AGENDA

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE
BOARD OF DIRECTORS

Meeting Date: March 22, 2012
Time: 2:30 PM
Location: 125 Worth Street, Room 532

CALL TO ORDER — **DR. STOCKER**

ADOPTION OF MINUTES
-February 29, 2012

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

METROPLUS HEALTH PLAN — **DR. SAPERSTEIN**

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

INFORMATIONAL ITEMS:

1. Research — **DR. WILSON/ MS. COIRO**
2. Chronic Disease & Preventive Health — **DR. WILSON**

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

MINUTES

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE BOARD OF DIRECTORS

Meeting Date: February 29, 2012

ATTENDEES

COMMITTEE MEMBERS:

Michael A. Stocker, MD, Chairman
Alan D. Aviles
Josephine Bolus, RN

OTHER BOARD MEMBERS:

Amanda Parsons, MD (representing Thomas A. Farley, MD)

HHC CENTRAL OFFICE STAFF:

Donna Benjamin, Restructuring Project Management Officer
Deborah Cates, Chief of Staff, Board Affairs
Louis Capponi, MD, Chief Medical Informatics Officer
Paul Contino, Chief Technology Officer
Joanne Haberlin, Corporate Risk Manager, Risk Management
Mark Hartman, Senior Counsel, Legal Affairs
Lauren Johnston, Senior Assistant Vice President/Chief Nursing Officer, Patient Centered Care
Irene Kaufmann, Senior Assistant Vice President, Community Physician Services
Robert Kurtz, MD, Senior Clinical Advisor to Chief Medical Officer
Patricia Lockhart, Secretary to the Corporation
Ronald Low, MD, Senior Director, Office of Statistics and Data Analysis
Tamiru Mammo, Deputy Chief of Staff, Office of the President
Ana Marengo, Senior Vice President, Corporate Communication & Marketing
Antonio D. Martin, Executive Vice President/Corporate Chief Operating Officer
Kathleen McGrath, Senior Director, Communications & Marketing
Susan Meehan, Assistant Vice President, Medical & Professional Affairs
John Morley, MD, Deputy Chief Medical Officer
Bert Robles, Senior Vice President, Information Technology/Corporate Chief Information Officer
David Stevens, MD, Senior Director, Health Care Improvement
Steven Van Schultz, Director, Office of Internal Audits
Manasses Williams, Assistant Vice President, Affirmative Action/EEO
Ross Wilson, MD, Senior Vice President/Corporate Chief Medical Officer, Medical & Professional Affairs

FACILITY STAFF:

Chris Constantino, MD, Executive Director, Elmhurst Hospital Center
Lynda D. Curtis, Senior Vice President, South Manhattan Network
Iris Jimenez-Hernandez, Senior Vice President, Generations +/Northern Manhattan Network
Terry Mancher, Chief Nurse Executive, Coney Island Hospital
George Proctor, Senior Vice President, Central & Northern Brooklyn Network
Arnold Saperstein, Executive Director, MetroPlus Health Plan, Inc.
Arthur Wagner, Senior Vice President, Southern Brooklyn/SI Network
William Walsh, Senior Vice President, North Bronx Healthcare Network
Meryl Weinberg, Executive Director, Metropolitan Hospital Center
Roslyn Weinstein, Executive Director, Kings County Hospital Center

OTHERS PRESENT:

Melissa Dubowski, Analyst, Office of Management and Budget
Scott Hill, Account Executive, QuadraMed Corp.
Richard McIntyre, Key Account Executive, Siemens
Megan Meagher, Analyst, Office of Management & Budget

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE Wednesday, February 29, 2012

Michael A. Stocker, MD, Chairman of the Board, called the meeting to order at 2:42 P.M. The minutes of the January 26, 2012 Medical & Professional Affairs/IT Committee meeting were adopted.

CHIEF MEDICAL OFFICER REPORT:

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

1. Health Home

HHC has been designated as a Health Home by NYS DOH in the Bronx and Brooklyn, for patients with multiple chronic conditions, serious and persistent mental illness or HIV. We have applied for the same status in Manhattan and Queens; and have again done so as an explicit partnership between the HHC delivery system with the HHC health plan, MetroPlus. Patients will commence being assigned in the next month and appropriate staffing and protocols are being developed. They have reduced the scope of the program (60%) by removing a large segment of patients who were the least complicated and they wish to start off with the most complicated 5% of patients who are extremely complicated with no connection to ambulatory services. This does have significant complications to us operationally and we are in discussion with them as to how that will actually work.

2. Emergency Operations Plans

The HHC Office of Emergency Management presented a Request for Proposal (RFP) to the Contract Review Committee to select a qualified vendor to develop Emergency Operations Plans (EOPs) for HHC's 11 Acute Care facilities, 4 Long Term Care facilities and Central Office. The EOPs must meet all applicable Federal, State, City and other organizations regulatory requirements. The vendor will develop EOPs that are consistent in content and layout, however are customized to each facility based on their Hazard Vulnerability Analysis, services provided, patient mix, catchment area, campus, etc.

In addition, the vendor will develop and provide EOP training for key personnel and develop a PowerPoint training program for remaining personnel that is facility specific. Separate from this RFP but to be included in the overall project, we will purchase a new computerized Incident Command System (ICS), Emergency Alert system and computer equipment for each facility Command Center. The project will conclude with a Corporate-wide functional exercise and After Action Report which will test the EOPs, Command Center systems and interoperability, and the efficacy of the training programs.

Funding for this project is provided from a $1,000,000 grant through the State Department of Homeland Security.

3. Credentialing

After many months of preparation and work we are nearing a significant milestone in our effort to have a single and consistent credentialing process for the Corporation. At a recent meeting with the HHC Medical Directors a presentation of the credentialing software was done by ***Medkinetics***™ - http://www.medkinetics.com/contact.cfm. ***Medkinetics*** is the vendor contracted by ***Anthem***. (HHC contracts with ***Anthem*** as our CVO, or Central Verification Organization.) Their on-line product will enable

central office and local views of credentials and privileges of all licensed physician and midlevel providers in the Corporation as well as Quality metrics meeting the Joint Commission criteria for FPPE and OPPE (Focused and Ongoing Professional Evaluation), as well as a consistent listing of privileges. The Medical Directors expressed clear support for the effort and look forward to the roll out over the next several months for every clinical department in each of the HHC facilities – Ambulatory, Acute and Long Term Care.

4. Drug Shortages

The issue of medication shortages has been in the press for well over a year. Unfortunately it is not getting better and in fact shows signs of getting worse. Chemotherapy, Anti-microbials and anesthetic agents are the most common category of medication in short supply. The state and federal governments are aware and a recent FDA Bulletin was issued to increase awareness (http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm292658.htm) and to announce a new effort to increase chemotherapy availability by permitting importation from Europe. Every facility is aware and the Pharmacy Directors and Medical Directors are coordinating those efforts. Medical staff are identifying alternative medications where feasible and restrictions are being placed on critical drugs in short supply to ensure optimum utilization. Would like to commend all HHC Pharmacy Directors who have been enormously resourceful in providing an ongoing supply of drugs – they have been amazing at what they have been able to achieve. Also physicians in authorizing regularized substitutions for common drugs that are not available – ongoing review to ensure our formulary do line up with existing guidelines that we use and if they don't we put substitutions into the guidelines – lastly, we are not using the grey market to source replacement drugs.

5. Emergency Department Dashboard

The Emergency Department (ED) standardization project began in March 2010, as HHC recognized that we had a high degree of variation in data capture among the EDs that made comparative and throughput reporting difficult. This project utilized electronic monitors (whiteboards) and enabled the tracking of patient flow via real-time updates triggered by electronic clinical documentation and standardized the data capture for key ED processes - the last facility (ten in total) went live in November 2011.

Although data capture was made consistent across the Corporation, ED directors still required access to their key performance metrics easily and quickly to reduce bottlenecks to improve operational workflow, analyze trends to identify areas for improvement and, for executives, enable comparative reporting between the EDs in the Corporation. The ED electronic dashboards project was conceptualized to meet these needs and began being implemented in November 2011, in order to support decision making. This dashboard enables the EDs to better manage their throughput by providing a solution that identifies bottlenecks in their ED in near-real time. The active and dynamic management of the ED reduces patient wait time, increases provider productivity and increases patient satisfaction, all leading to improved patient care.

Feedback from facilities has been highly positive. Facilities have commented the dashboard currently enhances team/area assignment, documentation, assessment of patient flow, and monthly reporting. Eight facilities currently have access to the dashboards. The last two facilities will have access by March 9, 2012.

6. Nurses Improving Care to Healthsystem Elders (NICHE) Program

Harlem Hospital Center, North Central Bronx Hospital, and Queens Hospital Center are participating in a grant funded by FanFox and the Hartford Foundation to improve the care of the elderly. They have all met

and exceeded the goals for the first year for education, enhancing the structure of the multidisciplinary approach, and are currently working to enhance the environment to make it more conducive to caring for the special needs of the elderly. HHC has done so well that NYU, a partner in the grant has filed for an expansion to include Lincoln Medical & Mental Health Center, Elmhurst Hospital Center, Jacobi Medical Center and Coney Island Hospital in the upcoming new grant year. A pamphlet is attached for more information.

7. GNYHA Nursing Interns Preceptor Program

GNYHA has invited HHC to participate in a grant funded project to provide a six (6) month internship for new licensed RN's with BSN. Bellevue Hospital Center, Metropolitan Hospital Center and Kings County Hospital Center have expressed the desire to participate. Each site will get three (3) – four (4) "interns" who will be paid by the grant. The facilities will be provided the incremental costs for the precepting of the nursing interns. If positions are available when the internship is complete we may choose to employ them.

8. RN to BSN Program

The RN to BSN federal grant through HRSA (Health Resources and Services Administration) is ongoing at Kings County Hospital Center and Generation +/Northern Manhattan Network. Approximately 50 RN's are in the midst of pursuing their BSN's. The Kings cohort is on target to complete the program this year and the Bronx group in 2013. There is also training for all staff who are involved with the precepting of new and transitioning staff. The second session of three sessions over the life of the grant is a three day event scheduled in March at Metropolitan Hospital Center. This is a grant worth approximately $850,000 - funds are administered through HHC, payable to St Francis College and the Vermont Nurses in Partnership who provides the precepting programs.

9. IPRO HAI Prevention Project

HHC acute care facilities are participating in a national project to reduce Healthcare Associated Infections. There has been a reduction in CLABS in nearly every unit participating. See attached report.

10. Patient Satisfaction

Press Ganey has commenced surveying our patients throughout the patient care spectrum - process is being perfected in English and Spanish, with plans to expand to 13 languages in many venues. Sample sizes have been increased, areas surveyed now include ambulatory surgery, rehab, outpatient testing areas and specialty clinics in addition to inpatient, outpatient, emergency department and behavioral health. Super-users have been identified, have received initial training and are assigning access at the facilities.

11. IT Psychiatric Emergency Services Project

In an effort to improve the efficiency and patient flow in HHC's eleven psychiatric emergency services, the Office of Behavioral Health is working with Central Office IT on the development of whiteboards for patient tracking. The project has been placed on a fast trick with a 12-month completion deadline. Currently, all psychiatric emergency services use a standardized assessment form that was developed over 5 years ago as part of a legal settlement. The project incorporates communication with regard to patient status, alerts and clinical documentation. The Psychiatric Emergency Services Directors have been working together with IT to develop a more standardized workflow that will be incorporated in the project. It is widely recognized that

individuals with serious and persistent mental illness die prematurely from chronic medical conditions. This project better integrates both psychiatric and medical care in the Emergency Department.

12. HHC Partners with the NYS Office of Mental health to Provide Corporate Crisis De-escalation Training

In HHC's ongoing effort to reduce seclusion/restraint (S/R) use and increase the patient-centered rehabilitation focus in the delivery of care, HHC has partnered with the State Office of Mental Health to utilized their training resources to provide an intensive five-day train-the-trainer project entitled "Preventing and Managing Crisis Situations." The first of two training sessions was held this week. All HHC facilities are participating. As an outcome of the training, we look forward to continuing HHC's decreased use of S/R and reducing the number of inpatient assaults and fights.

METROPLUS HEALTH PLAN, INC.

Dr. Arnold Saperstein, Executive Director, MetroPlus Health Plan, Inc. presented to the Committee.
Dr. Saperstein informed the Committee that the total plan enrollment as of February 1, 2012 was 425,439. Breakdown of plan enrollment by line of business is as follows:

Medicaid	356,923
Child Health Plus	17,823
Family Health Plus	36,265
MetroPlus Gold	3,089
Partnership in Care (HIV/SNP)	5,693
Medicare	5,646

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. In addition, he provided a graph showing net transfers for the month of January 2012 for Medicaid and Family Health Plus (FHP).

Dr. Saperstein informed the Committee that MetroPlus has been ranked #1 in the City of New York for five (5) out of the last six (6) years based on overall quality and member satisfaction that is published in the Medicaid Consumer Guide. This year, Dr. Saperstein is pleased to announce that MetroPlus, for the first time ever, has been ranked #1 in New York State. Dr. Saperstein has attached the rankings of all 18 plans that have Medicaid patients and operate in New York State. This score is based on Quality, Consumer Satisfaction, Preventive Quality Indicators and Compliance. As the Committee can see on the attached document MetroPlus achieved a 100% score in quality and was ranked the highest overall of all the plans in the State. These results are a testament to the excellent high quality care and service provided by all of MetroPlus providers, as well as the excellent work performed by MetroPlus staff.

Dr. Saperstein provided the Committee with a copy of the MetroPlus final draft of the Strategic Plan (attached hereto) for 2012 which summarizes goals and major projects for 2012. This Strategic Plan will be submitting to the MetroPlus Board of Directors for discussion and approval at the next meeting in March.

Dr. Saperstein informed the Committee that there is still much lively discussion occurring between the New York State Department of Health (SDOH) and health plans regarding the transition of the homeless population into managed care on April 1, 2012. MetroPlus' Chief Medical Officer, Dr. Van Dunn is on the State's implementation workgroup. There are significant challenges to manage a population that does not have a permanent residence and might be extraordinarily difficult to contact. In addition, the State has still

not finalized their expectations of how the plans will work with, and pay the homeless shelters and other homeless services.

Dr. Saperstein noted that in November 2011, he advised the Committee of the MetroPlus' first month experience since they took over the management of pharmacy benefits for FHP and Medicaid. As a follow up to that report, Dr. Saperstein provided a spreadsheet detailing the monthly pharmacy trend for October 2011 through January 2012. It shows that after four months, pharmacy costs have become more manageable, and the plan is no longer experiencing losses, after one quarter of pharmacy management.

MetroPlus is modifying some of its systems and operations to prepare for the Health Home initiative. The Plan is developing operations to assist in case finding outreach and consent to enroll individuals into the HHC/MetroPlus Health Home.

Dr. Saperstein concluded his report by informing the Committee that MetroPlus Medicare closed the 2011 Annual Open Enrollment Period with a total of 420 gross new members. As of February 1, 2012, MetroPlus has a total of 5,694 active enrollees in all Medicare products combined. As part of their 2012 Strategic plan, they are focusing most of their Medicare sales and marketing efforts on growing the two Dual Special Needs Plans, which offer competitive health care and value added benefits for the dual eligible population. MetroPlus is also in the process of reassessing their retention strategies for all Medicare lines. In general their retention rate has been maintained at over 97%.

INFORMATION ITEMS:

1. Business Intelligence Analytics

Presenting to the Committee was Paul Contino, Chief Technology Officer. Mr. Contino provided the Committee with an update on Health Home's (HH) progress on its Business Intelligence (BI) initiative. First he described what Business Intelligence really is: which is the processes, technologies, and tools that help us transform data into information, information into knowledge and knowledge into decisions and action. BI is various technologies for gathering, storing, analyzing and providing access to data to help enterprise users make better business decisions. BI is about getting the right information, to the right decision makers, at the right time.

The goals of BI is that it should: align with the enterprise goals and objectives of HHC; make the best use of information assets; enhance business processes with timely analytics; help enterprise with strategic, tactical and operational decision making; create a 'single source of truth'; deliver a predictable, complete, consistent, reliable and timely source of information; and transform data into information, information into insight, insight in action.

Swimming in data but gasping for information is a great way to categorize how we currently exist with data. There is a lot of disparity of data across multiple systems; data resides in silos resulting in multiple unsynchronized reporting solutions and shadow databases; there is few enterprise standards for data management; there is no data governance; there is a variety of metrics, methodologies and calculations that causes a lot of disparity in reports seen every day; more time is spent collecting/manipulating data than on analysis – some surveys conducted show that large groups of analysts are spending anywhere from 60-90% of their time just gathering data, manipulating it and creating presentations with very little time spent on analysis ; and there is an inability to reconcile data across the Corporation.

The benefits of BI include: improve efficiency of legacy financial and clinical systems and processes, including new electronic medical record and credentialing system; monitor and analyze key metrics and objectives, including quality, safety, risk, and compliance; provide insight and analytics around clinical performance and patient care; ultimate goal is to expand access to and availability of information to support decision-making; identify areas of competitive/comparative strength and weakness; and research opportunities.

Moving forward, the BI Executive Steering Committee was established to ensure that BI meets HHC's strategic needs and supports HHC's goals and mission. The importance of BI governance is to create a Business Intelligence Competency Center (BICC) that represents all lines of business; to create processes that enforce data integrity principles & support data quality initiatives; data / metric definitions & standardization, change control. The key strategy to BI will be the Enterprise Data Warehouse which is an integrated view of our data assets from across Corporation, from all sources such as clinical, financial, supply chain, and human resources and putting it into a an Enterprise Model from where we can actually do very sophisticated cross correlated analytics across our complete data set versus the silos of data sets that currently exist.

The Gartner CIO technology priorities for 2012, rank analytics and business intelligence as one of the top five. The study conducted in the fourth quarter of 2011 and entitled "Amplifying the Enterprise: The 2012 CIO Agenda," polled 2,335 CIOs covering 37 industries in 45 countries and representing some $321 billion in IT budgets.

A lawyer was engaged to assist with conducting a current state assessment of HHC's enterprise BI environment including needs, support processes, data governance, data warehouses, information quality, and support services. The HHC BI team has conducted a preliminary assessment on the current state of BI's readiness, which was used as part of the BI Strategy definition. The future state visioning is being completed this week and will be presented to the BI Steering Committee. The future state visioning will include: future state recommendations required to support enterprise wide information and analytics needs, and initiatives through implementation of Enterprise Data Warehouse; outline a framework to develop data standards, link disparate data assets, consolidate discrete data silos (internal and third party) and further develop analytical capabilities; and recommendations to develop a service oriented support model for data governance and data analytics. The next step will be to develop a high-level business case which will define project investment, timing and resource requirements and to assess the associated tangible and intangible benefits. Projected completion date is the end of February. The last phase with a projected completion date of March 5th is roadmap development will encompass the development of a roadmap with current to future state transition plan that aligns information technology & business initiatives and to recommend data quality & integration techniques along with technologies that support a services oriented platform.

Mr. Contino then provided the Committee with a high level overview of what they are proposing in terms of a technical framework for BI. There are three tiers: 1) data integration tier in which all data sources will be linked. Currently there are 2,200 different databases and 17 different applications which the BI Steering Committee will prioritize what data we need access to in order to begin the integration process; 2) data warehouse tier in which data is structured and designed to provide analytics and reporting which is the; 3) presentation tier.

Mr. Contino informed the Committee that the value that BI provides HHC is a seamless drill down capability from the highest level of executive report all the way down to line management with transaction detail. We will be able to navigate up or down the value chain data. Right now most executive dashboards are comprised of cobbled analytics that are designed in a disparate manner and put together and if you try to actually navigate from those dashboards down to any transactional level of detail – you are lost.

Mr. Contino concluded his presentation by discussing the BIO planning and implementation timeline – as mentioned earlier, the first piece of this strategy is around connecting to all the data sources – after we finish the lawyer assessment one of the key pieces is that we will be acquiring the technology [Extraction, Transforming and Loading (ETL)] that will allow us to connect and then stage data to our warehouse, software. The challenge with the data warehouse is typically in the past one had to actually build the warehouse from scratch, which could take three to four years. Fortunately the field has evolved and matured and there are vendors that have health care data models. We are currently evaluating the purchase of one of these health care models which gives us 60-80% of all the data definitions and data structure that is used in a typical health care organization. Goal is to have an ETL platform in place by the third quarter of this year and begin connecting to the different databases. Acquisition of Enterprise Healthcare System Data Warehouse will be completed by fourth quarter this year and then we will begin to migrate data which will occur in multiple phases but it is anticipated to be completed by the third quarter of 2013. By the second quarter of 2012 they will complete the evaluation, section and acquisitions of a BI Analytics Reporting Software. In addition a Business Intelligence Competency Center was developed which drives priorities and use of analytics systems and provides ongoing governance. Overtime the number of data sources will be increased in the data warehouse and work with leadership on which dashboards and metrics need to be developed for each institution will continue to evolve.

Dr. Stocker stated that his fear is that these organizations, like many others, have local databases which people are very dependent on to make decisions and that if we have an overlying standard database staff will use that in addition to their local database. Mr. Contino responded that yes, this could potentially happen and in order to alleviate this what needs to happen is from the top level of the organization there has to be a system of truth and when you hold people to a standard they will come and present data it has to be from that source and not another database – ultimately it is about building trust in the enterprise and re-enforcing use of the system.

Dr. Stocker stated that the Corporation is now developing and thinking of new data needs such as for Health Home we have a data reporting requirement and inquired as to whether we can do it as this is new and can it be standardized across the Corporation. Mr. Contino stated, even though he is involved in Health Home in conjunction with Dr. Louis Capponi, Chief Medical Informatics Officer and Dr. Ross Wilson, Senior Vice President/Corporate Chief Medical Officer, that this is not a BI application it is actually a separate system that collects the data. Getting data governance and standardization in play is important so that we have a culture that supports it moving forward.

2. Electronic Medical Record (EMR) Vendor Selection Update

Presenting to the Committee was Louis Capponi, MD, Chief Medical Informatics Officer. The iCIS Selection Committee continues to meet regularly and consider the strengths of each Electronic Medical Record vendor finalist in our negotiated acquisition process. The results of this extensive and detailed selection process will be presented to this Committee for consideration in the coming months as the vendor of choice for HHC's next generation EMR.

The selection Committee and eight (8) expert work groups, consisting of over 150 nurses, doctors, pharmacists, clinical support staff, and leadership from around the corporation are near completion of a second round of due diligence reviews. They have intensively studied the functionality and fit of these software products; focusing most recently on departmental systems such as laboratory, pathology, the OR, Radiology, and Long term care.

The selection Committee and HHC IT staff are intensively reviewing contract terms and conditions as well as the total cost of ownership among the finalists. In addition to creating the master implementation plan, we will determine if there is significant variation in implementation costs among the vendors.

A detailed interrogation of the software capacity to handle HHC's high transaction volumes is also underway. Three site visits were conducted to stress test potential vendors system from a technology perspective, simulating tens of thousands of simultaneous users and millions of transactions to understand how the system would perform and to make sure the system would not break. HHC has engaged two independent parties with the specific expertise to review the results of system performance and scalability tests. The results of these reviews are anticipated later this month.

The team will be transitioning into the contract negotiation phase early next month in order to secure the most aggressive software pricing and service level agreements possible.

The high level master project plan referenced earlier is comprised of two to three thousand lines of tasks and major activities that must occur over the next five to six years. A component of the master project plan includes preparation of a detailed staffing plan as well as review of the implementation costs differences based on the use of consulting staff vs. HHC employees.

HHC will need to engage one or more likely several vendors to supply at least a portion of temporary IT resources to achieve this extensive implementation effort. To that end, HHC will be presenting to the board a separate requirements contract of pre-qualified vendors with a talent pool from which HHC can draw upon to conduct the implementation.

Finally, HHC is evaluating the potential for ongoing staff development and employment of entry level staff by developing local college and university outreach programs to attract young professionals for a career in Health care IT.

Dr. Capponi noted that staff has worked tremendously hard, and he has been very impressed with the level of participation of the clinical staffs, Councils and the support of administration and leadership.

There being no further business the meeting adjourned at 3:59 P.M.

MetroPlus Health Plan, Inc.
Report to the
HHC Medical and Professional Affairs Committee
March 22, 2012

Total plan enrollment as of March 1, 2012 was 425,439. Breakdown of plan enrollment by line of business is as follows:

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Medicare	5,646

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. In addition, I have attached a graph showing net transfers for the month of February 2012 for Medicaid and Family Health Plus (FHP).

Also attached to my report is the new population carve in timeline from the Medicaid Redesign Teams Managed Care Benefit and Population Expansion. This report summarizes all of the current fee for service populations that are being carved into Medicaid managed care programs in the next nine months. Below are brief summaries of these populations, which are all effective April 1, 2012:

Individuals with End Stage Renal Disease (ESRD): Recipients with ESRD will no longer be exempt from enrolling in a Medicaid managed care plan. Current Medicaid recipients with ESRD will have 30 days to choose a Medicaid managed care plan. Anyone who fails to choose a plan within 30 days will be automatically assigned to a plan.

Homeless individuals: Where identifiable, SDOH will make an effort to target families with children prior to enrolling single individuals and childless couples. Individuals who are living on the street will be targeted last to allow sufficient time to educate this harder to locate population.

Individuals receiving services through the Chronic Illness Demonstration Program (CIDP): CIDP providers will be assisting recipients in choosing a health plan that includes the providers that the individual is currently seeing.

Infants born under 1200 grams or disabled under 6 months of age: Infants born on or after April 1, 2012 with a birth weight of less than 1200 grams and infants under six months of age who are disabled will no longer be excluded from enrolling in a Medicaid managed care plan. Infants born prior to April 1st that are already enrolled in fee-for-service will remain in fee-for-service until they are six months old, at which time their guardians will be required to choose a plan.

Individuals with characteristics and needs similar to those receiving services through an Long Term Home Health Care Program (LTHHCP), Care at Home (CAH) program, Traumatic Brain Injury (TBI) program, Nursing Home Transition and Diversion (NHTD) waiver program and the Intermediate Care Facilities for the developmentally disabled program (ICF/DD): Beginning in April 2012, the state will begin to enroll individuals who "look like" participants in the LTHHCP waiver program and are not currently enrolled in the program.

There are additional benefits and populations that are being carved into Medicaid managed care, and those include:

Dental: Effective July 1, 2012 plans will be responsible for dental benefits.
Skilled Nursing Facility services: Effective October, 2012 plans will provide benefits for residents of residential health care facilities – nursing homes.
Early Intervention services: Effective January 1, 2013, plans will provide benefits for individuals in the Long Term Home Health Care Program. These individuals will have the ability to opt out of mainstream managed care and enroll in the managed long term care program.
Consumer Directed Personal Assistance Program (CDPAP): This program is designed for elderly or disabled residents that require and are eligible to receive home care, personal care or skilled nursing services and wish to maintain control over whom provides these services. SDOH just informed plans that this change was postponed for the time being.

The U.S. Centers for Medicare and Medicaid Services (CMS) has informed the Plan that they will perform a financial audit for contract year 2010. MetroPlus, within the last year, completed a successful audit for 2008 in which the auditors reported no material findings and three minor observations, all related to true out-of-pocket costs (TrOOP) that should not occur again since CMS has now automated these TrOOP processes. CMS has not yet provided a start date for the audit. The 2008 audit took about six months for the auditors to complete.

The New York State Department of Health (SDOH) issued a revised date for requiring dual-eligible individuals, 21 and older, who need more than 120 days of non-institutional long term care services to enroll into a managed long term care (MLTC) plan. The implementation date, originally scheduled for April 1, 2012, is now July 1, 2012. This revised schedule is subject to receiving approval from CMS.

Lastly, as I've mentioned, SDOH is requiring that all Medicaid Health Plans transition coverage of dental services into the benefit packages by July 1, 2012. MetroPlus has been engaged in a Negotiated Acquisition for an appropriate vendor to cover our dental benefit. Two vendors pre-qualified, DentaQuest, our current vendor, and Healthplex. Both vendors were carefully reviewed and Healthplex was chosen as the vendor. The annual estimated costs will be approximately 56 million dollars for dental services and up to 5 million for administrative costs. This contract was approved by the MetroPlus Finance Committee in February and MetroPlus Board on March 13. It is being presented today to the HHC Board of Directors for approval.

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 02/14/2012

Other Plan Name	Category	2011_03		2011_04		2011_05		2011_06		2011_07		2011_08		2011_09		2011_10		2011_11		2011_12		2012_01		2012_02		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	
Affinity Health Plan	INVOLUNTARY	0	7	0	5	0	2	0	3	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	20
	VOLUNTARY	14	122	11	122	12	139	11	143	18	97	11	126	13	99	10	138	22	124	19	99	10	109	15	90	1,574
	TOTAL	14	129	11	127	12	141	11	146	19	99	11	126	13	99	10	138	22	124	19	99	10	109	15	90	1,594
CarePlus Health Plan	INVOLUNTARY	0	2	1	3	0	4	1	5	2	5	0	0	0	0	0	0	2	0	0	0	0	0	0	0	25
	VOLUNTARY	7	34	1	39	2	29	6	33	2	34	4	26	2	34	2	24	5	43	2	42	1	27	3	25	427
	TOTAL	7	36	2	42	2	33	7	38	4	39	4	26	2	34	2	24	7	43	2	42	1	27	3	25	452
Fidelis Care	INVOLUNTARY	0	19	0	7	0	8	1	3	0	3	0	0	0	0	1	1	0	0	0	0	0	1	0	0	44
	VOLUNTARY	25	237	21	227	27	196	32	280	27	211	42	252	20	176	22	201	27	258	28	233	25	223	33	266	3,089
	TOTAL	25	256	21	234	27	204	33	283	27	214	42	252	20	176	23	202	27	258	28	233	25	224	33	266	3,133
Health First	INVOLUNTARY	3	11	2	22	3	13	2	2	0	1	0	0	0	0	0	1	0	2	0	0	1	5	0	1	69
	UNKNOWN	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	VOLUNTARY	39	451	42	397	29	465	45	538	35	419	45	501	35	413	38	407	43	488	39	463	26	515	42	546	6,061
	TOTAL	42	462	44	419	32	479	47	540	35	420	45	501	35	413	38	408	43	490	39	463	27	520	42	547	6,131
Health Plus	INVOLUNTARY	0	2	4	13	1	6	2	4	2	5	0	0	0	0	0	0	0	6	0	1	0	0	0	0	46
	VOLUNTARY	23	192	17	176	18	191	13	208	13	160	22	208	18	186	20	145	24	217	25	188	9	176	15	239	2,503
	TOTAL	23	194	21	189	19	197	15	212	15	165	22	208	18	186	20	145	24	223	25	189	9	176	15	239	2,549
HIP/NYC	INVOLUNTARY	1	3	1	2	1	3	0	1	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	1	16
	VOLUNTARY	14	81	13	59	9	75	3	102	10	72	8	83	7	90	12	55	12	77	12	86	10	92	8	91	1,081
	TOTAL	15	84	14	61	10	78	3	103	10	75	8	83	7	90	12	55	12	77	12	86	10	92	8	92	1,097
Neighborhood	INVOLUNTARY	1	3	0	6	1	3	0	0	2	2	0	0	0	0	0	0	0	0	0	1	0	2	0	0	21

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 02/14/2012

		2011_03		2011_04		2011_05		2011_06		2011_07		2011_08		2011_09		2011_10		2011_11		2011_12		2012_01		2012_02		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	
Neighborhood Health Provider	VOLUNTARY	10	130	10	128	11	118	12	124	21	115	8	169	8	120	8	114	15	144	14	131	15	94	11	122	1,652
	TOTAL	11	133	10	134	12	121	12	124	23	117	8	169	8	120	8	114	15	144	14	132	15	96	11	122	1,673
United Healthcare of NY	INVOLUNTARY	1	3	1	4	1	3	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	16
	VOLUNTARY	15	76	14	53	5	74	11	107	11	69	14	68	10	72	7	48	18	111	16	78	14	70	8	82	1,051
	TOTAL	16	79	15	57	6	77	12	107	11	70	14	68	10	72	7	48	18	111	16	78	14	71	8	82	1,067
Wellcare of NY	INVOLUNTARY	0	4	1	5	1	2	0	3	0	5	0	0	0	0	0	0	0	0	0	0	0	1	0	0	22
	VOLUNTARY	1	14	2	15	1	29	4	26	2	33	2	27	3	22	8	18	0	9	2	29	0	20	2	26	295
	TOTAL	1	18	3	20	2	31	4	29	2	38	2	27	3	22	8	18	0	9	2	29	0	21	2	26	317
Disenrolled Plan Transfers	INVOLUNTARY	6	54	10	67	8	44	7	21	7	27	0	0	0	0	1	2	2	8	0	2	1	10	0	2	279
	UNKNOWN	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	VOLUNTARY	148	1,337	131	1,216	114	1,316	137	1,561	139	1,210	156	1,460	116	1,212	127	1,150	166	1,471	157	1,349	110	1,326	137	1,487	17,733
	TOTAL	154	1,391	141	1,283	122	1,361	144	1,582	146	1,237	156	1,460	116	1,212	128	1,152	168	1,479	157	1,351	111	1,336	137	1,489	18,013
Disenrolled Unknown Plan Transfers	INVOLUNTARY	0	7	2	39	1	66	4	51	6	46	5	47	3	35	6	51	5	31	2	18	2	32	1	20	480
	UNKNOWN	0	0	0	0	1	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	3
	VOLUNTARY	2	38	1	43	0	21	0	24	3	40	3	48	5	59	4	53	19	92	16	113	10	54	8	43	699
	TOTAL	2	45	3	82	2	88	4	75	9	86	8	96	8	94	10	104	24	123	18	131	12	86	9	63	1,182
Non-Transfer Disenroll Total	INVOLUNTARY	1,232	9,272	1,475	11,150	1,235	9,827	1,176	8,727	1,359	10,100	1,033	9,713	1,112	10,295	1,012	9,918	1,030	9,849	1,160	10,217	1,096	10,059	1,111	10,940	134,098
	UNKNOWN	4	1	0	2	0	7	1	1	1	0	1	2	1	3	1	3	1	4	1	3	0	3	1	6	47
	VOLUNTARY	0	81	0	83	0	67	0	61	0	42	0	52	0	52	0	54	253	386	2	59	2	79	1	39	1,313
	TOTAL	1,236	9,354	1,475	11,235	1,235	9,901	1,177	8,789	1,360	10,142	1,034	9,767	1,113	10,350	1,013	9,975	1,284	10,239	1,163	10,279	1,098	10,141	1,113	10,985	135,458

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 02/14/2012

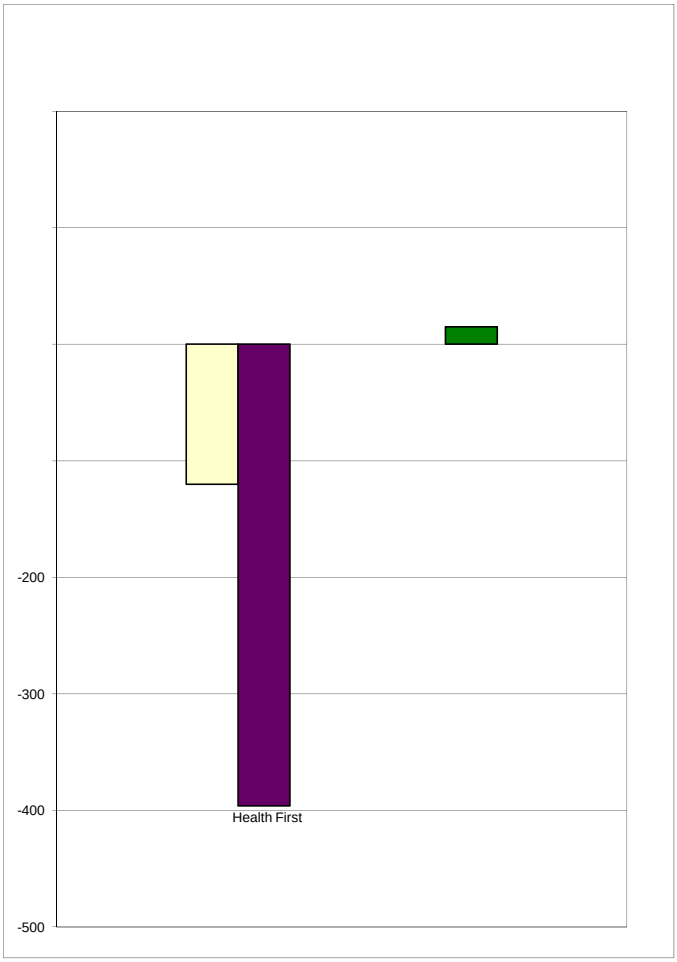
		2011_03		2011_04		2011_05		2011_06		2011_07		2011_08		2011_09		2011_10		2011_11		2011_12		2012_01		2012_02		TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
Total MetroPlus Disenrollment	**INVOLUNTARY**	1,238	9,333	1,487	11,256	1,244	9,937	1,187	8,799	1,372	10,173	1,038	9,760	1,115	10,330	1,019	9,971	1,037	9,888	1,162	10,237	1,099	10,101	1,112	10,962	134,857
	UNKNOWN	4	1	0	2	1	9	1	1	1	0	1	3	1	3	1	3	1	4	1	3	0	3	1	6	51
	VOLUNTARY	150	1,456	132	1,342	114	1,404	137	1,646	142	1,292	159	1,560	121	1,323	131	1,257	438	1,949	175	1,521	122	1,459	146	1,569	19,745
	TOTAL	1,392	10,790	1,619	12,600	1,359	11,350	1,325	10,446	1,515	11,465	1,198	11,323	1,237	11,656	1,151	11,231	1,476	11,841	1,338	11,761	1,221	11,563	1,259	12,537	154,653

Disenrollments TO Other Plans		Feb-12			Mar-11 to Feb-12		
		FHP	MCAD	Total	FHP	MCAD	Total
	INVOL.	0	0	0	1	19	20
	VOL.	15	90	105	166	1,408	1,574
Affinity Health Plan	TOTAL	15	90	105	167	1,427	1,594
	INVOL.	0	0	0	6	19	25
	VOL.	3	25	28	37	390	427
CarePlus Health Plan	TOTAL	3	25	28	43	409	452
	INVOL.	0	0	0	2	42	44
	VOL.	33	266	299	329	2,760	3,089
Fidelis Care	TOTAL	33	266	299	331	2,802	3,133
	INVOL.	0	1	1	11	58	69
	VOL.	42	546	588	458	5,603	6,061
Health First	TOTAL	42	547	589	469	5,662	6,131
	INVOL.	0	0	0	9	37	46
	VOL.	15	239	254	217	2,286	2,503
Health Plus	TOTAL	15	239	254	226	2,323	2,549
	INVOL.	0	1	1	3	13	16
	VOL.	8	91	99	118	963	1,081
HIP/NYC	TOTAL	8	92	100	121	976	1,097
	INVOL.	0	0	0	4	17	21
	VOL.	11	122	133	143	1,509	1,652
Neighborhood Health	TOTAL	11	122	133	147	1,526	1,673
	INVOL.	0	0	0	4	12	16
	VOL.	8	82	90	143	908	1,051
United Healthcare of NY	TOTAL	8	82	90	147	920	1,067
	INVOL.	0	0	0	2	20	22
	VOL.	2	26	28	27	268	295
Wellcare of NY	TOTAL	2	26	28	29	288	317
	INVOL.	0	2	2	42	237	279
	VOL.	137	1,487	1,624	1,638	16,095	17,733
Disenrolled Plan Transfers:	TOTAL	137	1,489	1,626	1,680	16,333	18,013
	INVOL.	1	20	21	37	443	480
	VOL.	8	43	51	71	628	699
Disenrolled Unknown Plan Transfers:	TOTAL	9	63	72	109	1,073	1,182
	INVOL.	1,111	10,940	12,051	14,031	120,067	134,098
	UNK.	1	6	7	12	35	47
	VOL.	1	39	40	258	1,055	1,313
Non-Transfer Disenroll Total:	TOTAL	1,113	10,985	12,098	14,301	121,157	135,458
	INVOL.	1,112	10,962	12,074	14,110	120,747	134,857
	UNK.	1	6	7	13	38	51
	VOL.	146	1,569	1,715	1,967	17,778	19,745
Total MetroPlus Disenrollment:	**TOTAL**	**1,259**	**12,537**	**13,796**	**16,090**	**138,563**	**154,653**

Disenrollments FROM Other Plans	Feb-12			Mar-11 to Feb-12		
	FHP	MCAD	Total	FHP	MCAD	Total
Affinity Health Plan	18	193	211	311	2,605	2,916
CarePlus Health Plan	25	130	155	290	2,032	2,322
Fidelis Care	10	169	179	229	2,563	2,792
Health First	7	186	193	225	2,394	2,619
Health Plus	19	216	235	396	3,344	3,740
HIP/NYC	8	88	96	112	1,337	1,449
Neighborhood Health	18	165	183	254	2,070	2,324
United Healthcare of NY	14	91	105	130	993	1,123
Wellcare of NY	14	99	113	223	1,644	1,867
Total	133	1,337	1,470	2,170	18,982	21,152
Unknown (not in total)	2,155	13,037	15,192	25,285	133,059	158,344

Data Source: RDS Report 1268a&c Updated 02/23/2012

Net Difference	Feb-12			Mar-11 to Feb-12		
	FHP	MCAD	Total	FHP	MCAD	Total
Affinity Health Plan	3	103	106	144	1,178	1,322
CarePlus Health Plan	22	105	127	247	1,623	1,870
Fidelis Care	-23	-97	-120	-102	-239	-341
Health First	-35	-361	-396	-244	-3,268	-3,512
Health Plus	4	-23	-19	170	1,021	1,191
HIP/NYC	0	-4	-4	-9	361	352
Neighborhood Health	7	43	50	107	544	651
United Healthcare of NY	6	9	15	-17	73	56
Wellcare of NY	12	73	85	194	1,356	1,550
Total	-4	-152	-156	490	2,649	3,139



MetroPlus Health Plan

New Member Transfer From Other Plans

	2011_03		2011_04		2011_05		2011_06		2011_07		2011_08		2011_09		2011_10		2011_11		2011_12		2012_01		2012_02		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	
Affinity Health Plan	19	224	19	209	35	241	42	273	37	231	51	264	16	194	21	175	23	203	17	191	13	207	18	193	2,916
CarePlus Health Plan	22	163	33	202	20	172	23	203	35	137	29	223	25	198	25	135	28	177	12	147	13	145	25	130	2,322
Fidelis Care	11	194	14	207	25	201	29	260	17	200	26	293	19	234	24	173	19	232	18	217	17	183	10	169	2,792
Health First	14	176	14	185	18	225	25	248	22	219	26	242	25	148	14	186	25	216	13	198	22	165	7	186	2,619
Health Plus	33	284	42	299	33	238	51	349	29	273	30	343	34	258	38	255	32	254	29	275	26	300	19	216	3,740
HIP/NYC	6	116	12	125	12	133	10	126	10	122	15	113	10	117	6	94	7	102	5	104	11	97	8	88	1,449
Neighborhood Health Pr	12	187	25	196	14	181	32	213	16	162	15	175	25	139	26	149	24	171	31	126	16	206	18	165	2,324
United Healthcare of NY	9	60	12	75	17	59	13	72	12	76	11	77	10	83	6	72	8	102	10	125	8	101	14	91	1,123
Unknown PLan	1,991	10,421	2,014	9,445	2,171	9,838	2,527	13,610	2,160	10,215	2,145	11,424	2,022	9,708	1,927	9,392	2,191	12,783	1,820	11,446	2,162	11,740	2,155	13,037	158,344
Wellcare of NY	21	131	16	157	19	132	24	157	15	123	21	157	11	127	20	146	28	145	15	126	19	144	14	99	1,867
TOTAL	2,138	11,956	2,201	11,100	2,364	11,420	2,776	15,511	2,353	11,758	2,369	13,311	2,197	11,206	2,107	10,777	2,385	14,385	1,970	12,955	2,307	13,288	2,288	14,374	179,496

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

February-2012

		Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12
Total Members	Prior Month	415,896	418,376	418,493	418,623	421,670	423,084	424,642
	New Member	17,708	15,578	15,093	19,149	16,987	17,649	17,343
	Voluntary Disenroll	1,864	1,630	1,558	2,586	1,855	2,036	1,916
	Involuntary Disenroll	13,364	13,831	13,405	13,516	13,718	14,055	14,630
	Adjusted	-29	-28	-28	-6	408	1,341	0
	Net Change	2,480	117	130	3,047	1,414	1,558	797
	Current Month	418,376	418,493	418,623	421,670	423,084	424,642	425,439
Medicaid	Prior Month	348,939	351,043	350,755	350,507	353,235	354,707	356,112
	New Member	14,371	12,294	11,913	15,552	14,058	14,075	14,317
	Voluntary Disenroll	1,561	1,323	1,257	1,949	1,521	1,459	1,569
	Involuntary Disenroll	10,706	11,259	10,904	10,875	11,065	11,211	11,937
	Adjusted	-26	-23	-21	7	409	1,429	0
	Net Change	2,104	-288	-248	2,728	1,472	1,405	811
	Current Month	351,043	350,755	350,507	353,235	354,707	356,112	356,923
Child Health Plus	Prior Month	18,927	18,784	18,856	18,899	18,878	18,712	18,216
	New Member	590	726	714	775	579	430	429
	Voluntary Disenroll	25	43	45	43	36	21	36
	Involuntary Disenroll	708	611	626	753	709	905	786
	Adjusted	1	1	1	0	7	-18	0
	Net Change	-143	72	43	-21	-166	-496	-393
	Current Month	18,784	18,856	18,899	18,878	18,712	18,216	17,823
Family Health Plus	Prior Month	34,485	34,915	35,114	35,348	35,561	35,554	35,934
	New Member	2,337	2,168	2,091	2,361	1,939	2,287	2,259
	Voluntary Disenroll	158	121	131	438	175	122	146
	Involuntary Disenroll	1,749	1,848	1,726	1,710	1,771	1,785	1,782
	Adjusted	-2	-3	-4	-7	-8	24	0
	Net Change	430	199	234	213	-7	380	331
	Current Month	34,915	35,114	35,348	35,561	35,554	35,934	36,265

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

February-2012

		Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12
HHC	Prior Month	3,037	2,980	2,986	2,976	2,998	2,989	3,082
	New Member	19	25	20	41	18	265	7
	Voluntary Disenroll	0	0	3	2	0	152	0
	Involuntary Disenroll	76	19	27	17	27	20	0
	Adjusted	0	-1	-1	3	8	-108	0
	Net Change	-57	6	-10	22	-9	93	7
	Current Month	2,980	2,986	2,976	2,998	2,989	3,082	3,089
SNP	Prior Month	5,323	5,379	5,398	5,432	5,499	5,547	5,672
	New Member	178	125	142	207	165	239	148
	Voluntary Disenroll	45	47	31	39	37	36	29
	Involuntary Disenroll	77	59	77	101	80	78	98
	Adjusted	-2	-2	-3	-9	-7	24	0
	Net Change	56	19	34	67	48	125	21
	Current Month	5,379	5,398	5,432	5,499	5,547	5,672	5,693
Medicare	Prior Month	5,185	5,275	5,384	5,461	5,499	5,575	5,626
	New Member	213	240	213	213	228	353	183
	Voluntary Disenroll	75	96	91	115	86	246	136
	Involuntary Disenroll	48	35	45	60	66	56	27
	Adjusted	0	0	0	0	-1	-10	0
	Net Change	90	109	77	38	76	51	20
	Current Month	5,275	5,384	5,461	5,499	5,575	5,626	5,646

Bert Robles
Senior Vice President, Information Technology Services
Report to the M&PA/IT Committee to the Board Report
Thursday, March 22, 2012 – 2:30 PM

Thank you and good afternoon. I would like to provide the Committee with the following update:

1. **Networking Infrastructure Refresh Program Update**:

In February 2011 the Board of Directors approved a capital spend of $25.3 million for a network infrastructure refresh program. This funding was to be used to upgrade and maintain Phase I of a five (5) year network infrastructure refresh program which will assist the Corporation in accommodating application growth, increasing bandwidth for faster application response times and maintaining stability.

The components of this upgrade include (but are not limited to) routers, switches, wireless access points, IPT phones, network cabling and uninterrupted power supplies. All of these networking components interconnect together allowing hospital Local Area Networks (LAN) the ability to share various different business, clinical and data applications over the Wide Area Network (WAN) both within HHC and over the Internet.

Applications such as Quadramed (QCPR), Siemens (Unity) and the Corporate messaging system (GroupWise email) would not be able to function unless these networking components are functioning and in place. This infrastructure upgrade is also required in order for the Corporation to communicate with our patients and business partners. In addition, this hardware is required to support new technologies for such initiatives as a new clinical Electronic Medical Record (EMR) and payroll/ time keeping systems. These systems and several others all require a robust data communication system in order to operate efficiently.

As of today, Enterprise Information Technology Services (EITS), has encumbered 12.1 million dollars and has another 7.9 million dollars of pending purchases orders associated with this upgrade. EITS is on track to

use remaining balance by the end of Fiscal Year 12 and we will be requesting additional funding to start Phase II.

We have completed upgrading the network and wireless infrastructure at Gouverneur, Queens and Coney Island hospitals. Work is underway at Elmhurst, Lincoln, Harlem, Metropolitan, Belvis, Morrisania, Woodhull and Cumberland. EITS projects that by the end of Calendar Year 2012 the upgrade will be completed at all 8 locations.

One factor impacting the progress of this project has been the readiness of the environmentals (power and cooling) at the facilities. We are now taking a joint approach with the Office of Facilities Development (OFD) to engage architectural/engineering resources to address this in a more comprehensive, corporation-wide way, rather than the site-by-site approach which was not proving to be efficient or effective.

This completes my report to the Committee today. Thank you.

MRT Managed Care Benefit and Population Expansion

Effective Date	Medicaid Managed Care - non dual changes for SFY 2012/2013

The populations below will be implemented per this time frame and subject to CMS approval

4/1/2012	
Population	Individuals with end stage renal disease
	Individuals receiving services through the Chronic Illness Demonstration Program
	Homeless persons
	Infants born weighing under 1200 grams or disabled under 6 months of age
	Individuals with characteristics and needs similar to those receiving services through an HCBS/TBI, HCBS/CAH, LTHHCP, or ICF/DD

7/1/2012	
Benefit	Dental (including orthodontia for children with severe handicapping malocclusions)

9/1/2012	
Benefit	Consumer Directed Personal Assistance Program (CDPAP)

10/1/2012	
Benefit	Skilled Nursing Facility Services
Population	Residents of residential health care facilities – Nursing Homes

1/1/2013	
Benefit	Early Intervention Services
Population	Individuals enrolled in the Long Term Home Health Care Program (LTHHCP) where capacity exists. This population will have the opportunity to opt out of Mainstream Managed Care and enroll in the Managed Long Term Care program

Medical & Professional Affairs/IT Committee Presentation:
-Research

Ross Wilson, MD
Senior Vice President & Corporate Chief Medical Officer
March 22, 2012

Why support research at HHC?

It is critical to HHC's mission:

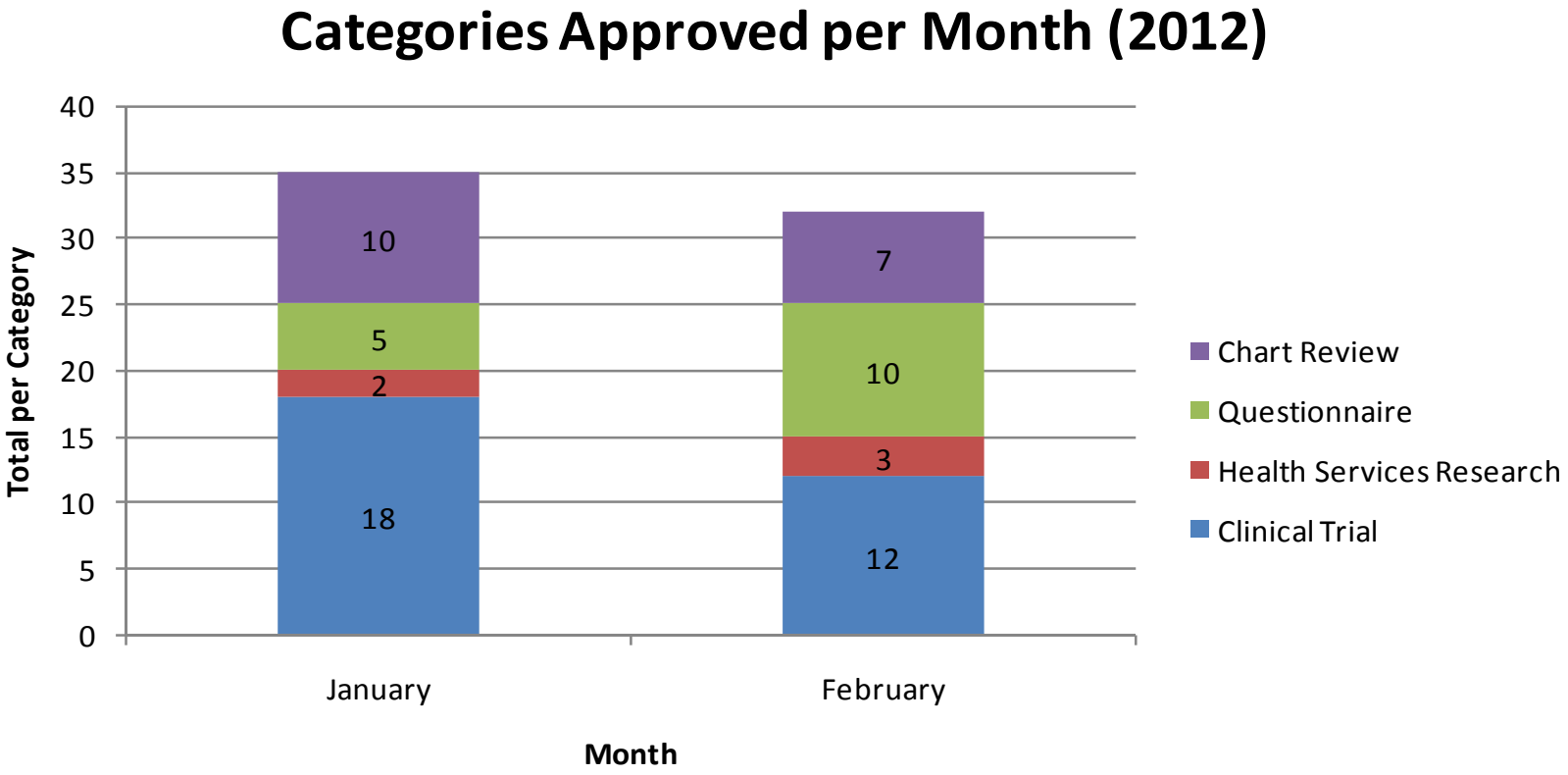
"To join with other health workers and with communities in a partnership which will enable each of our institutions to promote and protect health in its fullest sense -- the total physical, mental and social well-being of the people."

- The advancement of research activities at HHC is a way to promote state of the art health care and address the health disparities prevalent in New York City communities.
- Although addressing disparities in local communities is a priority, other research aiming to improve the lives and well-being of patients will be seen as a valuable contribution to HHC's mission to promote and protect health in its fullest sense -- the total physical, mental and social well-being of the people.

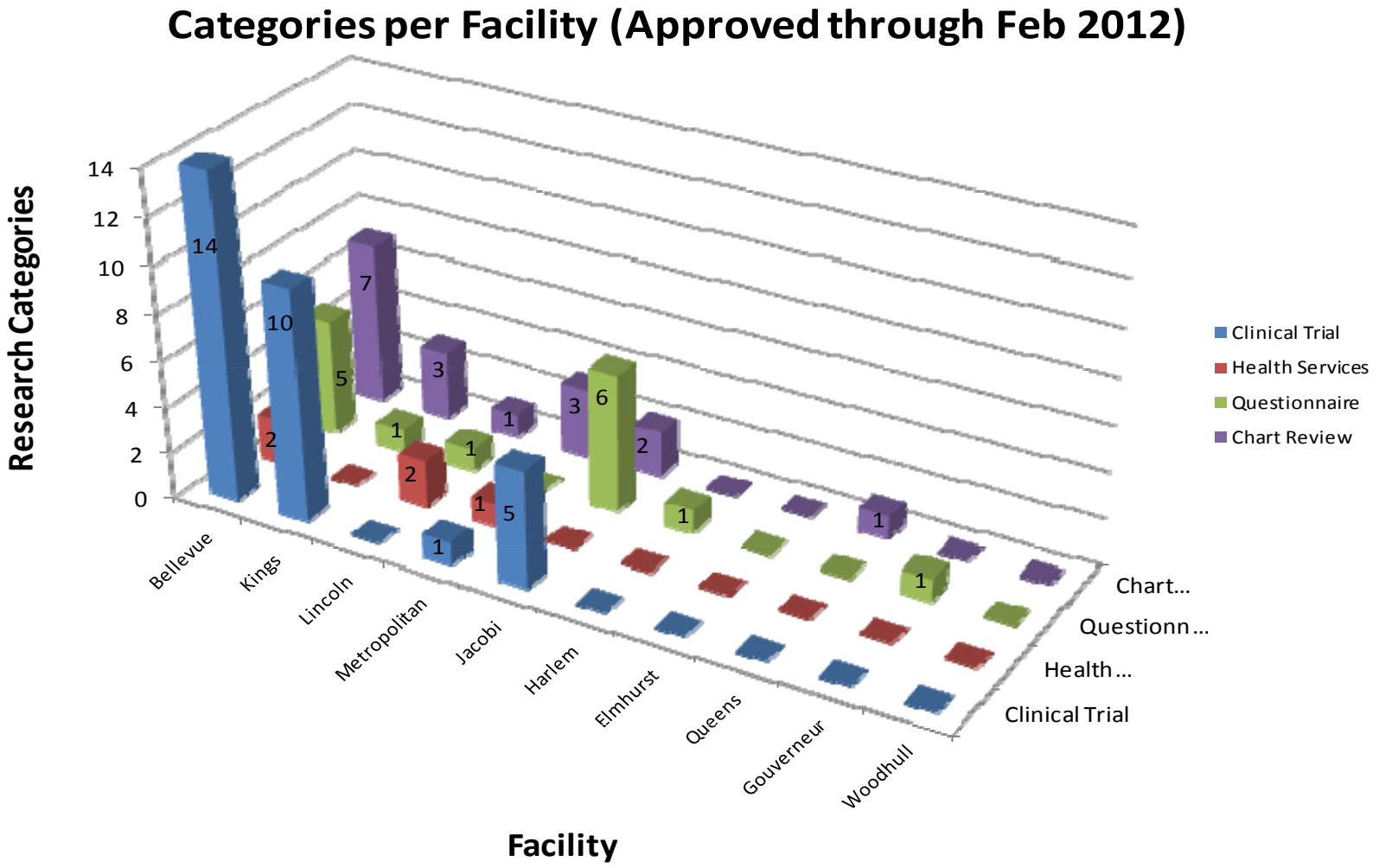
Research at HHC: Snapshot

- 402 protocols approved in 2010
- 425 protocols approved in 2011
- 79 protocols approved in 2012 (as of 3/9/12)
- Active protocols at 10 facilities
- 67 federal grants received in FY2011 with total award funding = $6.5mm

Types of Research Projects at HHC



Types of Research Projects at HHC (by facility)



Research at HHC: 2010 to present

- Streamlined HHC Research Approval Process
- Enhanced Research Administration Office
- Formation of HHC Research Council
- BRANY = corporate Institutional Review Board ("IRB")
- Clinical Translational Science Institute ("CTSI") 5-year partnership with NYU
- AHRQ-funded corporate-wide research conference

Research at HHC: Future Progress

- Strategic Research Plan
  - GOAL = to enhance HHC's infrastructure and processes to support financially sustainable research in collaboration with regional academic partners, industry and other sponsors, as well as the communities served by HHC facilities.
- Upgrade electronic research approval system
- Strengthening CTSI partnership with NYU
- Revising Corporate Research OP
- Public website for research
- Enhanced educational offerings

Goals for Research at HHC – Short-Term

Short-term Objectives (1-3 Years)

- To develop HHC research infrastructure, with streamlined resources and easy and efficient processes to maximize quantity and quality of research programs.
- A set of HHC research priority areas based on the priorities and health needs of NYC communities, including identifying opportunities unique and specific to HHC in areas such as health services delivery, cost effectiveness, comparative effectiveness and clinical translational research in collaboration with research stakeholders.
- Community-based and translational research collaborations with academic and community partners
- An assessment of barriers to participation in clinical research at HHC sites.
- A mechanism for dissemination, presentation and publication of results.
- An evaluation plan to evaluate the impact of the Strategic Research Plan.
- A mechanism to identify strengths and weaknesses in existing HHC systems and rapidly implement changes to advance the successful implementation of research opportunities.

Goals for Research at HHC – Long-Term

Long-term Objectives (Years 3 – 5)

- Increased funding to sustain the research infrastructure, creation of research centers of excellence and expertise in specific research areas based on health needs of New Yorkers.
- The establishment of a human research protections program at HHC and AAHRPP accreditation.
- An evaluation of the impact of HHC research on health outcomes and public health of New Yorkers and patients generally.
- A culture that values and maximizes human research subject protection and creates mechanisms to facilitate, monitor and enhance research compliance and human research participant protections.

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

Thank you.

Chronic Disease Management and Preventive Services at HHC

Plateaus, Disparities, and Opportunities

HHC Medical & Professional Affairs
March 22, 2012

Current State

- Accurate data in some metrics has driven sustained improvement in a number of areas
- Improvements have reached a ‘plateau’
- Control rates vary across facilities
- More data needed to expand scope of improvements

Aims

- Accurate, timely data in all priority areas
  - Drive improvement efforts, Reduce disparities
- Dissemination of best practices
  - PCMH: teamwork, training, coordination of care
  - IT: registries, decision support
  - Advances in Healthy Lifestyle Support

HHC-Wide 'Snapshot'

New York City Health and Hospitals Corporation
Office of Healthcare Improvement

Corporate Wide Preventive Services and Chronic Illness Control Dashboard

	ADULT Chronic Illness/ Prev Svcs	*Measure Status*	*Standard*	*Benchmark*	CY 2011 Data: HHC Wide Control Rate	CY 2011 Data: %of Facilities at or above Standard	CY 2011 Data: %of Facilities at or above Benchmark	CY 2010 Data: HHC Wide Control Rate	CY 2010 Data: %of Facilities at or above Standard	CY 2010 Data: %of Facilities at or above Benchmark
Diabetes Management Indicators	Glucose (A1c)		43%	51%	37%	11.8%	0%	36%	11.8%	0%
	Blood Pressure		33%	42%	36%	82.4%	12%	36%	64.7%	24%
	LDL		48%	57%	56%	88.2%	47%	54%	70.6%	24%
Cardiovascular Risk	DM Prevention Composite	Partial /Pending								
	Blood Pressure		60%	72%	44%	0%	0%			
	Lipids		63%		48%	0%	0%			
	Appropriate Aspirin Use (DM and non-DM)	Not Yet Available								
Cancer Screening Indicators	Mammography Screening		71%	80%	72%	71%	12%			
	Cervical Cancer Screening	Available/Pending	77%	83%						
	Colon Cancer Screening	Partial /Pending	63%	74%						
Non-Cancer Preventive Services	HIV/Know Your Status									
	Vaccines - composite	Partial /Pending								
	Geriatric Function Composite									
	Composite Non-Cancer Disease Screening									
Behavioral Health: Screening and Behavior Change	Depression Screening (Adults)	Available/Pending								
	Obesity/Diet	Not Yet Available								
	Alcohol and Drug Use	Not Yet Available								
	Tobacco Use	Not Yet Available								
	Sexual/Reproductive Health	Not Yet Available								
	Exercise Behavior	Not Yet Available								
Other Chronic Illness Control	CHF Discharge Management	Under Development								
	Asthma Control	Metro+								
	Pre-DM - weight loss	Not Yet Available								
	Tobacco/QUIT	Not Yet Available								
	Depession Management	Available/Pending								
	HIV Control/Undetectable VL	Available/Pending	80%	90%	82%	65%	4%			

"Standard": National Average of Commercial HMOs

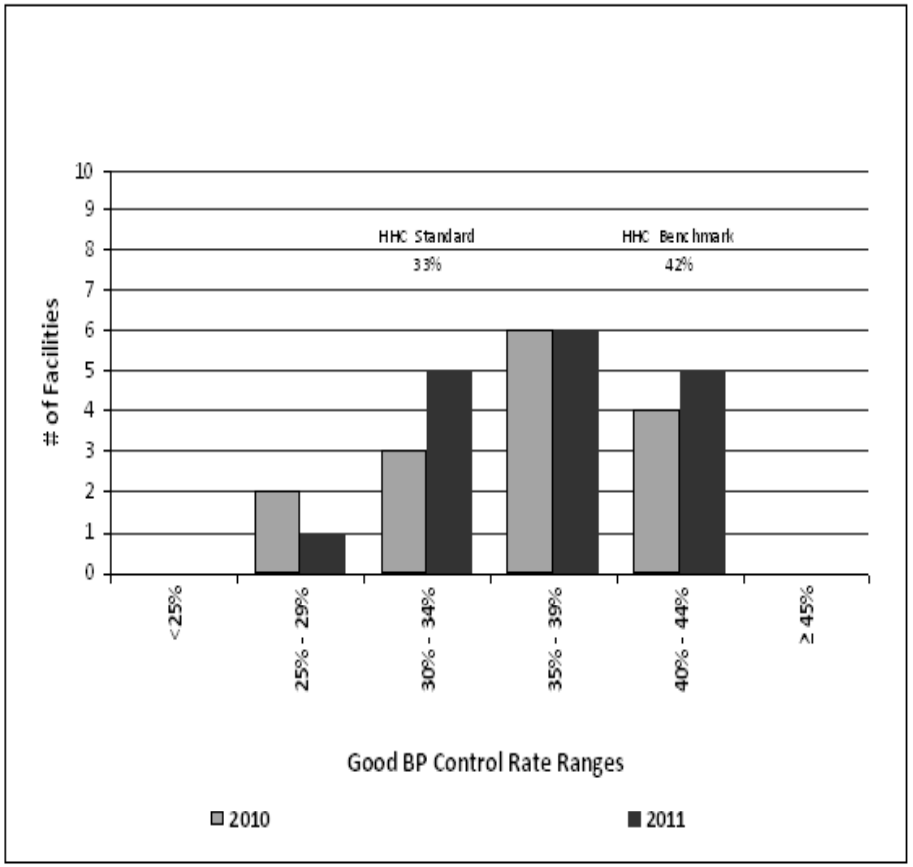
"Benchmark": 90th Percentile of Commercial HMOs

Goal: *Complete Data on All Metrics by end of 2012*

HHC Corporate Dashboard Data

Diabetics Good BP Control Rate

Time Period: 2010 vs 2011

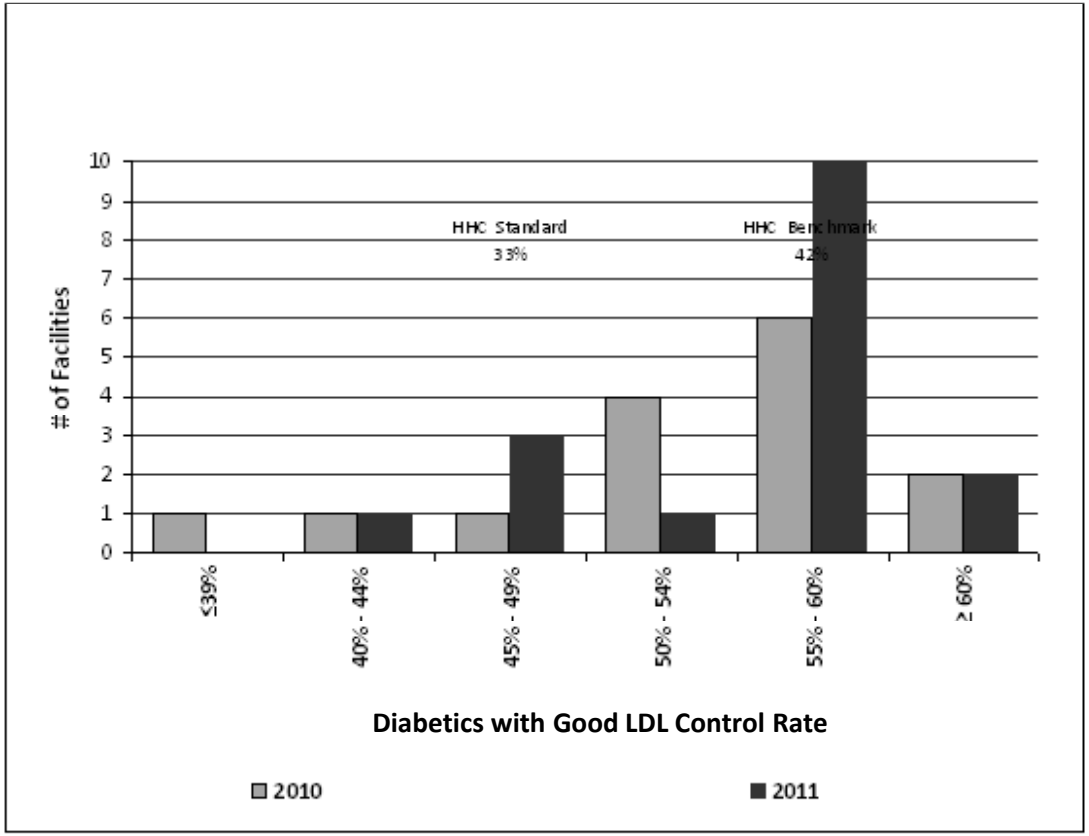


- **Standard = National Average Comm HMO**
- **Benchmark = 90th percentile Nat. Comm. HMO**
- **Improvement from 2010 to 2011**
- **Narrow variation across corporation**
- **Improvement strategies need to be system-wide**

2010 Facility %s in Ascending Order		2011 Facility %s in Ascending Order	
Harlem	27%	Harlem	27%
Cumberland	29%	Kings County	32%
Kings	32%	Queens	32%
Bellevue	32%	Morrisania	33%
Lincoln	34%	Renaissance	34%
Morrisania	35%	Bellevue	34%
East NY	35%	Jacobi	35%
NCB	35%	NCB	36%
Jacobi	36%	ENY	37%
Renaissance	36%	Cumberland	39%
Woodhull	39%	Woodhull	39%
Segundo Belvis	42%	Lincoln	39%
Coney Island	43%	Gouverneur	40%
Metropolitan	44%	Elmhurst	41%
Gouverneur	44%	SR Belvis	41%
Elmhurst	NA	Coney Island	43%
Queens	NA	Metropolitan	44%
HHC (Average)	36%	HHC (Average)	36%
Standard	33%	Standard	33%
Benchmark	42%	Benchmark	42%

HHC Corporate Dashboard Data

Diabetics with Good LDL Control Rate Time Period: 2010 vs. 2011

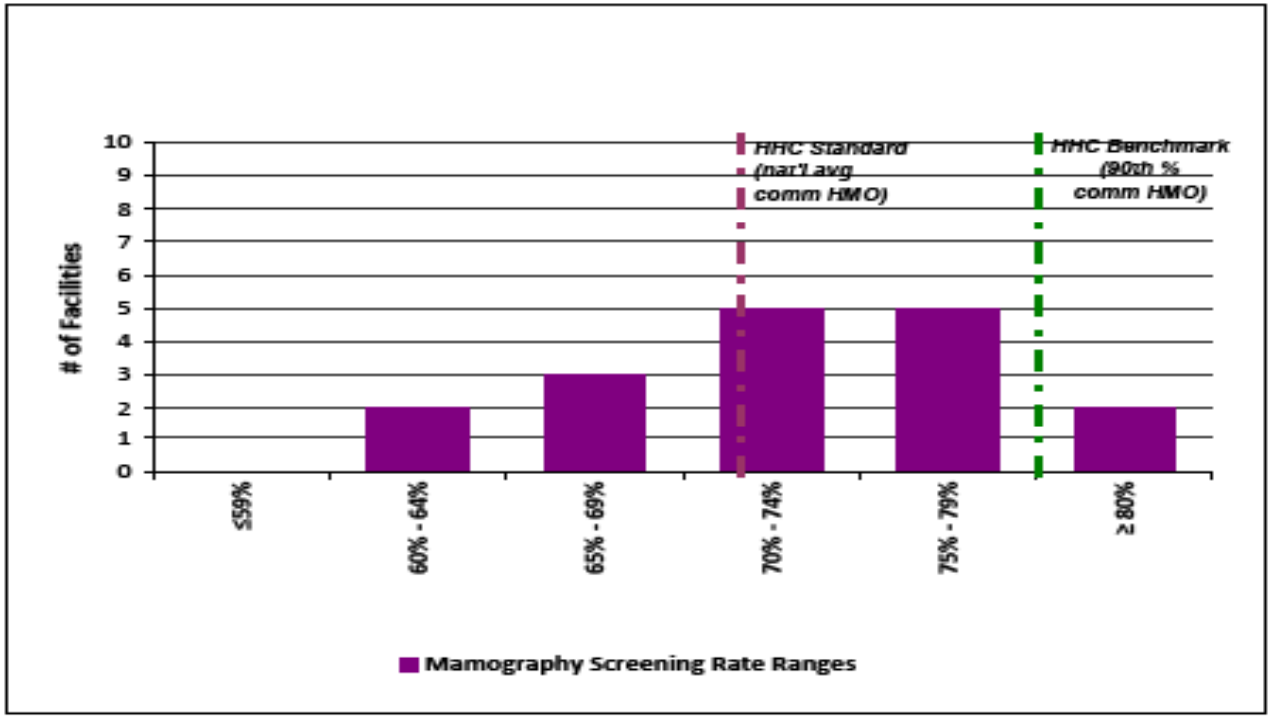


- **Standard = National Average Comm. HMO**
- **Benchmark = 90th percentile Nat. Comm. HMO**
- **Good Performance with Improvement from 2010 to 2011**
- **Long 'tail' → need to focus on lower performers**

2010 Facility %s in Ascending Order		2011 Facility %s in Ascending Order	
Renaissance	39%	Renaissance	40%
Harlem	42%	Harlem	45%
Morrisania	47%	Morrisania	49%
Woodhull	50%	Woodhull	49%
Bellevue	51%	SR Belvis	51%
Segundo Belvis	51%	Elmhurst	56%
Gouverneur	53%	Cumberland	56%
NCB	55%	ENY	57%
Lincoln	57%	Kings County	57%
Jacobi	57%	Gouverneur	59%
East NY	57%	NCB	59%
Metropolitan	57%	Jacobi	59%
Kings County	59%	Queens	59%
Cumberland	61%	Bellevue	59%
Coney Island	62%	Metropolitan	59%
Elmhurst	NA	Lincoln	60%
Queens	NA	Coney Island	63%
HHC (Average)	36%	HHC (Average)	56%
Standard	33%	Standard	33%
Benchmark	42%	Benchmark	42%

HHC Corporate Dashboard Data

Mammography Screening Rate
Time Period: CY 2011



Facility	Mammography Screening Rate
Kings County	62%
Renaissance	65%
Bellevue	66%
Harlem	67%
Coney Island	68%
Elmhurst	73%
Jacobi	74%
Lincoln	74%
Woodhull	74%
Queens	75%
Gouverneur	75%
Metropolitan	76%
ENY	77%
Cumberland	78%
NCB	79%
Morrisania	83%
SR Belvis	86%
HHC (Average)	72%
Standard	71%
Benchmark	80%

- Continuous distribution
- 'Long tail', most have significant room for improvement
- Improvement strategies both targeted and system-wide

Moving Beyond the Plateau

- Bring lowest performers into the ‘Pack’
  - Adoption of readily available best practices
  - Identify unique challenges

- Moving up the Whole ‘Pack’

  Target Different Barriers with New Tools
  - PCMH: “It takes a village” – enlist all team members
  - Proven approaches to lifestyle change
  - Closer follow-up of uncontrolled patients (care management, non-MD driven pathways)

Using Data to Drive Improvement

- Identify disparities and variations
  - Facility-to-facility
  - Subpopulations within a facility
  - Provider-to-provider within a facility
- Measure impact of interventions

2012 New Areas of Focus in Prevention and Chronic Illness

- Heart Failure (reduce readmissions)
- Geriatric syndromes (fall risk, dementia)
- Adolescent Wellness (obesity, reproductive health)
- Drug/alcohol “hazardous” use
- Obesity/Overweight (children, adolescent, adult)

2012 Priority Areas for Improved Data Collection/Reporting

- Depression management in primary care
- Preventive Measures in DM (eye/kidney/ feet)
- Colorectal screening (screening/quality rate)
- Prevention Composite (vaccines, screening)