NYC Health + Hospitals/Coney Island. He said we are going live with NYC Health + Hospitals/Jacobi and NYC Health + Hospitals/North Central Bronx next. Over the next six months, we will complete the implementation. It is on time and on budget.

MEANINGFUL USE AND QUADRAMED 6.2 UPGRADE.

Mr. Guido said QuadraMed needs major upgrades to meet Phase 2 and Phase 3 Meaningful Use (MU) standards. He said this will make NYC Health + Hospitals' QuadraMed-based facilities eligible for continued financial incentives. He said testing and configuration enhancements are almost complete, as we work with QuadraMed to resolve any new concerns during the testing phase. The roll-out is expected to start the second or third week of June (at NYC Health + Hospitals/Jacobi and NYC Health + Hospitals/North Central Bronx). The expected completion for all the facilities is the end of July. He said we are working on some issues with the Medication Reconciliation and those will be corrected by late July.

RADIOLOGY MCKESSON PROJECT

Mr. Guido said we are consolidating 12 different systems into one over multiple phases. He said the first phase was to put in a system that allows for a global worklist, peer reviews, and a physician concierge service. The phase 1 hospitals are NYC Health + Hospitals/Harlem, NYC Health + Hospitals/Metropolitan, NYC Health + Hospitals/Lincoln, and NYC Health + Hospitals/Coney Island. He said the overall feedback continues to be positive and it is widely accepted by Radiologists (around 92% are using every part of the system). He said we have been sharing the analytics with radiologists and site management, among others.

Ms. Youssouf asked if he anticipated adoption by the remaining radiologists.

Mr. Guido said yes but those last 8% are the toughest ones to get to adopt. He said we are piloting cross-reads, which allows us to do the imaging in one facility and read by a radiologist in another. Once testing is over, we can use across the organization for much better efficiency. It is working out very well for us right now.

Barbara Lowe said she remembered when these were read offshore.

Mr. Guido said yes, this system would replace any need for that and make us more efficient.

Ms. Lowe said she agreed.

SECURITY / WANNACRY RANSOMWARE UPDATE

Mr. Guido reminded everyone about the latest ransomware variant of WannaCry halting activities in major health organizations and companies around the world last month. He said NYC Health + Hospitals was not affected by it because we put a lot of tools and processes in place to prevent it. He said this Committee helped us to get these and we thank you for that.

Mr. Guido said we take many measures to deal with ransomware like WannaCry, including updated antivirus signatures released to all endpoints for latest variants; updated signatures released to all intrusion detection, and prevention devices and WannaCry activity being blocked on perimeter devices for latest variants. He said we have very effective, dynamic monthly patching efforts for all endpoints, including servers, have been applied across the organization with remaining machines being actively remediated on a daily basis. He said our data loss prevention (DLP) and intrusion prevention are patched on a dynamic basis.

He said we scan every single device for anomalies on a regular basis. This includes every desktop, laptop, and phone, no matter where they are.

Ms. Bolus asked if this includes personal devices.

Mr. Guido said we can only monitor the business aspect of any device, not the personal ones. He said there is software in place to help correct any problems on a device 24/7.

Ms. Bolus asked if an x-ray taken today can be sent on a phone.

Mr. Guido said correct, our DLP blocks any ePHI (private health information) to be sent out. It is also blocked from CD-ROMs and removable hard drives. There is no almost way to get information sent out without our knowing about it.

Karen Lane asked what if a patient leaves NYC Health + Hospitals and goes to another provider. How do we send the information?

Mr. Guido said we have a secure way of encrypting and sending files. Another way is via the RHIOs (regional health information organizations). He said an outside physician can make a request in the correct fashion and we will send the information through the RHIOs.

Ms. Bolus said she has seen people use private phones because they think they can treat someone.

Mr. Guido said we cannot stop two physicians from sending photos to each other. But if they use our systems, we can stop them from unauthorized sharing of information.

Ms. Youssouf said she cannot even use her personal email to send an email because it is blocked.

Mr. Guido said we do block a lot of things, including ePHI. He said we put things in place to read encryption and prevent ePHI from going out. This is automatic.

Ms. Youssouf asked about security insurance.

Mr. Guido said we worked with Salvatore Russo on this.

Salvatore Russo said someone on his staff has a master's in insurance law. We have looked into this. He said we have found the costs to be astronomical and we are already covered by the City of New York.

Mr. Guido said we will continue to monitor security insurance as the industry matures. But we are indemnified by the City. That ends my report.

Ms. Bolus asked Mr. Bhermani to explain his role.

Mr. Bhermani said his background includes working at public and private organizations in IT, including City organizations under multiple mayors. Regarding security, he said he is on the board of Symantec, which is a $20 billion public corporation specializing in cyber security. He said he is experienced in all aspects of technology as well as finance, housing and other sectors.

Ms. Youssouf said his service is free.

Mr. Brezenoff said that is why they are overjoyed. He then said it would be good to have an objective point of view since there are often competing, though equally valid opinions in certain situations. He said Mr. Bhermani is an expert to help us work out and weigh decisions.

Ms. Bolus said thank you.

Mr. Bhermani said his goal is to rationalize goals and get successful outcomes on projects.

Ms. Youssouf asked Mr. Guido to read both resolutions so that they could be considered at the same time. She said his team worked to help them understand what would be considered.

The presenters – Jeffrey Lutz, Dr. Cristina Jenkins, and Vijay Saradhi – introduced themselves.

ACTION ITEM 1:

RESOLUTION ON IMPLEMENTING A DIGITAL HEALTHCARE NETWORK

Mr. Guido read the following resolution: Authorizing the New York City Health and Hospitals Corporation ("NYC Health + Hospitals" or the "System") to take the necessary steps to implement a Digital Healthcare Network technology infrastructure platform, for a cost not to exceed $109.1 million of New York State ("NYS") Delivery System Reform Incentive Program ("DSRIP") capital reimbursable grant funds, over the next five years, including procuring the necessary contracts for: hardware; software; and staff augmentation to implement, configure and install hardware and software; all of such procurements to be effected in conformity with NYC Health + Hospitals' Operating Procedure 100-5 but without further Board authorization; provided that the Enterprise Information Technology Services division of NYC Health + Hospitals ("EITS") shall make regular, periodic reports to the Board of Directors to detail such procurements and to report on the progress of the implementation program and track the same to the budget hereby established.

The resolution was seconded.

ACTION ITEM 2:

RESOLUTION ON IMPLEMENTING A POPULATION HEALTHCARE NETWORK

Mr. Guido then read the next resolution Authorizing the New York City Health and Hospitals Corporation ("NYC Health + Hospitals" or the "System") to take the necessary steps to create a Population Health technology infrastructure platform, for a cost not to exceed $81.3 million of New York State ("NYS") Delivery System Reform Incentive Program ("DSRIP") capital reimbursable grant funds over the next five years, including procuring the necessary contracts for: hardware; software; and staff augmentation to implement, configure and install hardware and software; all of such procurements to be effected in conformity with NYC Health + Hospitals' Operating Procedure 100-5 but without further Board authorization; provided that the Enterprise Information Technology Services division of NYC Health + Hospitals ("EITS") shall make regular, periodic reports to the Board of Directors to detail such procurements and to report on the progress of the implementation program and track the same to the budget hereby established.

The resolution was seconded.

Dr. Jenkins spoke to the presentation, "OneCity Health Population Health, Digital Hospital." She asked the question, What is DSRIP? We are in year 3 of this program. She said DSRIP rewards providers including NYC Health + Hospitals for performance on delivery system transformation projects that improve care for low-income patients.

She said DSRIP funds federally via Medicaid 1,115 waivers, DSRIP shifts hospital supplemental payments from paying for coverage to paying for improvement efforts. She said you will hear the term, "transforming from volume to value."

Dr. Jenkins said DSRIP´s purpose is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal from the state's eyes of reducing avoidable or unnecessary hospital admissions and readmissions (state-wide) by 25% over 5 years.

Dr. Jenkins said the Centers for Medicare and Medicaid Services (CMS) have approved seven states thus far. There are other DSRIP-like programs as well. She said that the money for New York is safe through 2020. She said we are planning as if there will be no DSRIP 2 due to the presidential election. She said the state Medicaid director said that there is no risk of the program being ended earlier than 2020.

Dr. Jenkins went to the slide CFRP Background next. She explained that CRFP is the Capital Restructuring Financing Program. She gave a brief history of the project: In November 2014, the New York State Department of Health (DOH) released a request for applications for CRFP. There was $1.2B fund available total at the state level. It is a reimbursement program, meaning that we show we met the project aims and then we are given the money. She said this is distinct from the DSRIP funding pool. CRFP is intended to support DSRIP transformation for capital projects that enhance the quality, financial viability, and efficiency of healthcare delivery system.

Dr. Jenkins said that in May 2015, as required, in its role as fiduciary NYC Health + Hospitals submitted all capital requests on behalf of all DSRIP partners in the OneCity Health Performing Provider System (PPS). OneCity Health is our network of roughly 200 partners. She said that we have no role in the awarding of funds or capital project implementation process for any partner organization. We only have to worry about ourself as the biggest partner in the PPS. She said NYS DOH awards and reimburses funds directly to partners. We are not a pass through.

Ms. Youssouf asked if we have any liability with regard to our partners?

Dr. Jenkins said we do not have any liability on how they do their capital projects, how they implement them, or whether they are reimbursed.

Dr. Jenkins said that in May 2015 we submitted our applications. She said in March 2016, we were notified of an award up to $300M for five out of six capital applications. All 3 IT capital projects awarded at full ask. She said each of the IT projects is in service to integrated delivery system build, which may include non-NYC Health + Hospitals organizations. This includes subset provider partners who are important to our core business of Medicaid, uninsured, and behavioral health.

Dr. Jenkins said that since March 2016, we have intensified our IT project planning. This includes PPS Partner Inventory – IT Capability, Patient Consent Forms, and Contracts with Payers.

Dr. Jenkins went to the slide OneCity Health Capital Application Sources Final Submission, May 2015. She explained this is what the actual application looked like. She said we submitted three NYC Health + Hospitals-Led, Centralized/PPS-wide applications for roughly $210 million.

First, there was the contact center ($19 million), which was a way to schedule appointments more efficiently and across sites. It would also be the seed for a possible future clinical center in which nursing and health advice could be given.

She said the second was for a digital health network ($109 million) and the third was for population health IT ($81 M). She said you can think of these two as comprising many smaller projects, many based around hygiene. Let's say a patient goes to multiple hospitals, she said. As his provider, I want to see all of his records. The CRFP allows us to do this.

Dr. Jenkins said here is the summary of our applications led by non-NYC Health + Hospitals' partners, including space renovation, construction, HIT, and equipment. She said there were 23 applications for a total of $141 million (including SUNY for $77 million).

Dr. Jenkins said there were three NYC Health + Hospitals-Led, facility-based applications. These included primary/ambulatory care ($161 million), behavioral health integration ($60 million), and emergency department reconfiguration ($31 million). They totaled $253 million.

Dr. Jenkins said we got less than asked for in one category and got none for primary/ambulatory care. She wanted the Board to know and we do not know the reasons why since it was considered a high-quality application.

Gordon Campbell said it seemed oxymoronic that we would be denied ambulatory when this is the thrust of where we are supposed to be heading.

Dr. Jenkins agreed. She said our Service Line leadership is reviewing all these projects to see what makes sense now as opposed to what made sense in 2015.

Mr. Campbell asked if we took it in-house to try to identify funding since we did not get this.

Dr. Jenkins said we have gone forward with all other plans for ambulatory care expansion under the leadership of Steve Bussey and now Bill Foley. I am not the person to speak in detail to this. She wanted the Board to know that NYC Health + Hospitals got $463 million out of a total of $604 million for the PPS. She said very few applications across the state were awarded.

Dr. Jenkins went to slide CRFP Projects Enable Technology Strategy for Health Improvement. She said she wanted to show an example patient named Maria and the many types of providers she may visit to improve her care. She said they would all need to have connected data exchange to best serve her. She said I put some examples of the projects contained within the two CFRP projects for your consideration today. These include Health Information Exchange (HIE) / Regional Health Information Organizations (RHIOs) Connectivity, Clinical Record Locator Service (CRLS), Telehealth, Contact Center, Electronic Medical Record (EMR), and Social Services Referral Platform.

Dr. Jenkins said very few of our 200 partners in the network had the capability to share information within the RHIO. So we need to invest in some subset of this group to move them forward. She said we have multiple methods of telehealth currently. She said it is key to solving any access problems we have in both subset specialties as well as primary care. She said the contact center can expand to give clinical advice and care management. She said the EMR might be a way to allow a subset to access patient information (not via Epic, but through another method).

Dr. Jenkins said that the social services referral platform will link clinical and non-clinical providers together to understand if our patients are getting what they need, such as legal advice, food pantries, nutrition, and others.

Mr. Campbell asked about our 200 partners, including many which are social services organizations, have they been involved in what will be part of this and what will not?

Dr. Jenkins said multiple OneCity Health partners with us as we did the applications and we had a cross-organization group rank the projects before sending to the state. She said we had others as strategic advisors to make sure we met their needs as well as clinical providers'.

Ms. Lowe asked how you transform physicians' training of many years to go from disease management to wellness, such as population health management.

Dr. Jenkins said we do this slowly and carefully and it takes years. The good news is that we have a lot to build upon. For example, we can look at the Medicare ACO (accountable care organization) and the doctors and teams that lead the efforts on the ground. Here is where data and exchange are important. She said a doctor can say a patient is healthy enough because he only went to the emergency room once last year. But then other ACO lead doctors can use claims data (not just from the EMR) that shows everywhere he went, including more visits at other facilities. You can now get the patient a care manager to speak with him differently to better address his needs.

Mr. Guido said we need data from both internal and external sources so a physician can make these types of determinations. It does not help if they see only a small portion of it that is NYC Health + Hospitals data only. He said we need broader information.

Dr. Jenkins said there is pent up demand to do what seems like common sense. She said these are big ticket items that need joint design and a shared vision of what to build, where and when. She said we are moving as quickly as we can while keeping all the parts together. It will take longer than we want.

Ms. Bolus asked what triggers a doctor to start this process.

Mr. Guido said the doctor would refer to the RHIOs or ask for access to this patient's information. He said the patient will get a referral and the new doctor will automatically know the patient was at the first facility. He will make the request for patient information via his EMR through the RHIO to us. We will then send the information in a secure manner.

Dr. Jenkins said the technology is only useful if it serves the needs of the doctor and the care team. That means the data has to be reliable and as close to real time as possible. She said you have to trust that the physicians want to do the right thing but there are still ways to incentivize them to go look. You have to make sure they have the resources. She said that if a doctor has a patient with depression, is homeless or needs other services, they need a place to refer the patient in the right direction. These projects use technology to help give us a holistic vision of the patient.

Ms. Lowe said we are in the time of population health management. She said we need to know our patients very well to best serve them. We do have metrics for population health including social determinants. I hope the schools are teaching this and it needs to be a mandatory aspect.

Mr. Brezenoff said we need to remember that IT is not driving the policy; the policy is driving IT. IT is the enabler and OneCity Health is the sculptor shaping things. He said there has to be accountability in our organization from everyone for population health and making it happen. IT is a major tool in that.

Mr. Guido asked to remember we are making a large investment in Epic EMR, ERP and other technologies for this very purpose.

Vijay Saradhi addressed the slide DSRIP Program Requires Unprecedented Coordination Between Participating Providers. He said the slide is a microcosm of issues facing all health care organizations. He said you need a greater than 99.99% accuracy. He said we have technologies in place to build out infrastructure for population health.

Ms. Youssouf said there are is a lot of information on this page and we are short on time. So we are going to study this and get to you with any questions.

Mr. Guido said there will be an executive session on all the technologies for you to see.

Ms. Youssouf said that would be great.

Mr. Guido spoke to the slide CRFP Awards For NYC Health + Hospitals IT Projects. He said NYC Health + Hospitals, OneCity Health's lead partner, was awarded three IT capital project grants from New York State under the CRFP program, representing the largest total award by the state. This is how they were allocated: OneCity Health Patient Engagement and Contact Center – $19.4 million (approved by Board – March 2017 Board Meeting for $10 million for IT). We consolidated our 11 call centers into one, saving money and helping our patients.

He said the other projects were Population Health IT – $81.3 million; and Digital Healthcare Network – $109.1 million.

Mr. Guido said these IT projects will create a common access system across OneCity Health partners, enabling care coordination among multiple providers, organizations and CBOs. He said it will provide the ability to track patients, use of accurate data to inform care, and measure and improve care processes and outcomes over time.

Mr. Guido said NYC Health + Hospitals' Matching Funds Derive from the following IT projects: Network Infrastructure, Radiology McKesson, Epic EMR, and Business Intelligence. This means we had to show funds we were spending already to match state funds.

Mr. Saradhi spoke to the slide Population Health: Budget and Milestones. He said we need to collate the data properly. He said New York City Health + Hospitals was awarded a capital grant of $81.3 million to build a Population Health IT infrastructure that will enable the exchange of patient and provider records, accurate patient identification, and ability to aggregate data and leverage automated registries.

Mr. Saradhi went over the projected project durations for Performance, Management, and Analytics (1 – 5 years), Health Information Exchange (1 – 5 years), and Clinical Record Locator Service (1 – 5 years). He said these help with the timely exchange of patient data and communication between patient and provider.

Ms. Youssouf asked if the money has come in and if not, when does it come in.

PV Anantharam said the capital grants are reimbursements. That means we have to spend the money and then we get it back.

Mr. Guido said we have been working with the state on these reimbursements to understand when it will happen.

Ms. Youssouf asked to keep the IT Committee informed.

Mr. Guido said we planned on having status reports monthly on these projects. We want full visibility and transparency. He said we will keep you informed.

Ms. Lowe said that I have some concerns about the performance analytics here. Long term care, for instance, the numbers do not tell the whole story. For some groups, like diabetics, it does not make sense.

Mr. Guido said we are rolling out Epic and other technology to get us better information. We will then plug that information into this to get more accurate readings on clinicals, financials, claims, etc.

Ms. Lowe said we will have a lifetime record for patients.

Mr. Guido said yes. We have an archive system that is a precursor to this.

Ms. Youssouf said before we go to Action Item 2, can we get a motion to move forward.

Mr. Campbell seconded. Motion passed, with Ms. Bolus abstaining.

Jeffrey Lutz addressed Digital Health Care: Budget and Milestones. He said this is a lot of the foundation and support that enables our partners to take advantage of these technologies. He said New York City Health + Hospitals was awarded a capital grant of $109.1 million to build an Unified Communications IT infrastructure that will enable telehealth and telemedicine (which we can discuss in more detail later, if you want), sharing radiology/imaging, and communication with electronic health record systems (EHRs) to exchange patient information.

Ms. Bolus asked if we are connecting new ones or just those we already have.

Mr. Guido said we did a review of our partners' technology and we found that 50% do not connect into a RHIO. For DSRIP to be successful, we are helping them to do so.

Ms. Bolus asked if they do not have the correct equipment, do we supply them.

Mr. Guido said no, we will not supply them with an EMR. The grant allows us to help them get to an EMR platform. We will not become service providers to our partners.

Ms. Bolus said that when she met them, they were often computer illiterates. If it was me, I would need help.

Mr. Guido said we have funds to help them get there. He said we will contract a third party to help them.

Mr. Campbell said to clarify, this is to connect us with our 200 partners, not to Epic.

Mr. Guido said correct, this is just to get them to the state RHIOs.

Ms. Youssouf said that if they won this grant, they must have shown they had the capability to link up to us.

Mr. Guido said yes, they had to show they had an EMR in place. He said they have to attest that they will have these services in place.

Dr. Jenkins said in 2014 we started with DSRIP and the state said to form networks. They envisioned that these 25 PPSes would become legal entities. But that was not possible with less than 90 days of diligence and a lack of understanding as to what DSRIP was. She said we now have 200 partners linked by contract, relationships, small payments, and workflows. She said in the future we will figure out what our network will be.

Mr. Campbell said we have a way to go, but the CBOs have even longer to go.

Mr. Guido said there is a maturity level we need to get to as well.

Ms. Youssouf said you had more originally.

Dr. Jenkins said we originally had 220. It vacillated as we and they figured out how they were structured legally. We are at 185 now with our last contract.

Ms. Bolus asked if our name is in their offices.

Dr. Jenkins said we are working on this and they like us. We need to show them the advantages. There is a lot of co-branded materials.

Ms. Bolus said she would miss Dr. Jenkins, which Ms. Youssouf said she did not know.

Dr. Jenkins said thanks and she is leaving behind a fantastic team dedicated to their goals.

Ms. Youssouf said the first vote is for Action Item 1, the $109 million (Digital Health). Mr. Campbell seconded. Motion to approve the resolution for consideration by the Board of Directors was passed. Ms. Bolus abstained.

Ms. Youssouf said an executive and educational session would be very good.

Mr. Guido said we go before the Board on June 22 and we can discuss privately.

Ms. Youssouf said we should review our vision statement and goals and strategies. Perhaps it can be formal.

Mr. Campbell said there are parts of the digital scorecard we would like to review.

Mr. Guido said he wanted to reiterate Mr. Brezenoff's point: We are enablers of this; we do not put out the business or clinical strategy. That is why we work with groups like Dr. Jenkins'. We have expertise and will give opinions but we follow the business's requirements.

There being no further business, the meeting was adjourned 1:20 PM.

CHIEF INFORMATION OFFICER REPORT

Briefing of the Information Technology Committee of the NYC Health + Hospitals Board of Directors – October 11, 2017

Thank you and good afternoon. I would like to provide the committee with the following brief updates:

Delivery System Reform Incentive Payment (DSRIP) Program

- Population Health IT
  - ➢ Performance Management and Analytics – This is the ability to aggregate data across partners to better manage population health, leverage automated registry functionality, and meet DSRIP/One City Health (OCH)/EITS reporting requirements.
    - o Phase 1: Allowed business users to create ad hoc reports by using filters that can be applied to appropriate data sets. It provided metrics in the following data sets: Readmissions, Patients and Visits, Length of Stay, Patient Satisfaction Survey and Healthcare Associated Infections. This phase was completed and delivered in June 2017.
    - o Phase 2: Create a strategic solution to support OCH's data analytics needs by establishing self-service dashboards. These will allow business users to create ad hoc reports by using filters that can be applied to appropriate data sets. The dashboards will provide both high-level statistical information as well as drill-downs into patient-level details, where applicable. Work stream is currently in the process of setting up workshops for defining the scope and the requirements for the subsequent phases.
  - ➢ Health Information Exchange (HIE) – HIE provides support for OCH Performing Provider Systems (PPS) partners in achieving connectivity to one of the NYC Qualified Entities (QEs) and centralization of QE data at NYC Health + Hospitals. The project scope helps facilitate the exchange of data between NYC Health + Hospitals and three payers (HealthPlus, MetroPlus, and Emblem). This

was finalized as of July 2017. Requirements gathering was completed in August 2017 for the HealthFirst-ADT message type. Requirements gathering is currently in progress for the MetroPlus-ADT message type. It is expected that the scope and requirements finalization for Clinical and Labs for all the three payers will be completed by the beginning of December 2017.

➢ Clinical Record Locator Service – This capability will provide the ability to accurately identify and link patient and provider records across the PPS.

  o Biometrics: In order to meet the Clinical Record Locator Service objectives, a request for proposal (RFP) for Biometrics solution was drafted and approved in the second week of July 2017. This RFP was submitted to the vendors. Responses were expected by end of August 2017. It is expected that the RFP responses will be reviewed and two vendors will be shortlisted by the middle of September 2017. The two shortlisted vendors will begin their three month proof of concept in November 2017 and results reviewed for final vendor selection upon conclusion.

- Digital Healthcare Network

  ➢ Telehealth – This service enables clinicians and/or care teams to monitor or treat medical conditions in a timely and comprehensive manner without the need to be confined to a specific facility or clinic. The Telehealth work stream finalized the program's strategic framework in June 2017. Work stream is currently in the process of identifying and prioritizing high-value opportunities for Telehealth intervention based on clinical use cases. This is anticipated to be completed by November 2017. Business requirements will be determined per the defined priorities and finalized December 2017.

- Contact Center

  ➢ This work stream defined the business and technical scope specification and prioritization in June 2017. It is currently in the process of aligning and confirming the scope specifications and priorities. This is expected to be finalized by November 2017.

EMR GO Program Update:

In September, the GO Enterprise implementation team began the enterprise build and workflow adoption phase, where the gaps from direction are ushered through governance and specialized workgroups for resolution and sign off. The first adoption session is taking place from October 3-5, 2017. Currently, our program status remains at "caution." This is because we have been unable to finalize our enterprise charter due to outstanding scope questions on professional billing, clinical data repository, and third party vendor application standards & contracts. We were able to mitigate physical space limitations by finalizing recommendations to the leadership team and we have aligned EITS network remediation timelines at a high level. In the last two weeks, our support service level agreements (SLAs) dipped below the 90% threshold and we are following management protocols to complete root cause analysis documents. The upgrade to Epic version 2017 planned for December 10, 2017 is on schedule. We are currently in the testing phase and all work streams are reporting on track at this time. Several optimization projects went live in the last reporting period, including the Haiku/Canto Epic Mobile apps at Queens; build and reporting to enable Elmhurst to receive higher Certification from Joint Commission for their Comprehensive Joint Replacement program; and work begins on an analyst manual to standardize operating processes and tools.

Enterprise Resource Planning (Project *Evolve*) Update:

Enterprise Resource Planning (ERP) Phase 1/Wave 2 went live on-time and on-budget over the weekend at East New York, Kings County, MetroPlus, and McKinney. Command centers are currently helping users who reach out in need of help.

Wave 3 is scheduled to roll out in December 2017. Currently, Supply Chain, Finance and EITS staff are working with site Champions and leadership to gather all the necessary information for these coming go-lives.

The week of September 18, Cost Accounting implementation was successfully completed. This project team is currently working on the design of the system.

In order to prepare for coming go-lives, teams have been formed to address pre-Payroll tasks that have been identified throughout the business. The main participants are Finance, Human Resources, Office of Labor Relations, and EITS. The core team training for Payroll and Time & Labor is scheduled for this month. The first meeting for the Enterprise-wide Time Collection Device Evaluation Committee was held and the RFP was released September 25. Proposals are due for evaluation by October 19.

Meaningful Use and QuadraMed 6.2 Upgrade.

The QuadraMed major upgrades are necessary to meet Phase 2 and Phase 3 Meaningful Use (MU) standards. This will make NYC Health + Hospitals' QuadraMed-based facilities eligible for continued financial incentives. Testing and configuration enhancements are completed and now live at four NYC Health + Hospital facilities (Jacobi, North Central Bronx, Harlem, and Woodhull). This upgrade brings enhanced functionality. This includes a consolidated medication reconciliation solution for both Acute and Outpatient venues, improved patient education resources, secure messaging for physician-patient communication, and a newly-designed patient portal. The Patient Portal has been populated with over 70,000 clinical summaries for our patients to access. Training and onboarding continues for our patients and the functionality is expected to be live today, October 3, 2017.

Radiology McKesson Project

All Phase I (Harlem, Metropolitan, Lincoln, and Coney Island), Phase II (Kings, Jacobi, and NCB), and Phase III (Queens) NYC Health + Hospitals' patient care locations are now employing the Conserus Worklist, Peer Review, and the Physician Concierge Service. Elmhurst is scheduled to go live with Conserus Worklist and Concierge Service in October 2017 and Conserus Image Repository in November 2017. The Business Intelligence platform is available for Phase I and II locations, including Phase III Queens and Phase IV Elmhurst locations only. Collection of site-level information is in progress for all Phase I, II, III (Queens), and IV (Elmhurst) locations. It is generating valuable insights. The overall feedback continues to be positive and widely accepted by Radiologists. In particular, the "Physician Concierge Service" is especially popular. It

locates the ordering physician via phone and makes the connection between that physician and the radiologist. This allows for the prompt delivery of critical findings and appropriate care to the patient. A Cross Site Facility pilot solution is also underway for cross-facility readings. The Enterprise PACS Viewer consolidation project is also underway.

This completes my report today. Thank you.

Information Technology Committee Report Out
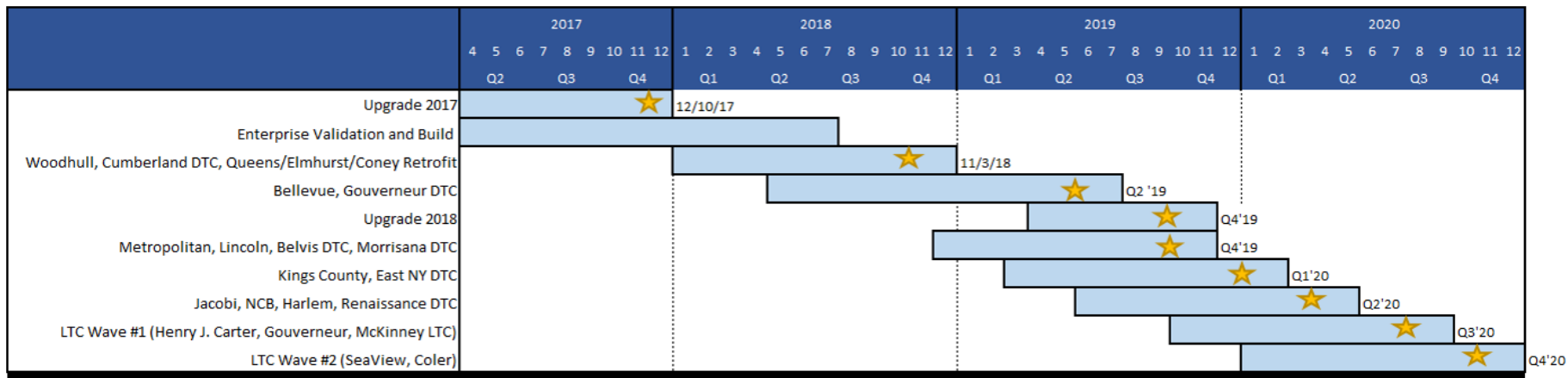
Office of the CIO

October 11, 2017

Table of Contents

GO Enterprise Sequencing

GO Sequencing Version 5.0
As of 6/9/2017
Approved by GO Executive Committee on 5/24/2017
DRAFT

	2017			2018				2019				2020			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Q2	Q3	Q4												
Upgrade 2017			★ 12/10/17												
Enterprise Validation and Build															
Woodhull, Cumberland DTC, Queens/Elmhurst/Coney Retrofit							★ 11/3/18								
Bellevue, Gouverneur DTC									★ Q2 '19						
Upgrade 2018										★ Q4'19					
Metropolitan, Lincoln, Belvis DTC, Morrisana DTC										★ Q4'19					
Kings County, East NY DTC											★ Q1'20				
Jacobi, NCB, Harlem, Renaissance DTC												★ Q2'20			
LTC Wave #1 (Henry J. Carter, Gouverneur, McKinney LTC)														★ Q3'20	
LTC Wave #2 (SeaView, Coler)															★ Q4'20

Executive Summary – GO Program

Status
- 🔴 High Alert
- 🟡 Caution
- 🟢 On Target
- 🔵 Complete
- ⚪ Not Started

GO Staffing

Soarian Integration

Ancillary Systems & Integration

Workflow Process & Build

Training

Facility & Operational Readiness

GO Program

Optimization

Testing

Support

Reporting

Infrastructure

Revenue Cycle Update

- **Direction Sessions:** The GO team conducted all three rounds of direction sessions in the month of August. These sessions set the foundation for future decision making and workflow design throughout the fall. The majority of sessions resulted in a "green" grade, which signifies that 80%+ of decisions needed were made.

- **Third Party Systems:** The GO team identified all Revenue Cycle future state third-party systems and began contracting with each system. This effort is consolidating 16 current systems down to 10 systems after Epic is fully live. We are working to identify target procurement dates for each system.

- **Adoption and Build Sessions:** Begin on September 4th. Ongoing efforts to finalize schedules for Adoption 1 and 2.

- **Professional Billing**: We are in the process of determining whether it is more cost effective to continue with the current outsourced billing solution versus bringing inhouse in preparation for GO Enterprise.

Transformation Activities

Highlighted Benefits of Newly Live Optimizations:

- **Communication Dashboard**: One stop within Epic for all communications and system updates.

- **My Chart Open Notes**: Now live at Coney Island and Queens. Progress Notes are automatically shared for providers in Primary Care and Geriatrics in all three live sites. Patients can view their doctor's note in MyChart and be more involved in their care and the notes the provider writes. This is part of the population health initiative.

- **ED Events**: Improves communication between ED and all services, especially at hospitals that don't use the transport model in Epic, like Queens. It also allows for a log to look back and determine delays between the two departments, and help track turnaround times.

ERP Wave Deployment Approach

The accelerated Wave Deployment schedule will require two Supply Chain Deployment teams who can work concurrently on alternating Waves. All other Project Workstreams will cover all Waves.
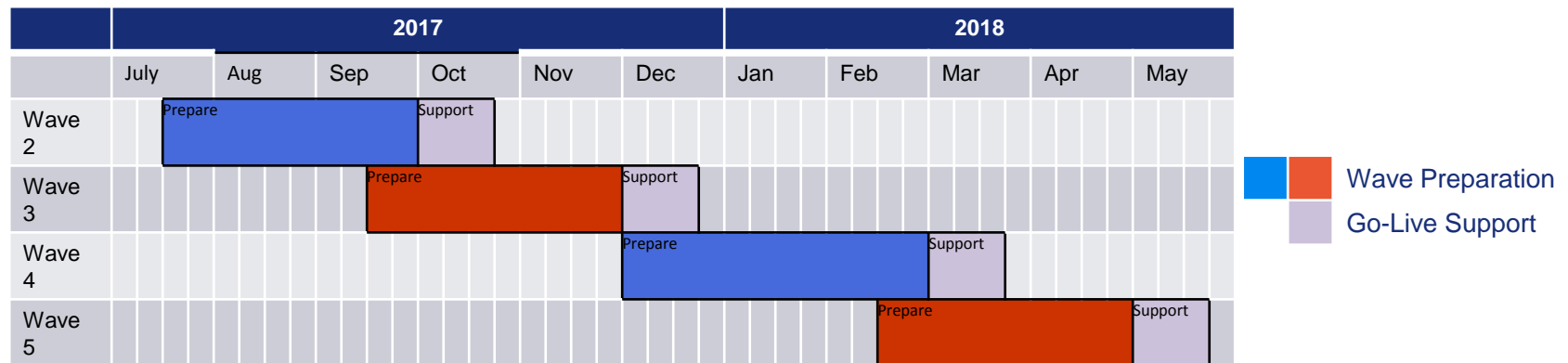
- The Blue Deployment Team will focus on Waves 2 and 4; and will also help support Wave 5 after completing Wave 4 Go-Live Support

- The Red Deployment Team will focus on Waves 3 and 5; and will also support Wave 2 and Production Support until Wave 3 activities begin on September 5th

Facilities in each Wave:
- Wave 2: Kings County, East New York, McKinney, MetroPlus
- Wave 3: Woodhull, Cumberland, Carter, Harlem, Belvis, Sydenham, Morissania
- Wave 4: Gouverneur, Elmhurst, Bellevue, Coler
- Wave 5: Coney Island, Mariner's Harbor, Stapleton, Seaview, NCB, Jacobi, Metropolitan

ERP Program Executive Summary

Wave 1 & 2 (Completed)

Completed Sites: Queens, Lincoln, Central Office, Correctional Health, MetroPlus, Kings, East New York
Issues Uncovered: Budget and requisitioned due to hard stop

Wave 3 ⬌

Project has started. Project plan is being finalized. Epic upgrade (Dec 2) impacts ERP Deployment schedule; revised Wave 3 deployment schedule.
Wave 3: Woodhull, Cumberland, Carter, Harlem, Belvis, Sydenham, Morissania

Overall ERP Program Risk Status ⬌

Cost Accounting ⬌

Material progress has been made on the Pre Work. Staff resources still required for the project. Extracts delayed due to competing project and implementation schedules for Epic & Revenue Cycle. Scheduling of RVU workshops for Elmhurst and Woodhull are behind.
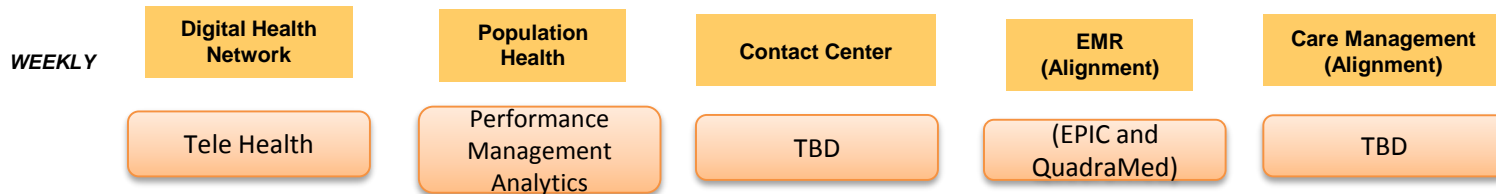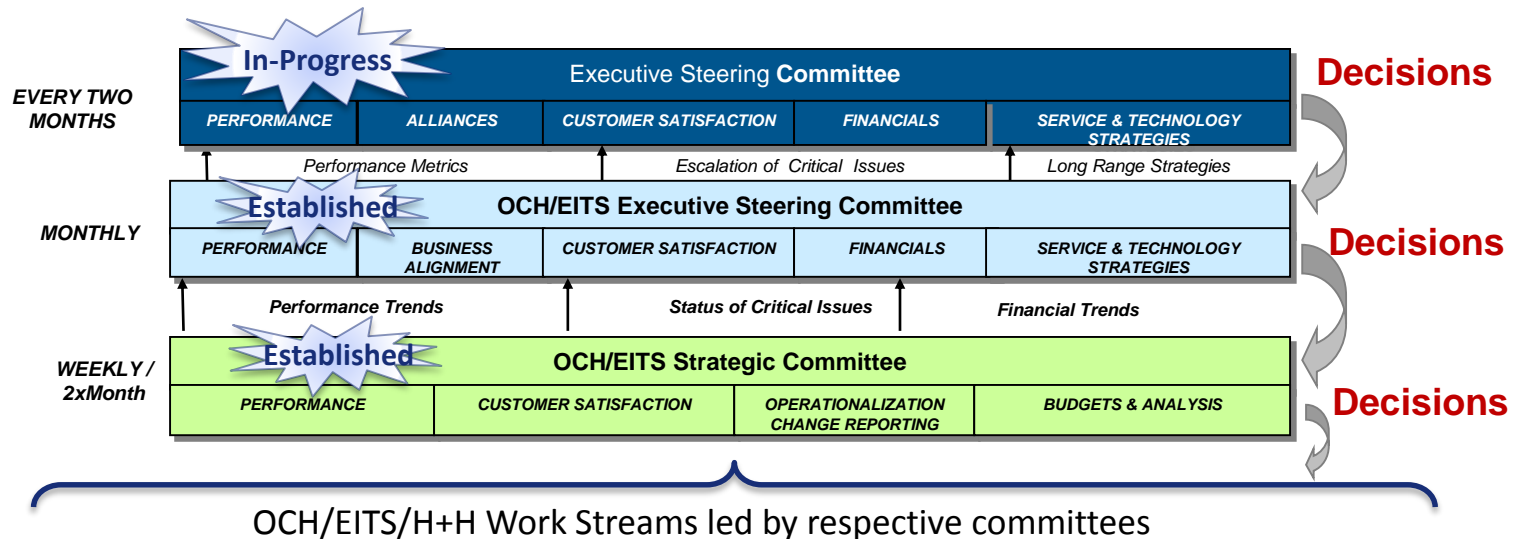
Payroll, Time & Labor ⬌

Pre work has started for the Payroll and Time & Labor project. Material progress on time and pay rules has been made and handoffs to labor are underway.

DSRIP OCH/EITS Program Governance Committees

Governance, asks <u>who benefits</u>, <u>who bears the risk</u> and <u>what resources are needed</u> for decisions
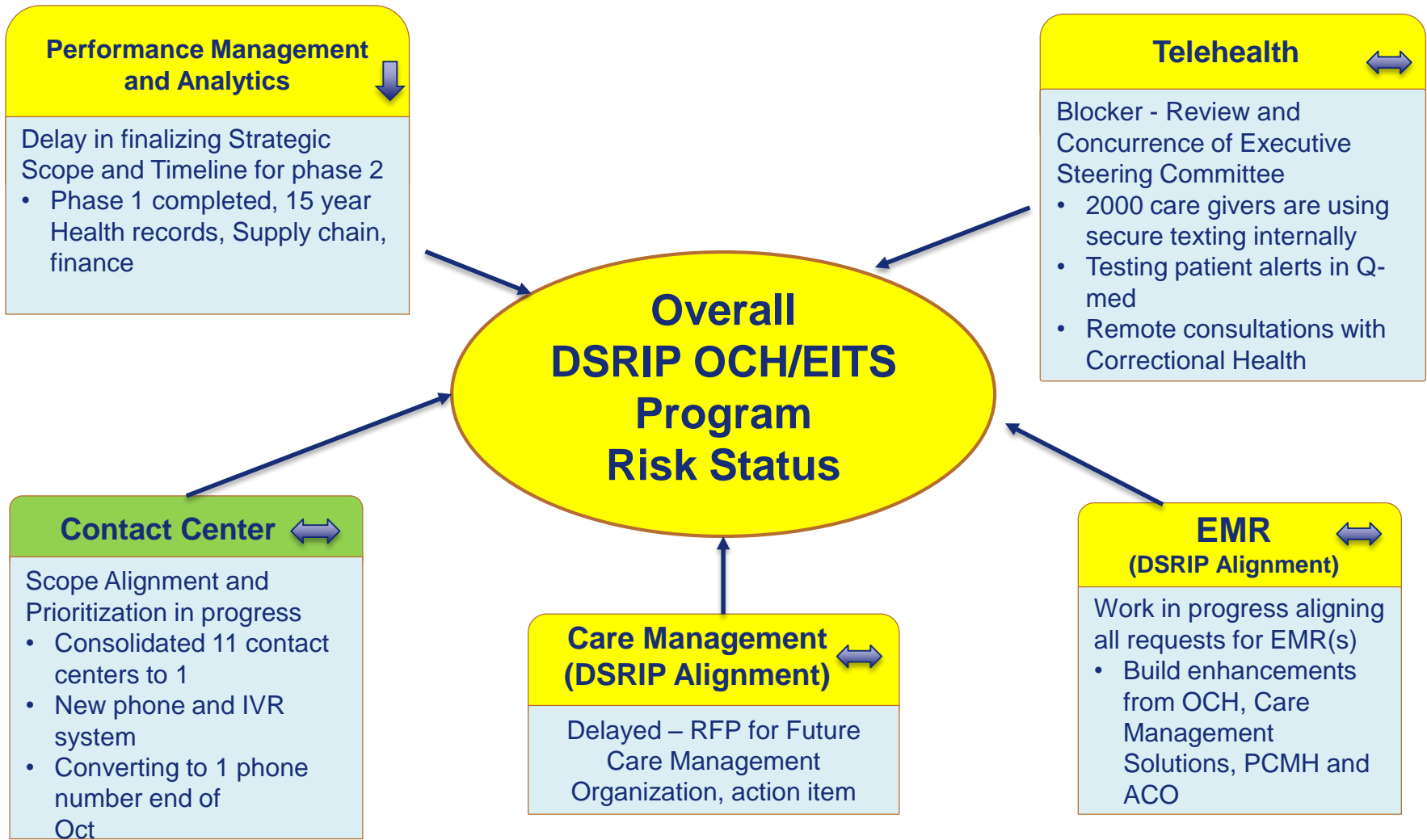
Governance, is about <u>negotiating and making decisions</u> by stakeholders

EVERY TWO MONTHS	In-Progress	Executive Steering **Committee**				**Decisions**
	PERFORMANCE	*ALLIANCES*	*CUSTOMER SATISFACTION*	*FINANCIALS*	*SERVICE & TECHNOLOGY STRATEGIES*	

Performance Metrics — *Escalation of Critical Issues* — *Long Range Strategies*

MONTHLY	Established	OCH/EITS Executive Steering Committee				**Decisions**
	PERFORMANCE	*BUSINESS ALIGNMENT*	*CUSTOMER SATISFACTION*	*FINANCIALS*	*SERVICE & TECHNOLOGY STRATEGIES*	

Performance Trends — *Status of Critical Issues* — *Financial Trends*

WEEKLY / 2xMonth	Established	OCH/EITS Strategic Committee			**Decisions**
	PERFORMANCE	*CUSTOMER SATISFACTION*	*OPERATIONALIZATION CHANGE REPORTING*	*BUDGETS & ANALYSIS*	

OCH/EITS/H+H Work Streams led by respective committees

WEEKLY	Digital Health Network	Population Health	Contact Center	EMR (Alignment)	Care Management (Alignment)
	Tele Health	Performance Management Analytics	TBD	(EPIC and QuadraMed)	TBD

Solution Management Framework Driven Commitments and Deliveries

NOTE: Refer to appendix for the DSRIP OCH/EITS Executive Steering Committee member names and charter.
Pritam Dhavale, DSRIP EITS PMO Program Manager will facilitate the DSRIP OCH/EITS Work Stream Committee meetings.

DSRIP OCH/EITS Executive Summary

NYC HEALTH+ HOSPITALS

Performance Management and Analytics ⬇

Delay in finalizing Strategic Scope and Timeline for phase 2
- Phase 1 completed, 15 year Health records, Supply chain, finance

Telehealth ⬌

Blocker - Review and Concurrence of Executive Steering Committee
- 2000 care givers are using secure texting internally
- Testing patient alerts in Q-med
- Remote consultations with Correctional Health

Overall DSRIP OCH/EITS Program Risk Status

Contact Center ⬌

Scope Alignment and Prioritization in progress
- Consolidated 11 contact centers to 1
- New phone and IVR system
- Converting to 1 phone number end of Oct

Care Management (DSRIP Alignment) ⬌

Delayed – RFP for Future Care Management Organization, action item

EMR (DSRIP Alignment) ⬌

Work in progress aligning all requests for EMR(s)
- Build enhancements from OCH, Care Management Solutions, PCMH and ACO

Trending> ⬆ ⬌ ⬇

| No Risk / In control | At Risk / Caution | At Risk / High Alert |

10

Meaningful Use Eligible Professional Incentives

The objectives of this program are to;

- Improve quality, safety, and efficiency
- Reduce health disparities, and engage patients and family
- Improve care coordination, and population and public health

Specific goals and objectives are created by the Centers for Medicare and Medicare Services (CMS) in which eligible professionals (EPs) must achieve to qualify for Incentive Programs and dollars. Qualifying for Meaningful Use and the Incentive dollars is a two step process:

Step I   Focuses on registering (commonly referred to as Adopt/Implement/Upgrade "AIU") providers who meet specific criteria
Step II   Focuses on providers who successfully meet the objectives of the program (commonly referred to as Attesting).

Step I – Adopt/Implement/Upgrade = $21,500 per provider
2014 – NYC Health + Hospitals successfully completed AIU for 894 providers = Incentive dollars = **$18,997,500**
2015 – NYC Health + Hospitals continued the AIU for an additional 1,291 providers = Incentive dollars = **$21,972,500**
2016 – Final year for AIU process for approximately 1,364 providers = Incentive dollars = **$28,985,000**
         [Elmhurst and Queens will demonstrate and attest to Meaningful Use with Epic in 2016]

Step II – Attesting = $8,500 per provider
2017 – 2021 (5 yr. Period) – Approximately 3,547 Eligible Providers = Approximate 5 year total **$131,622,500**

Meaningful Use Executive Summary
Attestation (Demonstrating) Incentive Dollars for both EMRs

QCPR ⟷

All functionality is in place with 6.2 upgrade occurring Q4-17

Epic ⟷

All functionality currently in place

EP Monitoring ⟷

Clinical Leadership is essential to assure providers achiever benchmarking.
CIS supplies reports and tools monitoring for leadership.

Success dependent on 6.2 Upgrade. Provider performance monitoring is **essential** to assure successful attestation

Dependent on continued monitoring of Provider Performance for successful attestation

EP Monitoring ⬆

Clinical Leadership is essential to assure providers achiever benchmarking.
CIS supplies reports and tools monitoring for leadership.

EH Monitoring ⬆

Clinical Leadership oversight. CIS supplies reports and tools monitoring performance data

EH Monitoring ⬆

Clinical Leadership oversight. EITS Reports and tools monitoring performance data

EP Incentive Dollars for successful demonstrating amounts to ~ 25-28M per year from 2017 through 2012 for a total ~ 131M.

EH Incentive Dollars have already been received from prior years.

Trending> ⬆ ⟷ ⬇

| No Risk / In Control | At Risk / Caution | At Risk / High Alert |

Meaningful Use Executive Summary
Attestation (Demonstrating) Key Areas Epic/QuadraMed

Medication Reconciliation

In place at Jacobi, NCB. Roll out to continue every two weeks for all other sites

Patient Education

Functionality exists at all sites however provider performance has been extremely low with a very high risk of not achieving the benchmarks.

Med Rec and Patient Education are two very key benchmarks that have the **highest risks** for providers not meeting the goal.

Clinical Leadership at both the Senior and Facility levels have been engaged and CIS continues to supply the reports and tools necessary to track providers performance

Patient Portal

Functionality testing continues but ability to achieve benchmark is positive

Secure Messaging

Functionality testing continues but ability to achieve benchmark is positive

Health Information Exchange

Successful testing

Trending>

| No Risk / In Control | At Risk / Caution | At Risk / High Alert |

Radiology Executive Summary

Phase 1, 2 and 3 Sites ⬌

Phase 1 Completed sites: Harlem, Metro, Lincoln, Coney Island
Phase 2 Completed sites: Kings, Jacobi, NCB
Phase 3 Completed sites: Queens and Elmhurst

All sites using Conserus Worklist (CWI) and Concierge Service

Data Migration ⬌

Data migration of historical images for Agfa Site is in progress. Sectra Migration is behind schedule. Solution has been agreed to and will be in place to initiate a fast migration model with the Sectra Sites.

Overall Radiology Program Risk Status ⬌

Phase 4 ⬌

Phase 4 In Progress: Bellevue integrated testing ongoing.

Phase 4 In Progress: Woodhull on schedule to start Oct'2017.

Workforce and Operational ⬌

Workforce decisions, operational decisions & Transformation.
Workforce Design - Ongoing with key stakeholders
Intervention may be needed if the Workforce related changes, agreement and transformation that are still ongoing as part of the negotiation remain delayed. These decisions are key and if require technical adjustments, it may impact the timeline and/or the interdependencies with IT.

Trending> ⬆ ⬌ ⬇ | No Risk / In control | At Risk / Caution | At Risk / High Alert

Appendix

Function	Current State*	Future State	Disposition
Clinical Bill Coding Compliance	Soarian	3m Encompass 360	Replaced
Dictation and Transcription	WebMD and FutureNet	Dragon and TBD(Transcription)	Replaced
Patient Transfers and acute care referrals	Soarian	Epic Tapestry	Replaced
Mobile access to Patient Portal	N/A	Epic MyChart	Replaced
Patient Kiosk	Soarian	Epic Welcome	Replaced
Patient portal	N/A	Epic MyChart	Replaced
Patient Services on Smartphone's	N/A	Epic MyChart	Replaced
Dental	Dentrix	Dentrix	Remains
Acute care charge coding	3M	3m Encompass 360	Remains
Acute care claims management and EDI	HDX	Change Healthcare (Emdeon)	Replaced
Address Verification	HDX	Change Healthcare (Emdeon)	Replaced
Admit/Discharge/Transfer (ADT)	Soarian	Epic Grand Central (BedTime)	Replaced
Ambulatory care claims Electronic Data Interchange (EDI)	HDX	Change Healthcare (Emdeon)	Replaced
APC Grouping	3m	3m Encompass 360	Remains
Claims Clearing House	HDX	Change Healthcare (Emdeon)	Replaced
Encoder	3m	360 Encompass	Remains
Health care insurance payors	HDX	Change Healthcare (Emdeon)	Replaced
Hospital Billing	Soarian	Epic HB	Replaced
Hospital owned medical and radiation oncology coding	N/A	3m Encompass 360	New
Hospital owned outpatient service coding	PhyCare	3m Encompass 360	Replaced
Insurance/Medicare Elgibility	HDX	Change Healthcare (Emdeon)	Replaced
Managed Care	Allscripts	TBD	Replaced
Patient Scheduling	Soarian	Epic Cadence	Replaced
Payment Safe	Unknown	Chase	New
Pharmaceutical 340B program support	Sentry	Sentry	Remains
Physician Credentialing	IntelliCred	IntelliCred	Remains
Professional Billing	PhyCare	Epic PB	Replaced
Provides patient cost estimates	PPS Pricer	3m Encompass 360	Replaced
Registration	Soarian	Epic Prelude	Replaced
Reminder phone calls	TeleVox	TeleVox	Remains
Scheduling	Soarian	Epic Cadence	Replaced
Statement Printing	HDX	Change Healthcare (Emdeon)	Replaced
Enterprise Master Person Index	Soarian	Epic EMPI	Replaced

*In some cases current state is known or in progress of change.

ERP Program - PeopleSoft Wave 3

NYC HEALTH+ HOSPITALS

Overall Summary	Y
	➡

Scope	Resources	Schedule
Y	Y	Y
➡	➡	➡

Project Trends Key:
⬆ Trending Up (Improving) ➡ Flat Trend (Steady) ⬇ Trending Down (Declining)

Key Accomplishments & Decisions

SUMMARY: Due to 2 week delay start of Wave 3 and the aggressive schedule, project plan dates were adjusted to fit the reduced timeline.
- Decision needed to address resource deficit of 4 people identified due to reallocation and loss of resources.
- Leadership kickoff conference calls have been held.
- Wave 3 facility kickoff meetings have been scheduled.
- Data extract files from the Wave 3 facilities have been received.
- Project team members onsite at the Wave 3 facilities performing validations.
- Budget workshops being held with local facilities.
- Begin gathering end user security lists from the facilities.

Planned Activities

- Continue with Budget workshop meetings with the Wave 3 facilities.
- Continue onsite validations at the facilities.
- Continue end user security list gathering for the facilities.
- Facility kickoff meetings to be held.
- Prepare Test and QA database environments.
- Configure Wave 3 business units in Test and QA environments.
- Start data conversions in Test environment.
- Schedule and plan Training logistics.
- Update finance and supply chain training materials.
- Schedule post go live local command centers for each facility.

Top Risks or Issues Needing Leadership Attention (see next slide)	Priority/ Severity	Target Resolution Date
Due to the delay with finalizing wave 3 facilities wave three activities started 2 weeks later than planned and could impact the 12/4 go live.	High	10/17
Long Term Production Support – Determined that additional resources are needed for production support to provide ongoing support for waves 1 & 2 as well as additional needs for future wave facilities.	High	10/17
Project Team Resource Deficit for Wave 3	High	10/17
Harlem and Woodhull does not have COO which impacts Project Team efforts.	Medium	10/17

■ High impact/concern   ■ Moderate impact/concern   ■ Low impact/concern

Milestone Name/Description	% Complete	Target	Status
Data Extracts	100%	09/15	Completed
Budget Detail	15%	10/17	In Progress
End User List and Security	5%	10/17	In Progress
Data Validation	20%	10/27	In Progress
Configuration	0%	10/12	Not Started
Database Environments	0%	10/30	Not Started
Data Conversion & Sign Off	0%	11/21	Not Started
Security Configuration	0%	11/01	Not Started
End User Training	0%	12/01	Not Started
Smoke Testing	0%	11/22	Not Started
Production Cutover	0%	12/02	Not Started

Note: % Complete = # of subtasks / total subtasks, **R** indicates an agreed revision in target date

■ Milestone complete   ■ Milestone on track   ■ Milestone at risk   ■ Missed milestone

NYC HEALTH+ HOSPITALS

ERP Program - Cost Accounting

		Scope	Resources	Schedule
Overall Summary	Y	G	Y	Y
	→	→	→	→

Top Risks or Issues Needing Leadership Attention (see next slide)	Priority/ Severity	Target Resolution Date
Scheduling of CT Scanner & Medicine Workshops	Medium	10/10 R

🟥 High impact/concern   🟨 Moderate impact/concern   🟩 Low impact/concern

Project Trends Key: ⬆ Trending Up (Improving)   ➡ Flat Trend (Steady)   ⬇ Trending Down (Declining)

Key Accomplishments & Decisions

- Facilitated HPCM Design Meeting with focus on reporting and costing methodology
- Conducted Cost Accounting Data Mart and Integrations Design Meeting
- Produced workbooks with populated RVU output tabs for individual job categories to input into future HPCM System for all ED, Surgery, and Diagnostic Radiology departments
- Continued developing physician financial structure that consistently aligns affiliation contract expenses with physician revenue
- Completed plan to transfer knowledge from pre-work to HPCM implementation teams

Milestone Name/Description	% Complete	Target	Status
RVU Workshops – ED, Surgery, X-Ray, OB/GYN	100%	9/30 R	Completed
RVU Workshops – CT Scanner, Medicine	37%	10/30	In Progress
Reconciled Workbooks – ED, Surgery, X-Ray	100%	9/30 R	Completed
Reconciled Workbooks – OB/GYN, CT Scanner, Medicine	27%	10/30	Not Started

Planned Activities

- Review deliverable checklist with NYCHH cost accounting team
- Continue conducting design sessions with HPCM stakeholders
- Determine methodology for aligning revenue and expense for OB/GYN services and reconcile workbooks to develop labor RVUs
- Schedule and facilitate remaining CT Scanner and Medicine workshops in October by NYCHH DSS team
- Continue populating indirect allocation *Statistics Configuration Template*
- Test extracts for patient accounting and clinic systems for HPCM

Individual Project	% Complete	Target	Status
Project #1 - PMO Oversight	100%	8/31	In Progress
Project #2 - Revenue Alignment	100%	7/30 R	Completed
Project #3 – RVU Development	85%	10/30 R	In Progress
Project #4 – Extract Dev (Cerner)	80%	10/15 R	In Progress
Project #5 – Governance & Policy	100%	9/30 R	Completed
Project #6 – Advanced Costing Prep	40%	9/30 R	In Progress
Project #7 – DSS Education (CM)	100%	9/30 R	Completed

Note: % Complete = # of subtasks / total subtasks, **R** indicates an agreed revision in target date

🟦 Milestone complete   🟩 Milestone on track   🟨 Milestone at risk   🟥 Missed milestone

NYC HEALTH+ HOSPITALS

DSRIP EITS/OCH Program - Performance Management and Analytics

Overall Summary	Y
	⬆

Scope	Resources	Schedule
G	G	Y
➡	➡	➡

Top Risks or Issues Needing Leadership Attention (see next slide)	Priority/ Severity	Target Resolution Date
Lack of adequate communication from DOH	High	TBD

■ High impact/concern   ■ Moderate impact/concern   ■ Low impact/concern

Project Trends Key: ⬆ Trending Up (Improving)   ➡ Flat Trend (Steady)   ⬇ Trending Down (Declining)

Key Accomplishments & Decisions

- Initial meeting conducted to discuss requirements for the DSRIP Outcome metrics
- Schedule weekly OCH/EITS Analytics work stream meeting
- Develop standardized process for requesting, vetting, and engaging for DSRIP Outcome metrics (EITS Data Reporting In-Take Process)
- Draft Performance Management and Analytics Charter reviewed by Co-Chairs
- Delivered the first 3 tactical reports:
  - 30 Day Follow-up Post Psychiatric Hospitalization
  - Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8%)
  - Comprehensive Diabetes Care: A1c (HbA1c) Poor Control (>9.0%)

Planned Activities

- New Updates: Data Sciences team gathering requirements for 43 tactical reports
- Co-chairs to review and finalize plan for next phases
- Resource plan and hiring in progress by EITS Data Sciences
- Regular meetings scheduled to gather requirements for tactical metrics
- EITS to schedule workshop meetings to gather and complete the strategic analytics and data reporting requirements over the next 3 - 4 weeks.

Milestone Name/Description	% Complete	Target	Status
EITS to crosswalk completed and pending Phase 1 work with CRFP PMA grant deliverables and enumerate remaining outstanding deliverables	100%	6/16/17	Completed
EITS to map completed and pending Phase 1 work to CRFP PMA budget and enumerate $ resources used, in use, and remaining	100%	6/30/17	Completed
OCH to complete internal scoping of new work streams as part of OCH transformation		12/29/17	In Progress
Presentation of draft scope and approach to OCH leadership to discuss and align strategically	100%	9/29/2017	Completed
EITS BA to gather program data requirements for reporting and analytics from OCH work streams to develop working inventory of data and analytics needs		12/29/17	In Progress
OCH to create high level initial draft of PMA strategic plan inclusive of infrastructure, reporting, analytics, visualization and resources needed		1/26/18	In Progress
OCH PMO to draft a project plan for an approach to meeting those data needs outlining strategies, timelines, and resource requirements		1/26/18	Completed

Note: % Complete = # of subtasks / total subtasks, **R** indicates an agreed revision in target date

■ Milestone complete   ■ Milestone on track   ■ Milestone at risk   ■ Missed milestone

DSRIP EITS/OCH Program - Telehealth

NYC HEALTH+ HOSPITALS

Overall Summary	Y
	➡

	Scope	Resources	Schedule
	G	G	Y
	➡	➡	➡

Top Risks or Issues Needing Leadership Attention (see next slide)	Priority/ Severity	Target Resolution Date
Lack of adequate communication from DOH	High	TBD

■ High impact/concern   ■ Moderate impact/concern   ■ Low impact/concern

Project Trends Key:
⬆ Trending Up (Improving)   ➡ Flat Trend (Steady)   ⬇ Trending Down (Declining)

Key Accomplishments & Decisions

- Prioritization matrix and weights
- Rounding out initial Work Stream membership
- Scheduled regular meeting cadence for Work Stream
- Approved Prioritization and Governance Structure within Telehealth Work Stream and sent deliverables

Planned Activities

- Subgroups identified to develop survey and methods for User Feedback strategy to collect patient and provider input on Telehealth access, literacy and preference
- *Telehealth Learning Opportunities* for Work Stream from different departments
- Prepare budgets and identify needed resources
- Collecting program and technical requirements for first round of Telehealth Initiatives (Patient Appointment Reminders)
- Socialize Vision across corporation including Board, Senior Management and Hospital Leadership.
- Deeper review of QuadraMed Patient Portal and alignment with Vision / identified area of concentration – Patient Portal
- Continue with Work Stream *Telehealth Learning Opportunities* to evaluate and prioritize use cases for potential technology procurement

Milestone Name/Description	% Complete	Target	Status
Transition Task Force to Work Stream	100%	4/28/17	Completed
Hire Telehealth Program / Project Managers	100%	6/30/17	Completed
Finalize Telehealth Strategic Framework	100%	6/30/17	Completed
Approve Prioritization and Governance Structure within Telehealth Work Stream	100%	8/31/2017	Completed
Collect Patient Feedback		12/29/17	In Progress
Initial Interventions Approved by Telehealth Work Stream		10/27/17	In Progress
Finalize Projected Spending for FY 1 Based on Prioritized Use Cases and Scope		10/27/17	In Progress
Identify and prioritize high-value opportunities for telehealth intervention based on clinical use cases		11/30/2017	In Progress
Communicate telehealth work stream governance and goals across system		10/27/17	In Progress
Determine business requirements and program support necessary for telehealth interventions per defined priorities		12/29/17	Not Started

Note: % Complete = # of subtasks / total subtasks, **R** indicates an agreed revision in target date

■ Milestone complete   ■ Milestone on track   ■ Milestone at risk   ■ Missed milestone

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NYC HEALTH+ HOSPITALS

DSRIP EITS/OCH Program - Contact Center

Overall Summary	Y
	⬇

Scope	Resources	Schedule
G	G	Y
➡	➡	➡

Top Risks or Issues Needing Leadership Attention (see next slide)	Priority/ Severity	Target Resolution Date
Lack of adequate communication from DOH	High	TBD

🟥 High impact/concern   🟨 Moderate impact/concern   🟩 Low impact/concern

Project Trends Key: ⬆ Trending Up (Improving)   ➡ Flat Trend (Steady)   ⬇ Trending Down (Declining)

Key Accomplishments & Decisions

- Initial requirements for Contact Center work stream were drafted

Planned Activities

- Determining the breakdown of the funds allocated from the DSRIP CRFP grant to align with needed system integration.
- Convert to single phone number for all four centers
- Discovery and gap analysis underway
- Consolidation of internal operations currently under review:
  - Call abandonment rate
  - Ticketing system
  - Call tracking
  - Process consistency
- Results of review to be incorporated into short term and long term roadmap

Milestone Name/Description	% Complete	Target	Status
Define Scope Specs and Prioritization (Business & Technical)	100%	6/28/17	Completed
Align Scope Specs and Prioritization (Business & Technical)	100%	8/30/17	Completed
Finalize Scope Specs, establish High Level Milestone		10/30/17	In Progress
Select and Procure full contact center solution		2/28/2018	Not Started
Complete design and finalize call flows based on selection		2/28/2018	Not Started
Publish finalized implementation plan		2/28/2018	Not Started
Integrate solution with Soarian Scheduling		7/27/18	Not Started
Integrate solution with Epic Scheduling (Cadence)		7/27/18	Not Started
Convert/Pilot Bronx Call Center		18/27/18	Not Started
Convert Brooklyn Call Center		10/29/18	Not Started
Convert Queens Call Center		12/29/2018	Not Started
Convert Manhattan Call Center		2/28/2019	Not Started

Note: % Complete = # of subtasks / total subtasks, **R** indicates a revision in target date per NYCHH request due to resource limitations

🟦 Milestone complete   🟩 Milestone on track   🟨 Milestone at risk   🟥 Missed milestone

NYC HEALTH+ HOSPITALS

OCH/EITS Partner Portal (Support/Development)

Overall Summary	G
	➡

Scope	Resources	Schedule
G	G	Y
➡	➡	➡

Top Risks or Issues Needing Leadership Attention (see next slide)	Priority/ Severity	Target Resolution Date

🟥 High impact/concern   🟨 Moderate impact/concern   🟩 Low impact/concern

Project Trends Key: ⬆ Trending Up (Improving)   ➡ Flat Trend (Steady)   ⬇ Trending Down (Declining)

Key Accomplishments & Decisions

- Decision made to move current state cloud hosted environment in-house
- Development environment on-prem configuration completed (DB/VM)
- Azure DB environment converted to on-prem completed
- Decision made to complete September Metrics development in Azure, in parallel to on-prem environment configuration
- Production environment:
  - 1 server in each datacenter, internal LTM load balancing will not be required
  - Internal FQDN will be load balanced by GTM only
  - DMZ LTM will be the reversed proxy for internal servers via port 443
  - Public certificate will be reside on the servers
- Two metrics were developed and moved to production on Sep 15, 2017.
- Remaining 4 September Metrics developed and deployed to Production on Sept 28, 2017

Planned Activities

- 2017 Remaining Metrics Development:
  - Securing the environment. Building an on-site environment and migrating data and code to the new environment.
  - October/December Metrics: Approximately 30+ metrics will be added as part of this deliverable
- User Acceptance Testing
- Go-live transition/migration activities to on-prem environment.
- 2018 Metrics Development:
  - Requirements are yet to be defined. We will streamline the process so that we can collect the requirements and generate the metrics in an orderly fashion while enhancing auditability and reporting.

Milestone Name/Description	% Complete	Target	Status
Development Environment Config	100%	9/15/17	**Completed**
Azure DB environment converted to on-prem	100%	**9/15/17**	**Completed**
Modify upload process to store files in new DB as opposed to Azure Blob storage	50%	10/4/17	**In Progress**
Test Migration	0%	9/22/17	**In Progress**
Test Migration (App/DB only)	100%	9/22/17	**Completed**
Production Environment Config	95%	10/2/17	**In Progress**
September Metrics Development & Testing (total of 6)	100%	9/30/17	**Completed**
Production Migration (Azure to On-Prem)	0%	10/11/17	**In Progress**

Note: % Complete = # of subtasks / total subtasks, **R** indicates an agreed revision in target date

🟦 Milestone complete   🟩 Milestone on track   🟨 Milestone at risk   🟥 Missed milestone

Radiology Program

Overall Summary	Y
	➡️

	Scope	Resources	Schedule
	G	Y	Y
	➡️	➡️	➡️

Project Trends Key:
- ⬆️ Trending Up (Improving)
- ➡️ Flat Trend (Steady)
- ⬇️ Trending Down (Declining)

Top Risks or Issues Needing Leadership Attention	Priority/ Severity	Target Resolution Date
Data Migration Progress Delays – Start Migration	Medium	12/30/17

- 🟥 High impact/concern
- 🟨 Moderate impact/concern
- 🟩 Low impact/concern

Key Accomplishments & Decisions

- Cross Site Facility in PROD and validated between Met to Harlem; Harlem to Lincoln; Met to Lincoln; Harlem to Lincoln.
- Concierge Service - majority of all Radiologists trained at facilities Phase I, II and Queens.
- Bellevue integrated testing continuing with Carter, Coler, Goveneur DTC/SNF
- Elmhurst Integrated testing has begun
- Servers for Sectra Fast Migration were configured, testing is complete.
- Queens CIR GL – Completed
- Cross Facility Production Pilot & Demo Completed

Milestone Name/Description	% Complete	Target	Status
Interface Connections – Queens	100%	9/13	Completed
CIR Testing – Queens	100%	9/19	Completed
CWI Worklist – Elmhurst	90%	10/13	In-Progress
Concierge Service – Elmhurst	50%	10/20	In-Progress
CIR – Elmhurst	10%	11/17	In-Progress
Business Intelligence – Woodhull	0%	11/16	Not Started

Planned Activities

- CIR 3.0 - upgrade will take place – Targeted for end of October.
- Data Migration 12/2017
- EHC – CIR GL 11/19/17
- Radimetrics Implementation 2/23/2018
- Sectra Fast Data Migration
- Woodhull integrated testing begins 10/5
- Powerscribe upgrade slated for October & November

Individual Project	% Complete	Target	Status
Project - Queens	100%	9/27	Completed
Project - Elmhurst	25%	11/17	In Progress
Project - Woodhull	6%	12/6	In Progress
Project – Bellevue	8%	10/19	In Progress

Note: % Complete = # of subtasks / total subtasks, **R** indicates an agreed revision in target date

- 🟦 Milestone complete
- 🟩 Milestone on track
- 🟨 Milestone at risk
- 🟥 Missed milestone