AGENDA

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE

Meeting Date: September 11th, 2014
Time: 12:30 PM
Location: 125 Worth Street, Room 532

BOARD OF DIRECTORS

CALL TO ORDER — **DR. CALAMIA**

ADOPTION OF MINUTES

- ***July 10, 2014***

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

METROPLUS HEALTH PLAN — **DR. SAPERSTEIN**

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

ACTION ITEM:

1. Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to enter into a contract with Hyland Software, Inc. (the "Contractor") for OnBase Enterprise Electronic Content Management ("ECM") software through a Federal General Services Administration agreement ("GSA") contract in an amount not to exceed $6,399,646 which includes a 10% contingency of $581,786, over a three year term, with two one-year options to renew. — **MR. RAMLAKHAN**

INFORMATION ITEMS:

1. **MetroPlus Health Plan Annual Report** — **DR. SAPERSTEIN**
2. **Patient Safety** — **MS. JACOBS/ MS. KONG**

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

MINUTES

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE BOARD OF DIRECTORS

Meeting Date: July 10, 2014

ATTENDEES

COMMITTEE MEMBERS

Vincent Calamia, MD, Committee Chair
Ramanathan Raju, MD, President
Josephine Bolus, RN
Gerald Cohen, MD (representing Hillary Kunins, MD, in a voting capacity)

HHC CENTRAL OFFICE STAFF:

Sharon Abbott, Assistant Director, Corporate Planning and HIV Services
Machelle Allen, MD, Deputy Chief Medical Officer, Office of Health Care Improvement
Janette Baxter, Senior Director, Risk Management
Jen Bender, Associate Director, Media Relations
Gary Belkin, MD, Senior Director, Office of Behavioral Health
Suzanne Blundi, Deputy Counsel, Office of Legal Affairs
Nicholas V. Cagliuso, Assistant Vice President, Office of Emergency Management
Louis Capponi, MD, Chief Medical Informatics Officer
Tammy Carlisle, Associate Executive Director, Corporate Planning
Eunice Casey, Senior Management Consultant, Corporate Planning
Deborah Cates, Chief of Staff, Board Affairs
Maria Arias-Clarke, Assistant Director, Corporate Budget
Paul Contino, Chief Technology Officer
Nelson Conde, Senior Director, Office of Professional Service & Affiliation
Megan Cunningham, Associate Director, Accountable Care Organization
Robin Dasilva, Associate Director, Quality Performance and Innovation
Barbara Deiorio, Senior Director, Internal Communications
Christine Desrosiers, Office of Legal Affairs
Joel Font, Consultant, Enterprise IT Service (EITS)
Mary Ann Etiebet, Director, Medical and Professional Affairs
Juliet Gaengan, Senior Director, Clinical Affairs
Marisa Salamone-Greason, Assistant Vice President, EITS
Sal Guido, Assistant Vice President, Infrastructure Services
Terry Hamilton, Assistant Vice President, Corporate Planning Services
Mark Hartman, Senior Counsel, Legal Affairs
Lauren Haynes, Assistant System Analysis, President Office
Lydia Isaac, Assistant Director HIV
Caroline Jacobs, Senior Vice President, Safety and Human Development
Lauren Johnston, Senior Assistant Vice President/Chief Nursing Officer, Patient Centered Care
Christina Jenkins, MD, Senior Assistant Vice President, Quality, Performance and Innovation

Imah Jones, Senior Director, Research
Mei Kong, Assistant Vice President, Patient Safety
Elizabeth Lagone, Assistant Director, Office of Healthcare Improvement
Patricia Lockhart, Secretary to the Corporation
David Larish, Director Procurement, Operation
Ronald Low, MD, Senior Director, Office of Statistic and Data analysis
Katarina Madej, Director, Marketing
Ana Marengo, Senior Vice President, Communications & Marketing
Antonio D. Martin, Executive Vice President/Corporate Chief Operating Officer
Karen Mattera, Director, Office of Emergency Management
Kathleen McGrath, Senior Director, Communications & Marketing
Randall Mark, Chief of Staff, President Office
Ian Michaels, Director, Communication & Marketing
Charlotte Neuhaus, Senior Management Consultant, Corporate Planning Services
Deirdre Newton, Office of Legal Affairs
Praveen R. Pannala, Associate Director, Research Office
Joseph Quinones, Senior Assistant Vice President, Operations
Bert Robles, Senior Vice President, Chief Information Officer
Deborah Rose, Director, Medical and Professional Affairs
Salvatore Russo, Senior Vice President & General Counsel, Legal Affairs
Steven Van Schultz, Director, Internal Audits
Jared Sender, Enterprise Information Technology Service
Lori Schomp, Senior Consultant MIS
David Shi, Senior Director, Primary Car/Medical and Professional Affairs
Pat Slesarchik, Assistant Vice President of Labor Relations
Jessica Steinhart, Assistant Director, Office of Healthcare Improvement
David Stevens, MD, Senior Director, Office of Healthcare Improvement
Nicholas Stine, MD Chief Medical Officer, Accountable Care Organization
Yolanda Thompson, Asst. Director, IT
Diane Toppin, Senior Director, M&PA Divisional Administrator
Steven Van Schultz, Director, IT Audits
Joyce Wale, Senior Assistant Vice President, Office of Behavioral Health
Rick Walker, Chief Finance Officer, North Bronx Health Network
Tony Williams, Director of Information Services
Ross Wilson, Senior Vice President/Corporate Chief Medical Officer, Medical and Professional Affairs

FACILITY STAFF:
Steve Alexander, Executive Director, Bellevue Hospital Center
Ernest Baptiste, Executive Director, King County Hospital Center
David Baksh, Assistant Executive Director, Queens Hospital Center
Yolanda Bruno, Medical Director, Coler-Carter Specialty Hospital
Vito Buccellato, Chief Operating Officer, Coney Island Hospital
Joseph Carter, Associate Director, Bellevue Hospital Center
Aaron Cohen, Chief Financial Officer, Bell
Chris Constantino, Senior Vice President, Queens Health Network

Marie Elivert, Senior Associates, Executive Director, Queens Hospital Center
Elizabeth Gerdts, Chief Nurse Executive, North Central Bronx Hospital
Neal Glaser, Affiliation Administrator, Coler-Cater Specialty Hospital
Carolyn Harvey, Associate Executive Director, Queens Hospital Center
Robert Hughes, Executive Director, Coler –Carter Specialty Hospital
George Leconte, Assistant Executive Director, Queens Hospital Center
John Maese, MD, Medical Director, Coney Island Hospital Center
Terry Mancher, Chief Nurse Executive, Coney Island Hospital
Seth Marine, Coordinating Manager, Bellevue Hospital Center
Paul Pandolfini, Chief Financial Officer, South Bronx Network
Ellen O'Connor, Chief Nurse Executive, Jacobi Medical Center
Lillian Rodriquez, Finance Associate Director, Bellevue Hospital Center
Richard Stone, MD Medical Director Metropolitan Hospital
Arnold Saperstein, MD, Executive Director, MetroPlus Health Plan
Rajiv Pant, MD, Assistant Medical Director, Woodhull Medical and Mental Health Center
Denise Soares, Senior Vice President, Generations+/No. Manhattan Network, Harlem Hospital Center
Arthur Wagner, Senior Vice President, Southern Brooklyn/Staten Island Network
Marcellus Walker, MD Medical Director East New York D&TC
Meryl Weinberg, Executive Director, Metropolitan Hospital
Maurice Wright, MD, Medical Director, Harlem Hospital Center

OTHERS PRESENT
Moira Dolan, Senior Assistant Director, DC37, Research & Negotiations Department
Denise Dudley, Director/Affiliation Administrator, NYU Affiliation
Simon Herelle, EMC Corporation
Scott Hill, Account Executive, QuadraMed
Richard McIntyre, Siemens
Thomas J. Petrone, President of Petrone Associates Medical Physicists
Samantha ReBurne, Assistant Administrator, NYU
Kristyn Raffaele, Analyst, OMB
Lori Schomp, OMB
Dhruneanne Wood, Analyst OMB

MEDICAL AND PROFESSIONAL AFFAIRS/
INFORMATION TECHNOLOGY COMMITTEE
Thursday, July 10, 2014

Dr. Vincent Calamia, Chair of the Committee, called the meeting to order at 12:00 pm. The minutes of the June 12, 2014 Medical & Professional Affairs/IT Committee meeting were adopted with the following amendment: Dr. Gerald Cohen was in attendance representing Committee member Dr. Hillary Kunins in a voting capacity. Dr. Calamia also announced that Dr. Cohen is present at this meeting in the same capacity.

CHIEF MEDICAL OFFICER REPORT

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

HHC ACO

Each HHC facility is now receiving an ACO Attributed Patient Dashboard, which brings together demographic, financial, clinical, provider and Medicaid patient data in a simple resource for each facility ACO team to use in understanding and managing their population.

Facility-level ACO pilot collaborations with HHC Home Health and Health Home are underway at multiple facilities, leveraging the intensive support services of these partner programs for the ACO's highest-risk patients.

In order to drive ACO performance and accountability, facility and patient-level ER/Inpatient utilization reports are now being provided on a monthly basis.

AS required by CMS ACO patient notification process implementation is underway across the Corporation, as patients arrive for registration.

Emergency Management

In preparation for the upcoming coastal storm season, which officially commences on August 1, Central Office Emergency Management, in partnership with our facilities, the Deputy Mayor's Office for Health and Human Services, NYC OEM and other key stakeholders are meeting weekly to ensure progress on key findings and recommendations following Superstorm Sandy. We are convening the Corporation's Emergency Management Council to review and comment on the initiatives and to ensure the highest levels of resiliency across our sites. In addition, training for the NY state E-Finds system is being undertaken for our ER staff to track evacuees. Expansion of training for "send word now" alert system, and "e-team" request system is being undertaken. External assessment of our emergency readiness will be undertaken by Incident Management Solutions (IMS) over the next 10-12 weeks

DSRIP

On June 26th, HHC submitted its initial planning applications for the Delivery System Reform Incentive Program (DSRIP), a $6.42B Medicaid Waiver program intended to both transform care delivery in NYS and significantly reduce costs, with overall program goal of 25% statewide reduction in preventable admissions over 5-year timeframe.

Seven of our acute care hospitals have submitted an initial, non-binding application to lead seven (7) Performing Provider Systems (PPS), each of which will undertake 7-10 clinical projects intended to improve the health of Medicaid and uninsured patients in its local geographic area. NYS DOH is in process of reviewing all NYS applications, and we expect

to receive their input/guidance by late July or early August. We will incorporate their advice into our future efforts leading to a binding, final application in mid-December.

The work of strategic alignment, partnership formation, community needs assessment, and project selection is conducted under guidance of a Corporate Steering Committee and with support from a consultant vendor, and aims to have a completed application by December 2014 which will assist with the strategic transformation of our healthcare delivery system over the next 5 years.

Research

It is planned to bring the newly revised Research Operating Procedure to the next meeting of this committee. At that time we will brief the committee on the research approval and monitoring processes that are currently being implemented to further strengthen this important work.

MetroPlus Health Plan, Inc.

Arnold Saperstein, MD Executive Director, MetroPlus Health Plan Inc. Presented to the Committee. Dr. Saperstein informed the Committee that the total plan enrollment as of June 1, 2014 was 469,843. Breakdown of plan enrollment by line of business is as follows:

Medicaid	374,326
Child Health Plus	11,855
Family Health Plus	20,127
MetroPlus Gold	3,382
Partnership in Care (HIV/SNP)	5,214
Medicare	7,944
MLTC	577
QHP	45,754
SHOP	664

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.

One of the challenges we are currently facing is that the NYSOH website does not allow applicants to choose a Primary Care Provider (PCP). MetroPlus must auto-assign the PCPs. This has generated some member dissatisfaction and excessive call volume for members to choose or change their PCPs. The State is aware of this issue and claims that addressing it is a priority.

We are beginning to see a minor decrease in the number of members due to non-payment. Members are billed monthly and are given either a 30- or 90-day grace period to pay based on their income and APTC status. Only when the grace period is exhausted are the members disenrolled. As of May 1, 2014, the number of members who were disenrolled due to nonpayment is 2,202.

The Finance Department has been working on a variety of projects in the month of June. The Medicare Bid for 2015 was due the beginning of the month. This was successfully submitted and will now undergo Desk Review.

On June 13th, 2014, MetroPlus successfully submitted the Exchange bid that included a rate increase (to meet costs based on actuarial predictions). Our Silver rates were increased by 17% (from $359.26 to $421.52). This submission includes all actuarial data and exhibits as well as all Contract Language. The rate increase was due to a significant increase in pharmacy costs and network inpatient costs.

The FIDA 2015 Plan submission was also completed. On February 21, 2013, MetroPlus completed our application of supporting documents for the New York State Demonstration to Integrate Care for Full Dual Eligible Individuals (FIDA). The FIDA program will be available starting October 2014, marketing for FIDA begins September 2014. Under the program, care will be coordinated for Medicare, Medicaid and Managed Long Term Care eligible individuals who require 120 days or more of long term support services. Medical Management completed the Model of Care component of the application in February 2014. MetroPlus received a three year approval for our FIDA demonstration plan, scoring a 91.67% on the MOC, the highest MOC submission MetroPlus has received for one of our Medicare programs.

Metroplus underwent virtual systems testing in April 2014, where we had to demonstrate our internal system's preparedness for FIDA. Our system's testing demonstrated overall we were on target in preparation for this product launch. We received feedback that our home grown Case Management program met the needs of the requirements of FIDA and the IDT team expectations. Reviewers were very impressed with our DCMS system and the Care Plan developed within the software for FIDA.

During the month of June, CMS/DOH made revisions to the requirements of the FIDA IDT policy. These changes required modifications to some of our policies and procedures in Medical Management and MIS Core, from a systems perspective to meet the requirements of the revised policy. On June 24, 2014, MetroPlus will undergo another Remote Systems Testing to demonstrate our "system readiness" to support the final IDT policy. We (internal departments and external vendors), have been meeting over the past weeks to prepare for this initiative and are confident we will do well. We have completed "test cases" and our interactive sessions have been very positive in preparation for this initiative.

New York State Department of Health released the 2013 Consumer Guide to Medicaid Managed Care in New York City, based on preventive and well-care for adults and children, quality of care provided to members with illnesses, and patient satisfaction with access and service. MetroPlus came in second place, tied with EmblemHealth and Health Plus (Amerigroup).

In order to meet the comprehensive requirements of the Health and Recovery Plan (HARP) for the severely mentally ill population, as well as the requirements to assume behavioral health coverage for the plan's SSI population, MetroPlus has published an RFP for a Behavioral Health Organization to assist us in meeting these requirements. The project was awarded to Beacon. The contract was approved by the MetroPlus Finance Committee on June 10, 2014.

INFORMATION ITEMS:

EMR Implementation Update

Dr. Louis Capponi presented on EMR Implementation Update, EPIC Update, program Update, and a brief demonstration of the development system

Governance process is in place it includes a monthly presentation to the monthly EITS Executive meetings which is serving as the steering committee in the overall implementation. There is a high level review performance to budget and

to also make the committee aware of any current items that have any concerns or that is being monitored closely. The process allows the Escalation Monitoring to the Executive Triage Process which is the last step if it can't be resolved; only one item had to go to that level. There are 4 major watch monitor areas that are continued to monitored, (staffing and build progress, Soarian, Lab, procurement). Staffing was lost to a significant competitor in the city, they were analysis who was training to become certified to build in the EPIC environment, however, there had been some update to Humane Resource policy and better retention programs are being developed to help keep the staff on board. The Soarian implementation and revenue cycle is very important the existing plans to have Soarian staple for six months before implementing the EPIC clinical system, discussion are taking place on how to make that process work giving that we are further billed on soarian and EPIC. The Committee will be updated at a later date. The laboratory restructure of an electronic health record is being implemented. We are implementing the Cerner lab system with our joint partnership with LIJ. There was a demo that took place on the anatomic pathology system. Next week there will be a formal kickoff of the technology and the installation and will take up to twelve months; for procurement, there are a lot of systems that need to be updated as far as the implementation of EPIC. All topics are a watch level and there are strategies in place for them. In EPIC there is good progress in the build, a lot of participation from doctors, nurses and other staff. To date there has been over 342 meetings with clinical staff to improve work flow. There are two major milestones on the build side; one is the workflow which is at 81% completion and the content which is 55 % complete on the total content. The first activation go live site is Queens and Elmhurst and following on the schedule is Jacobi and NCB. The activation team has been meeting with Queens and Elmhurst to prepare them for the infrastructure Biomedical Integration and planning for training.

Dr. Capponi provided a Demo on the training environment that has been worked on to date. There is a Dashboard review, which is what the physicians see when they log in. Dr. Capponi demonstrated the steps which were, Send his self a Reminder, review patient information, manage Orders, Update the Problem List and Write a Progress Note. A patient scenario was provided. Dr. Capponi elaborated on the Dashboard.

Health Information Exchange (HIE)

Paul Contino, Chief Technology Officer, Enterprise IT Service presented the Health Information Exchange HHC Update, which covered the background on HIE, Regional Health Information Organization (RHIO) landscape in NY (esp. NYC), the collaboration of HHC and Interboro RHIO, New York eHealth Collaborative (NYeC) as a Public Utility and RHIO Consideration.

Brief Background on HIE in New York -- Since 2006, New York has led the nation in its investments in Health Information Technology and executing on the vision to build a statewide, interoperable health information network.

Over $960 million dollars has been invested:
$440 million in State HEAL grants
$120 million in other State and Federal funding
$400 million from hospitals, insurers and other stakeholders

The Health Care Efficiency and Affordability Law for New Yorkers Capital Grant Program (HEAL-NY):

Heal 1: $52.9 million (HIE infrastructure)
Heal 5: $105.7 million (Interoperable EHRs)
Heal 10: $140 million (PCMH and care coordination)
Heal 17: $140 million (Expanding care coordination)

HIE Ecosystem: New York and National Milestones

Heal 1 was established in 2006, 2008 The Office of the National Coordinator for Health Information Technology (ONC) started their National Health infrastructure Network trails. In 2009 HiTech was signed. The Statewide Health Information Network for New York (SHIN-NY) was put in place. SHIN-NY comprised of 10 RHIOs across New York State. Six RHIOs are in large areas upstate and four primarily take care of the New York City area. In the upstate RHIO there are not a lot of crossovers -- the RHIOs can support their patients. In the downstate area, there is a significant amount of patient crossover; therefore they came up with the consolidation of RHIO. There four RHIOs-- the BronxRHIO, Healthix, Interboro, and on Long Island e-health. Interboro and NYCHHC have agreed to join the SHIN-NY and utilize their consolidated technical architecture. There has been Re-Platform of Technical Architecture. Interboro will fully convert over from Axolotyl to Intersystem. The HealthShare (NYeC HIE platform) Edge Servers to house HHC data have been setup, Health Level 7 (HL7) Interfaces are in progress for all HHC facilities, migration of data for early RHIO participants (HEAL 5/17), and HHC has agreed to comply with the state wide policy guidance and consent process.

NYeC's HealthShare infrastructure supports not only the Brooklyn Health Information Exchange (BHIX) and Healthix RHIOs, but also Southern Tier HealthLink (STHL), and the Tahonic Health Information Network and Community (THINC). The New HIE Architecture for HHC was presented to show the steps. The 2014 RHIO Project Timeline indicated each phase for each facility. Interboro RHIO participants + Over 200 Physician Practices. SHIN-NY as a public utility - a universally accessible, reliable, public utility. NYeC has $75 Million in State and Federal funding over 3 years. “Dial Tone” Services to be provided by March 2015.

Below are the breakdown of services:

Statewide Patient Record Lookup
Statewide Secure Messaging (DIRECT)
Notifications (Alerts / Subscribe and Notify)
Provider & Public Health Clinical Viewers
Consent Management
Identity Management and Security
Public Health Reporting Integration
Lab Results Delivery
No charge for these services beyond initial setup

RHIO Considerations
SAMHSA – Substance Abuse and Mental Health Services Administration
Official position on HIO as trusted custodians of PHI
No need for consent to upload for HIE

Edge-Server Model - Encryption of Data at Rest and in Motion
Consent

Minutes of July 10, 2014
Medical and Professional Affairs/
Information Technology Committee

Transition from two step consent to single consent for access
Consider multi-provider consent (Health Home model)
HHC Wide Consent (Epic – one longitudinal patient record)

There being no further business, the meeting was adjourned at 1:25 p.m.

Bert Robles
Senior Vice President, Information Technology Services
Report to the M&PA/IT Committee to the Board
Thursday, September 11, 2014 – 12:30 PM

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

1. **Meaningful Use (MU) Stage 2 Update:**

There are five (5) weeks left to go for facilities to attest for Meaningful Use (MU) Stage 2. Over the past several weeks all facilities have seen an increase in their percentages over their previous week's performance. Corporate leadership, HHC providers and the QCPR team have all focused their attention on increasing their numbers and making their attestations.

With continued sustained performance, Jacobi and North Central Bronx Hospitals could successfully attest for this reporting quarter.

The following HHC facilities are fully engaged and could potentially meet the attestation requirements for MU Stage 2 by September 30th:

- Coney Island Hospital
- Bellevue Hospital
- Kings County Hospital
- Queens Hospital

However, the following facilities have low performance on Indicator C6- Patient Portal (50% is needed) with less than 5% increment each week.

- Lincoln Hospital @21%
- Harlem Hospital @ 21%
- Metropolitan Hospital @ 9%
- Woodhull Hospital @ 21%
- Elmhurst Hospital @ 31%

Two (2) Core objectives that are in progress - Risk Assessment and Intra-operability EHR to EHR test via direct HISP.

As mentioned in previous reports to the Board, if during the attestation window, we find facilities are not going to make Stage 2 criteria we can attest with 2014 Stage 1criteria.

The 2014 Participation Options that apply to HHC are as follows:

1. Providers currently working on Stage 2 in 2014 would be able to attest using:

Stage 1 (2014+ Definition) using 2014 Edition Certified Electronic Health Record Technology (CEHRT); or
Stage 2 (2014+ Definition) using 2014 Edition CEHRT.

The 2014 Stage 1 objectives were updated to include:

1. Provide patients the ability to view online, download and transmit information about a hospital admission
2. More than 50 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or Critical Access Hospitals (CAH) have their information available online within 36 hours of discharge.

2014 Stage 1 objectives do not include the TOC (Transition of Care) - Measure 12 Objective which has been the most difficult measure to meet due to the immaturity of the technology needed to support this measure (i.e., lack of direct addresses amongst providers, unavailable HISP functionality and lack of provider directories).

I continue to strongly suggest we stay the course and continue with push for Stage 2. We will be required to meet these measure and objectives in 2015 and we need to ramp up our volumes so we can sustain the measure thresholds.

2. 2014 Best IT Collaboration Among Organizations Award:

HHC EITS, the Fire Department of New York (FDNY) and the Department of Information Technology and Telecommunications (DOITT) were awarded the **"2014 Best IT Collaboration Among Organizations Award"** for the Electronic Patient Care Reporting (ePCR) Wireless Tablet project. Our combined effort was recognized by the Center for Digital Government, which acknowledges through their achievement awards outstanding agency and department web sites and projects at the application and infrastructure level throughout the United States and internationally.

Through this project, HHC integrated its wireless network at all hospital emergency rooms to the FDNY/EMS mobile dispatched vehicles (i.e., ambulances, FDNY Early responder units) using DOITT network infrastructure to seamlessly connect the early responders to the hospitals. As a result, vital patient information can now be transmitted from these remote vehicles to the Emergency Room physicians for early patient diagnostics and admittance.

I'd like to commend both Sal Guido, AVP for Infrastructure and Operations and Kevin Brown, Senior Director, Unified Communications for their work on this critical project.

3. HHC Security Measures Update:

Due to recent reporting by the news media regarding security breaches as well as the ever growing need to remain proactive with safeguarding HHC data and systems, I thought it was important to share with you the security measures EITS has put in place.

HHC's security posture remains at a heightened level with proactive security measures in place. The potential breach recently reported was due to a penetration in internal data bases at several companies. This means that the hackers got into their internal networks and removed the user name and password sequence for the data bases storing this information. Even with complex passwords put in place, the hackers would still poses the required information to get into the individual user accounts. HHC's email system is safeguarded by spam detection, blocking and filtering.

Over the last several year EITS has deployed security product safeguards to protect out Internet connections from breach using Firewalls and Intrusion Protection products that will detect, block and report on unauthorized access and Virtual Private Networks (VPN) using sophisticated encryption algorithms to protect HHC's data. We have recently deployed a Data Loss Prevention product (DLP) that will safeguard HHC's intellectual property and ensures compliance by protecting sensitive data wherever it lives — on premise, in the cloud, or at the endpoints. The Data loss/leak prevention solution system is designed to detect potential data breach / data ex-filtration transmissions and prevent them by monitoring, detecting and blocking sensitive data while in-use (endpoint actions), in-motion (network traffic), and at-rest (data storage). Such sensitive data can come in the form of private or company information, intellectual property (IP), financial or patient information, credit-card data, and other information for the Healthcare industry. EITS has deployed advanced technology to protect our data from potential breaches. While these products safeguard HHC from intrusions and theft of data, it is not a 100% guaranteed that breaches will not occur.

EITS remains diligent on detecting abnormal access to data, researching potential attacks and constantly monitoring and analyzing in- and out-bound traffic to determine and rectify any identified potential gaps. Our thorough EITS security team meets weekly to review the trend analysis for vulnerabilities and threats indications from scans throughout our network.

4. EITS SkillSoft Training Update:

Back on November 1st, 2013, I reported to this Committee that as part of the IT Training & Professional Development program within EITS, all employees were assigned mandatory on-line training to enhance and complement their current skill set. The goal of this program is to further develop those core competencies needed by EITS staff to support HHC's strategic goals.

We developed a core curriculum of essential skills for employees with special curriculums for Project Managers, New and Experienced managers as well as the Enterprise Service Desk employees. Each curriculum was approximately 20 hours in length and employees were given a completion date of June 30, 2014. As of July 1st I am pleased to report that 94% of the EITS staff completed their first year of the Training program. Level 2 training is currently underway and consists of 20-25 hours of foundational and advanced training with five (5) hours of electives chosen by each EITS employee. As with Level 1, all course completions are tracked through the PeopleSoft application. All EITS employees have been informed that timely completion of these courses will factor into staff evaluations and future promotions.

This completes my report today. Thank you.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to enter into a contract with Hyland Software, Inc. (the "Contractor") for OnBase Enterprise Electronic Content Management ("ECM") software through a Federal General Services Administration agreement ("GSA") contract in an amount not to exceed $6,399,646 which includes a 10% contingency of $581,786, over a three year term, with two one-year options to renew.

WHEREAS, the Corporation is undertaking an initiative to implement a single enterprise ECM system; and

WHEREAS, Enterprise IT Services has recommended that the Corporation use ECM software to support the new EMR as well as support integration to existing Enterprise Resource Planning systems; and

WHEREAS, the Corporation solicited proposals from ECM vendors who offer their software and services via New York State Office of General Services contracts and GSA contracts; and

WHEREAS, the Contractor offered the lowest price for the requested software, maintenance, and services and the prices for such services and maintenance are discounted from market price; and

WHEREAS, under the proposed agreement with the Contractor, the Corporation will execute an enterprise license agreement with the Contractor to secure the Corporation's right to use the software; and

WHEREAS, the overall responsibility for managing and monitoring the agreement shall be under the Senior Vice President/Corporate Chief Information Officer.

NOW THEREFORE, be it:

RESOLVED, THAT the President of the New York City Health and Hospitals Corporation be and hereby is authorized to enter into a contract with Hyland Software, Inc. for OnBase ECM software, maintenance and services, through a Federal General Services Administration agreement in an amount not to exceed $6,399,646 which includes a 10% contingency of $581,786 over a three year term, with two one-year options to renew.

EXECUTIVE SUMMARY

The accompanying resolution requests approval to enter into a contract with Hyland Software, Inc. (the "Contractor") for Enterprise Electronic Content Management ("ECM") software through a Federal General Services Administration ("GSA") contract in an amount not to exceed **$6,399,646** which includes a 10% contingency of $581,786 over a three year term, with two one-year options to renew. The funding for this purchase will be provided from the EMR budget previously presented to the Board of Directors.

Under the proposed agreement with the Contractor, the Corporation will execute an Enterprise License Agreement to secure the Corporation's right to use the software.

Through this Enterprise License Agreement ("ELA"), HHC is undertaking an important initiative to implement an ECM software system to support the Electronic Medical Record (EMR) System. The software will enable HHC to integrate with the Epic EMR, providing a complete view of a patient's medical record. Additionally, the system will provide the capability to support and integrate with HHC "Non-clinical" Enterprise Resource Planning (ERP) systems such as those used by Finance or Human Resources.

EITS has recommended the use of Enterprise ECM software to support the new EMR/EPIC application as a technical requirement to store and manage all unstructured patient information in a standardized electronic patient medical record that can be retrieved and viewed from within the Epic system. Maintaining a single ECM system rather than multiple systems builds efficiencies within the infrastructure environment to allow EITS to redirect resources to other high level activities.

An Enterprise ECM has many benefits. This ECM system can provide immediate access to all patient data from within the EPIC system. This ECM system minimizes risk by enforcing security policies, reporting and auditing on information stored, and automating retention and records management requirements. This ECM system integrates to Enterprise Resource Planning (ERP) Systems to unite data and documents without users having to leave their ERP system.

The new ELA has the potential to avoid costs by enabling integration to ERP systems without having to purchase additional software, giving HHC the ability to manage all their clinical and non-clinical unstructured corporate content in a single system. The proposed ELA (not including contingency) is **$5,817,860** versus the non-bundled cost to purchase the software, maintenance and services which would total over $8.1 million, over the five year term. The Corporation conducted a solicitation via NYS OGS and Federal GSA contracts for the requested software, maintenance and services for a five year term. Hyland Software, Inc. offered the lowest proposed price for the requested software, maintenance and services, totaling **$5,817,860** over the five year term.

CONTRACT FACT SHEET

New York City Health and Hospitals Corporation

Contract Title: Enterprise Content Management System

Project Title & Number: Enterprise Content Management System to Support Epic Implementation

Project Location: HHC Corporate and Facilities

Requesting Dept.: Enterprise IT Services

Successful Respondent: Hyland Software, Inc.

Contract Amount: $5,817,860 plus a 10% contingency fee of $581,786

Total Not to Exceed: $6,399,646

Contract Term: Three years with two (2) one (1) year options to renew, exercisable solely at the discretion of HHC.

Number of Respondents: 4
(If Sole Source, explain in Background section)

Range of Proposals: $5,817,860 to $8,232,682

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

Funding Source: ☐ General Care ☑ Capital
☐ Grant: explain
☑ Other: explain OTPS

Method of Payment: Lump Sum ☐ Per Diem ☐ Time and Rate
☑ Other: Initial payment for Software, monthly payments for professional services, and scheduled payments for annual maintenance

EEO Analysis: N/A

Compliance with HHC's McBride Principles? ☐ Yes ☐ No ☑ Pending

Vendex Clearance ☐ Yes ☐ No ☑N/A (Caution Check Only)

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

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

The purpose of this Contract is to purchase a new enterprise Electronic Content Management (ECM) system to support the enterprise-wide program to implement a new Electronic Medical Record (EMR) system. As part of this EMR program, HHC is procuring an enterprise-wide Enterprise Content Management System (ECM) that meets its needs now and in the future. The New York City Health and Hospitals Corporation (HHC) requires an Enterprise Content Management system to manage unstructured data content (such as scanned documents, email, reports, medical images and office documents). The ECM system that HHC selected will integrate to the new Epic (EMR) system to provide a single view of a patient's medical record for clinical staff from the Epic system. Additionally, the ECM must provide long term, value added capabilities that can support administrative areas such as Revenue Cycle, Finance, HR and supply chain.

The selected vendor, Hyland Software, Inc., has more than 11,500 installations of their OnBase ECM worldwide. Hyland Software has customers that have deployed the OnBase solution in unique, mission critical, enterprise environments. They have numerous enterprise installations that are of comparable size and complexity of the proposed New York City Health & Hospitals Corporation document management system. 125 Epic customers have implemented Hyland's OnBase as their ECM in support of their Epic EMR system.

Additionally, OnBase was designed to be an ECM that has the ability to expand and grow within an organization. The OnBase system can be configured to integrate with HHC's "non-clinical" Enterprise Resource Planning systems such as Human Resources, Legal and Finance.. The core modules being purchased are enterprise licenses and may be utilized in other departments to expand the solution across the HHC organization.

Contract Review Committee

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

The Contract was presented to the CRC for approval on July 16, 2014.

The funding for this purchase will be provided from the EMR budget previously presented to the Board of Directors.

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

N/A.

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

Selection Committee Members:

1. Enrick Ramlakhan, EITS, Business Applications, Assistant Vice President
2. Dr.Glenn Martin, Queens Health Network, CMIO
3. Dr. Peter Peacock, King's County Hospital Network, CMIO
4. JoAnn Liburd, Patient Safety/Accreditation & Regulatory Services, Senior Director
5. Julio Santos, EITS Clinical Information Systems, Sr. Director
6. Erin Moss, Metropolitain Hospital, Senior Associate Director, HIM
7. Lebby Delgado, Generations Plus, Associate Executive Director
8. Media Oliver, Queens Hospital, Director, HIM
9. Richard Minott, Finance, Revenue Cycle
10. Tony Williams, EITS Network Services, Director Storage/Virtualization

Additional Input from: (Recommendations Only)

1. Nicholas Aprigliano, ICIS -PMO
2. Joseph Hood, EITS Clinical IS
3. Nelly Valentin, Harlem Hospital, HIM
4. Erin Moss, Metropolitain Hospital, HIM
5. Vijay Saradhi, EITS Master Data Management
6. Andrey Yatsko-EITS Network Services, SQL
7. Sunil Rao-EITS Network Services, Network
8. Chakradhar Narayana-EITS Network Services, Storage
9. Priya Prabhakaran-EITS Network Services, Backups
10. Ghanshyam Daga-EITS Network Services, VMWARE
11. Damal Raval- Daga-EITS Network Services, Security
12. EPIC – Ed Wundlin, HIM Implementation Services
13. EPIC – Clarke Vierheller, HIM Implementation Services

<u>List of firms responding to solicitation:</u>

1. IBM, Inc.
2. EMC, Inc.
3. Hyland Software, Inc.
4. Perceptive Systems, Inc.

<u>List of Firms Considered</u>

1. <u>Hyland Software, Inc.</u>
2. <u>Perceptive Systems, Inc.</u>

On August 28, 2013 HHC issued a solicitation for an Enterprise Content Management System. On September, 27, 2013, the four (4) firms listed above responded to this solicitation. The criteria used to select the vendors included:

Vendors:

1. Vendors must be established in the Enterprise Content Management space. Listed as leaders in Gartner's Magic Quadrant for ECM.
2. Vendors must have extensive experience with healthcare organizations of similar size to HHC.
3. Vendor software must be available via Federal (GSA), NY State (OGS), or GPO Contracts.
4. Vendors must have installed their proposed software solution in five (5) Epic clients within the last three (3) calendar years and it must be in full production
5. Total Cost of proposal.

Technology:

1. Seamless integration with Epic for both structured and unstructured data
2. Seamless integration with QuadraMed and Soarian.
3. Supports and integrates with "non-clinical" Administrative departments of HHC (Finance, HR, etc.).
4. Technical Requirements – Image Capture, Document Management, Document Storage, User Friendly, and intuitive technology.

Two (2) of the four (4) firms responses were considered; Hyland and Perceptive. EMC did not meet the requirement for having their proposed software solution in five (5) Epic clients within the last three (3) years. IBM sent an 'Intent to No-Bid.'

Presentations were made to the Evaluation Committee by Perspective on 12/16/2013 and Hyland on 12/18/2013. Each vendor participated in Vendor Infrastructure conference calls on 12/24/2013. Reference calls and site visits for the references provided by each vendor were completed during the period of 3/5/2014 and 3/20/2014. The Evaluation Committee completed their Scorecard voting on 3/24/2014. Both firms were scored using an evaluation with weights assigned to each selection criteria in the areas noted above. The firms were ranked in descending order based on this scoring. As the firm with the highest score, Hyland Software was selected as the vendor of choice to provide HHC with their new ECM. Hyland Software has a GSA Contract (GS-35F-4127D). A Vendex caution check was performed for this vendor on August 28, 2014 which found no cautions.

Scope of work and timetable:

The proposed solution has been scaled to meet HHC's implementation approach. The hardware being proposed accounts for a 5 year growth based on the trends provided in the solicitation. The proposed software would allow for all hospitals and clinics to go live with Epic over the next 5-6 years. The implementation of the OnBase ECM will follow the rollout schedule of the Epic EMR implementation

The scope of work includes procuring a comprehensive Electronic Content Management system and integrating it with the Epic EMR system to store and manage the 25 – 35% of patient data that will not be managed by the Epic system. Currently, this data is scanned into the QuadraMed system by the HIM organizations.

The following services will be provided through this contract:

Software Licenses
- Perpetual Enterprise Licenses for all ECM modules

Software Maintenance
- Annual maintenance as modules are used

Professional Services
- Implementation support for each Epic rollout to the Network
- Conversion of data and images from the QuadraMed Systems into the ECM
- Technical Support during the implementation and Epic rollouts
- Training

The high level rollout timeframe for the first Epic implementation is noted below separated into Phases:

1) Initiation and Planning – Estimated Duration 3-6 Weeks
2) Discovery - Estimated Duration 2-5 Weeks
3) OnBase Implementation – Estimated Duration 3-7 Weeks
4) Customer Testing/Training – Estimated Duration 4-6 Weeks
5) Production Readiness – Estimated Duration 1-2 Weeks.
6) Initial - Go Live Estimated Duration 2-3 Weeks

Each subsequent Network rollout for Epic will follow the same timeline.

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

Purchasing each of the items in the ELA individually at list price would have cost the Corporation over $8.1 Million over the next 5 years. The selected proposal is for $5.8 Million for the same products and services.

The new ECM will extend the value of existing IT investments by integrating with HHC's Epic, ERP and other HHC business systems. HHC requires an ECM to integrate to the new Epic Electronic Health Records to support the non-structured patient data that will continue to exist outside of the Epic system after Epic implementation. HHC needs an ECM solution to integrate and support "Non-clinical" administrative areas such as Revenue Cycle, Finance, Human Resources or any other are within the organization that may need ECM functionality.

The efficiencies gained by implementing a new ECM system address the short comings of storing and accessing paper medical and non-medical records. A new ECM system that can integrate with all existing applications reduces the learning curve and training costs of adopting a new information management system. In most cases, the users will work in their current system. This can result in a in a more satisfied work force, less turnover and reduced personnel costs.

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

N/A

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

The Corporation is purchasing a new ECM system that will require some customization/coding to integrate with the Epic EMR by Hyland staff. HHC employees will be trained by Hyland and work with Hyland staff. After knowledge transfer is complete, the Corporation staff will take over the system administration and configuration activities for roll-out to support "Non-clinical" Enterprise Resource Planning (ERP) systems supporting administrative areas such as Revenue Cycle, Finance, Human Resources or any other area within the organization that may need ECM functionality.

Will the contract produce artistic/creative/intellectual property? Who will own It? Will a copyright be obtained? Will it be marketable? Did the presence of such property and ownership thereof enter into contract price negotiations?

Not applicable.

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

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

Equal Employment Opportunity Analysis *(include outreach efforts to MBE/WBE's, selection process, comparison of vendor/contractor EEO profile to EEO criteria. Indicate areas of under-representation and plan/timetable to address problem areas):*

Not Applicable – Procured via Federal GSA contract

Received By E.E.O. _____
Date

Analysis Completed By E.E.O._____
Date

_____
Name

Enterprise Content Management

Enrick Ramlakhan, AVP Business Applications
Peter Peacock, MD, Kings County Hospital Center
Stephanie Jordan, Director Business Applications

Medical and Professional Affairs/IT Committee Meeting

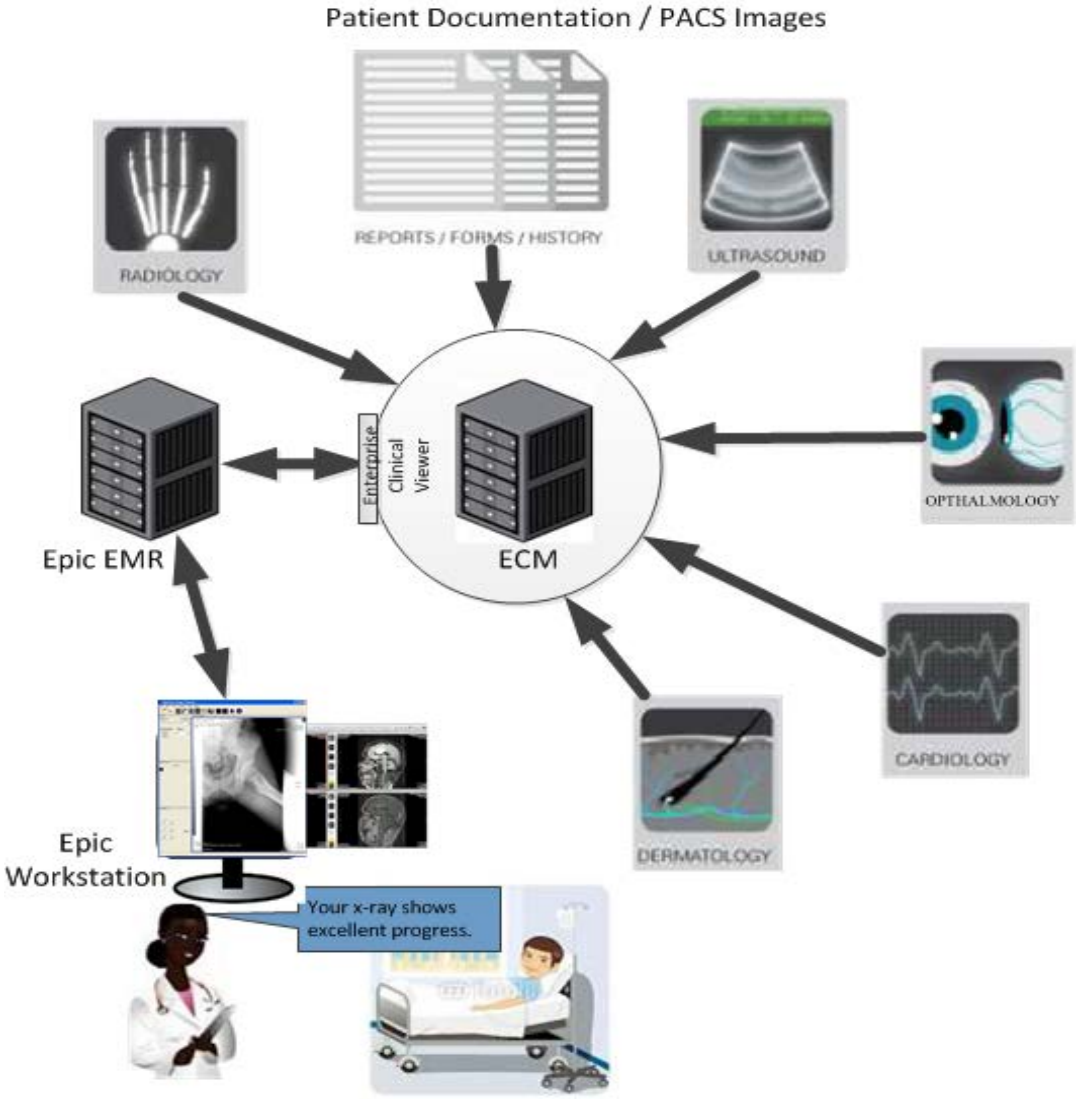
September 11, 2014

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

nyc.gov/hhc

What is Enterprise Content Management

- ECM pulls information from separate clinical / diagnostic systems, such as Cardiology, Radiology, Ophthalmology, etc.
- Physicians and other clinicians on the care team will have access to patient data from within the Epic EMR system. They would not have to 'leave' Epic and access another application where patient information resides.
- The ECM enables physicians and other clinicians on the care team to work more efficiently which increases the clinical time available to spend at the bedside.
- Current literature and research indicates that content outside of the EMR can make up to 25% of a patient record. To achieve a true and meaningful patient record, an EMR must transcend hardware and software systems and unite patient information no matter where and how it originates.
- **One Patient, One System of Record**



EMR Budget Presented to Board of Directors in September 2012

Funding for Enterprise Content Management

Funding source for ECM for Software, Maintenance, and Services

- Approximately $6.4M funding from EMR budget

Component	Description	15-year Cost Presented in September 2012 Capital & Operating (in millions)
1. EPIC Contract	Epic Resolution Term 2012-2027	$303
2. QMED	Continuation of current contract through the transition	$80
3. Third Party & Other Software	To be installed over the next 5 years and to be funded through 2027. Includes transition of other existing applications.	$144
4. Hardware	To be purchased over the next 3 years and replacements to be funded through 2027	$191
5. Interfaces	To be purchased over the next 3 years and replacements to be funded through 2027	$157
6. Implementation Support	Vendors to be identified through RFP, Includes cost of non IT Staff participation, training & clinical staff coverage. *(Includes costs associated with backfilling non IT staff with temps.)*	$203
7. Application Support Team	New and Existing HHC Staff to be used through the implementation and maintenance period. (*Includes existing and net new FTEs including fringe benefit costs*)	$ 357
		Total: $1,435

The ECM Solution Completes The EPIC EMR

- Patient's information exists outside of an EMR system – paper, forms, faxes, clinical images, and more that need to be stored in the ECM.
- The Epic EMR without an ECM in place would require HIM (Medical Records) to pull charts; clinicians would not have immediate access to a single view which incorporates a patient's history of care that occurred outside of the EMR.
- The ECM is needed to capture, index, manage, store and quickly access the large volumes of images and unstructured electronic data across the HHC enterprise that provides a 360° view of a patient within Epic for a more efficient and effective healthcare effort. The goal of the ECM is to achieve "One patient, One system of record".
- Clinicians simply click a link in Epic and the relevant patient content from the ECM is displayed to them. Users do not need to learn a separate system or switch between applications.
- Gain efficiencies without changing established healthcare business processes, which in turn, reduces the learning curve and training costs of adopting a new information management system.
- Empower more informed care for improved outcomes and patient satisfaction.
- The ECM is a critical component of the HHC enterprise imaging strategy and architecture and is capable of seamlessly integrating with all industry leading Vendor Neutral Archiving (VNA) systems.

ECM Solicitation Requirements

Essential Requirements

- Vendors must be established in the Enterprise Content Management space. Listed as leaders in Gartner's Magic Quadrant for ECM.
- Vendors must have extensive experience with healthcare organizations of similar size to HHC.
- Vendor software must be available via Federal (GSA), NY State (OGS), or GPO Contracts.
  - IBM, EMC, Hyland, Perceptive met these qualifications and received RFEI solicitation
- Vendors must have installed their proposed software solution in five (5) Epic clients within the last three (3) calendar years and it must be in full production.
  - EMC did not meet this minimum requirement
  - IBM sent an 'Intent to No-Bid'
  - Finalists: Hyland and Perceptive met this requirement

ECM Proposals

- Four vendors were solicited
- Three vendors submitted proposals. One vendor submitted a no bid.
- Two of the three vendors met all minimum qualification requirements.
- The grid below indicates the bid response with the Best and Final Offer for the two remaining vendors:

	Hyland	Perceptive	EMC	IBM
Met Vendor Minimum Qualifying Requirements	Yes	Yes	No	No bid
Enterprise ECM License w/Maintenance – Years 1 -5 (BAFO)	**$5,817,860**	**$8,232,682**	N/A	N/A

- HHC leveraged the subscription services of Gartner Group and ECRI. HHC acquisition reflects a 38% discount which surpasses ECRIs market analysis for an acquisition of this magnitude (25% best in their database).

Recommendation for Award

Recommendation

- Vendor Selection Committee voted to award Contract to Hyland Software, Inc. based on:
  - Lowest responsive bid for the ECM Enterprise Licensing Agreement
  - Validated quotations and discounts/ pricing with ECRI and Gartner “quote review” and analyst calls. HHC acquisition reflects a 38% discount which surpasses ECRIs market analysis for an acquisition of this magnitude (25% best in their database).
  - Seamlessly integrates with the Epic EMR system, and 125 customers have chosen Hyland’s product to integrate with their EPIC system (7 times more than any other bidder).
- Reference calls
  - Organizations would renew their contracts with Hyland because of ease of use and access to support services along with the ability to leverage software solution for non-clinical areas. Organizations highly valued Hyland’s support and user groups to fully leverage capability of the solution.
- Site Visits
  - Vendor Selection committee observed greater utilization in the Hyland product over Perceptive
- Award contract in an amount not to exceed $6,399,646 which includes a 10% contingency of $581,786 over a five year term.
- The Contract Review Committee approved DCN2170 on July 16, 2014 to move forward

Evaluation Committee

Evaluation Committee: (Voting Members)

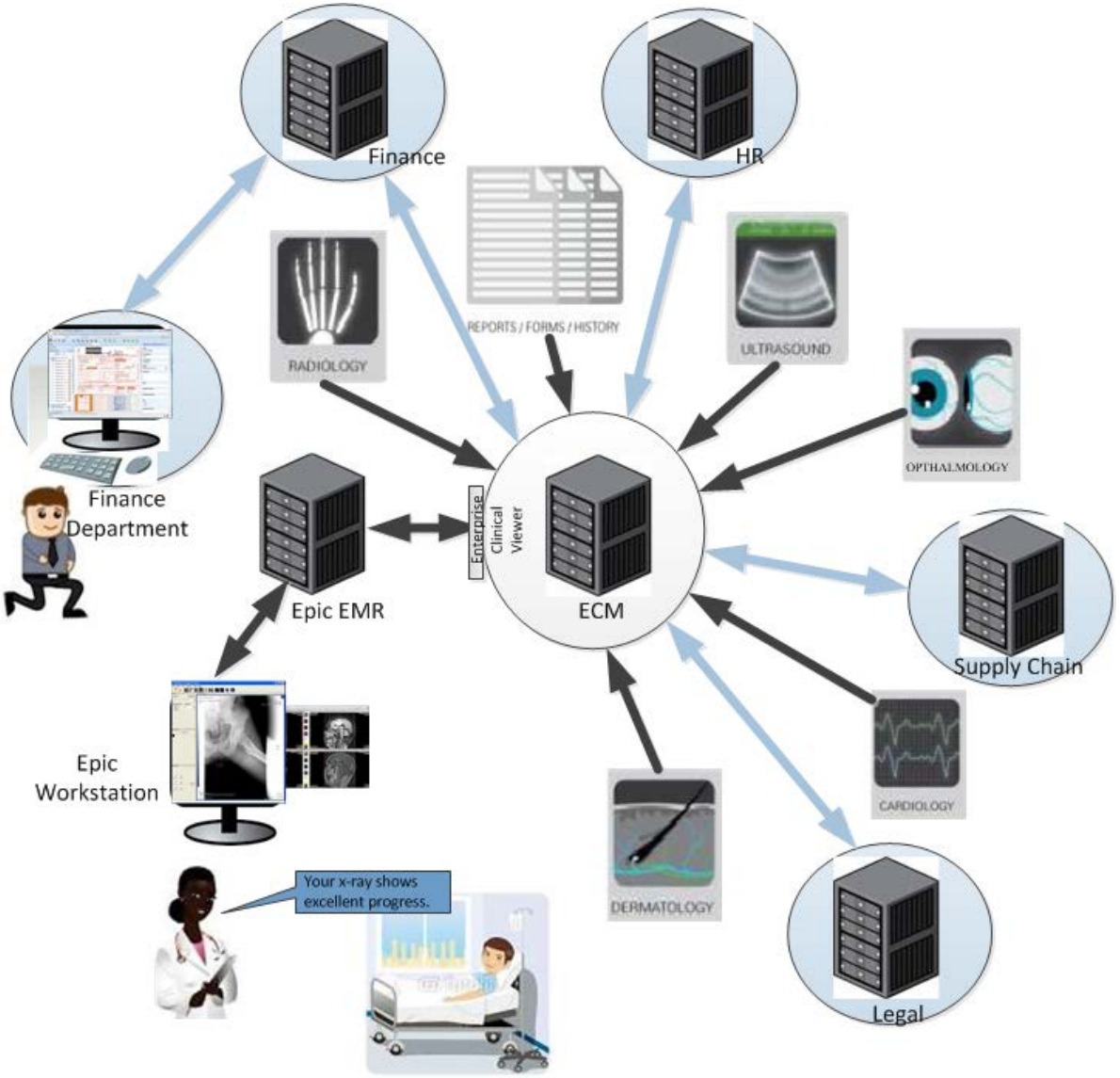
- Enrick Ramlakhan, EITS, Business Applications, Assistant Vice President
- Dr.Glenn Martin, Queens Health Network, CMIO
- Dr. Peter Peacock, King's County Hospital Network, CMIO
- JoAnn Liburd, Patient Safety/Accreditation & Regulatory Services, Senior Director
- Julio Santos, EITS Clinical Information Systems, Sr. Director
- Erin Moss, Metropolitan Hospital,Senior Associate Director, HIM
- Lebby Delgado, Generations Plus, Associate Executive Director
- Media Oliver, Queens Hospital, Director, HIM
- Richard Minott, Finance, Revenue Cycle
- Tony Williams, EITS Network Services, Director Storage/Virtualization

Advisory Group to the Evaluation Committee

- ICIS - Nicholas Aprigliano, PMO
- Joseph Hood, EITS Clinical IS
- Nelly Valentin, Harlem Hospital – HIM
- Erin Moss, Metropolitan Hospital - HIM
- Vijay Saradhi, EITS Master Data Management
- Andrey Yatsko-EITS Network Services, SQL
- Sunil Rao-EITS Network Services, Network
- Chakradhar Narayana-EITS Network Services, Storage
- Priya Prabhakaran-EITS Network Services, Backups
- Ghanshyam Daga-EITS Network Services, VMWARE
- Damal Raval- Daga-EITS Network Services, Security
- EPIC – Ed Wundlin, HIM Implementation Services
- EPIC – Clarke Vierheller, HIM Implementation Services

FUTURE: Non-Clinical Departmental ECM Integration

- ECM pulls and stores information from “non-clinical” systems such as Finance, HR, Supply Chain, and Legal.
- Example, finance worker would have access to invoices in the ECM from within their own ERP application.
- Office workers would not have to ‘leave’ their application to access documents from the ECM application. This will increase productivity and make for a more efficient workflow.



Questions

MetroPlus Health Plan, Inc.

Report to the New York City Health and Hospitals Corporation's Medical and Professional Affairs Committee

Arnold Saperstein, MD

Executive Director, MetroPlus Health Plan

September 11, 2014

Contents

- MetroPlus Background, Mission, Values
- Membership
- Provider Network
- Relationship with HHC
- HHC Financial Arrangement
- Administrative Cost Comparison
- Consumer Guide Results
- MLTC
- FIDA
- Exchanges
- HARP
- Challenges

MetroPlus Background

- Licensed since 1985 in New York State as a Managed Care Organization
- In 2001 the Plan converted from an HMO to a Prepaid Health Services Plan (PHSP)
- Wholly owned subsidiary corporation of the New York City Health and Hospitals Corporation (HHC)
- Lines of business include Medicaid Managed Care, Family Health Plus, Child Health Plus, Medicare plans, two Special Needs Plans (SNP) for the care of HIV+ members in Medicaid and Medicare, Managed Long Term Care, Exchange Products, MetroPlus Gold and, as of January 1, 2015, FIDA and Health and Recovery Plan (HARP)

Mission

- The **MetroPlus Mission** is to provide our members with access to the highest quality, cost-effective health care including a comprehensive program of care management, health education and customer service. This is accomplished by partnering with the New York City Health and Hospitals Corporation (HHC) and our dedicated providers.

Vision

- The **MetroPlus Vision** is to provide access to the highest quality, cost-effective health care for our members, to achieve superior provider, member and employee satisfaction, and to be a fiscally responsible, ongoing financial asset to HHC. MetroPlus will strive to be the only managed health care partner that HHC will ever need. This will be accomplished by our fully engaged, highly motivated MetroPlus staff.

Values

- **Performance excellence** - hold ourselves and our providers to the highest standards to ensure that our members receive quality care
- **Fiscal responsibility** - assure that the revenues we receive are used effectively
- **Regulatory compliance** - with all City, State and Federal laws, regulations and contracts
- **Team work** - everyone at MetroPlus will work together internally and with our providers to deliver the highest quality care and service to our members
- **Accountability** - to each other, our members and providers
- **Respectfulness** - in the way that we treat everyone we encounter

MetroPlus Membership

- Membership at 470,517 as of August 1, 2014.
- MetroPlus membership has increased by 10% in the last 12 months due to the new Exchange and SHOP products

	August 1, 2013	August 1, 2014		% Change
CHP	12,391	11,673	↓	(5.79)
FHP	33,551	14,937	↓	(55.48)
HHC	3,306	3,438	↑	3.99
Medicaid	364,628	380,373	↑	4.32
Medicare	7,038	8,254	↑	17.28
MLTC	286	629	↑	119.93
QHP	0	42,801		
SHOP	0	711		
SNP	5,447	5,198	↓	(4.57)

Primary Care Assignment	
HHC	54%
Community	46%

MetroPlus Health Plan

Strategies to Increase Membership

- Aggressive and strategic marketing initiatives and retention campaigns
- Increased outreach to members for recertification
- Working closely with HHC to maximize referrals of the eligible uninsured patients to MetroPlus

Provider Network

MetroPlus Network Sites	12/3/2013	8/1/2014	% Change
Primary Care Providers (PCPs)	3,357	3,649	8.70
Specialty Providers	13,260	16,259	22.62
OB / GYN	757	728	(3.83)
TOTAL	17,374	20,636	18.78

	2Q 2011	2Q 2012	2Q 2013	2Q 2014
Unique HHC PCPs	526	517	554	540

- "Unique HHC PCPs" represents non-duplicate HHC PCP providers. If a PCP is at multiple locations, for the purpose of this report, he/she is only counted once.

- Much of the significant increase in provider count is due to the **addition of Jamaica and Flushing hospital providers**, as well as increased volume of initial credentialed providers.

Relationship with HHC

- Close collaboration with HHC at all levels of the clinical and administrative spectrum:
  - Forward-thinking environment
  - Mutual population served: low-income, inner city communities, many racial minorities with higher health risk profiles
  - Mutual achievements
  - Increased MetroPlus membership and improved member/patient access to care.
- The continued growth of MetroPlus and our expansion into new lines of business has allowed for the capture of new populations
  - MetroPlus membership growth through in-facility referrals from HHC
  - Increased HHC patient and revenue base

HHC Financial Arrangement

- HHC assumes full risk for all members who select an HHC site.
- HHC assumes risk for all the medical care other than primary care when the member selects a community physician (that is part of the HHC Community Provider network) as their primary care provider.
- MetroPlus assumes full risk for all members assigned to a primary care provider not affiliated with the HHC network and for all members in Medicaid HIV SNP and Medicare plans.

Benefits of HHC Risk Arrangement

- Allows for the alignment of incentives:
  - Improved outcomes and decreased utilization benefits both MetroPlus and HHC.
- MetroPlus provides revenue enhancement through:
  - Insurance reimbursement for service
  - Risk arrangement surplus dollars
  - Quality incentive pools
- Lessons learned from years of partnership will allow MetroPlus and HHC to successfully develop and operate an Accountable Care Organization (ACO) model of care.

2013 Admin Cost Comparison (Q2, 2013)

2013 Q2 - Data		Child Health Plus		Family Health Plus		Medicaid	
Plan		Member Months	PMPM	Member Months	PMPM	Member Months	PMPM
Affinity Health Plan	1	87,983	$ 41.52	174,796	$ 37.93	1,313,664	$ 25.26
Amerigroup	1	230,605	$ 29.35	297,885	$ 41.76	2,095,040	$ 46.71
Capital District Physicians Health Plan	1	87,748	$ 32.58	38,488	$ 33.72	424,395	$ 33.67
Empire Healthchoice	1	223,020	$ 29.65				
Excellus Health Plan	1	220,944	$ 31.04	133,452	$ 34.28	1,080,954	$ 31.23
Health Insurance Plan of Greater New York, Inc.	1	67,604	$ 75.66	149,778	$ 67.54	1,195,246	$ 49.49
HealthFirst PHSP, Inc.	1	138,254	$ 40.49	340,651	$ 39.78	3,206,400	$ 26.93
HealthNow/BCBS-WNY/Community Blue	1	62,507	$ 29.69	30,504	$ 30.47	240,947	$ 25.82
Independent Health Association, Inc.	1	8,682	$ 66.57	21,551	$ 34.82	265,506	$ 38.00
MetroPlus Health Plan	0	77,747	$ 22.20	207,683	$ 22.53	2,234,771	$ 22.59
MVP Health Plan	1	11,508	$ 49.27	16,942	$ 55.28	179,751	$ 48.28
Neighborhood Health Providers	1	45,146	$ 30.09	100,880	$ 32.13	924,060	$ 22.07
NYS Catholic Health Plan	1	368,167	$ 7.67	608,494	$ 16.42	4,114,123	$ 18.66
SCHC Total Care, Inc.	1	14,416	$ 16.64	14,760	$ 29.97	184,072	$ 33.06
United Health Care Plan of NY, Inc.	1	131,989	$ 22.95	270,558	$ 42.78	1,683,675	$ 45.38
Univera Community Health (Buffalo)	1	29,296	$ 37.38	34,373	$ 36.91	233,686	$ 36.96
WellCare of New York, Inc.	1	23,782	$ 29.19	64,766	$ 54.95	392,045	$ 57.62
Westchester PHSP/HealthSource/Hudson Health Plan	1	96,019	$ 35.10	67,942	$ 32.77	555,426	$ 28.85

Aggregate with MetroPlus	$ 34.84	$ 37.89	$ 34.74
Aggregate without MetroPlus	$ 35.58	$ 38.84	$ 35.50

MetroPlus Health Plan

Consumer's Guide to Medicaid Managed Care in NYC: MetroPlus Ranking

- MetroPlus has been rated #1 Medicaid Managed Care health plan in NYC for seven out of the last nine years*. For the first time ever, in 2011 MetroPlus was ranked #1 in New York State and New York City.

Year	Rank
2013	2nd
2012	1st
2011	1st
2010	1st
2009	1st
2008	2nd
2007	1st
2006	1st
2005	1st

* Based on indicators chosen by the New York State Department of Health (NYSDOH) and published in the Consumer's Guide to Medicaid Managed Care in New York City. The 2013 guide, based in part on quality ratings submitted by the health plans and a NYSDOH member satisfaction survey, shows MetroPlus with a 70% percent overall rating. The ratings are based on measures including plans' preventive and well-care for adults and children, quality of care provided to members with illnesses and patient satisfaction with access and service.

2014 Changes

- Managed Long Term Care
- FIDA
- New York Health Exchange
- HARP

Managed Long Term Care (MLTC) Overview

- MetroPlus began offering full services for enrolled members as of January 2013 and received our first auto-assigned members in February 2013.

- Managed long-term care (MLTC) offers assistance to people who are chronically ill or have disabilities and who need health and long-term care services, such as home care or adult day care. The goal of the MLTC plan is to allow these individuals to stay in their homes and communities as long as possible. The MetroPlus MLTC plan arranges and pays for a large selection of health and social services, and provides choice and flexibility in obtaining needed services from one place.

- Our current membership stands at 629 MLTC members; some of the members are auto-enrollees via NYS, while others choose to apply for this product.

Q4 2013 MLTC Membership Detail Age Distribution	
over 65	75%
50 - 65	22%
21 - 49	3%

FIDA

- FIDA is a State of NY partnership with CMS to test a new model for providing Medicare-Medicaid enrollees with more coordinated, person centered care experience.
- MetroPlus Successfully underwent CMS readiness review and an analysis of our policies and procedures in January 2014.
- CMS pushed back the FIDA implementation date to January 1, 2015.
- The marketing period will begin December 1, 2014.
- Education and training for providers contracted for FIDA will be completed by MetroPlus Provider Service Representatives between September and November 2014.

New York Health Exchange

- MetroPlus offers a total of 38 products across the Individual and SHOP markets.
  - Individual (includes non standard)
  - SHOP (includes non standard)
  - Child Only
  - Catastrophic

- MetroPlus currently offers the lowest cost products in three out of four metal levels.

- The 2015 proposed rates have been submitted to NYS for approval

- 100% of FEs trained as Marketplace FEs (formerly known as Certified Application Counselors).

New York Health Exchange
Impact on Medicaid and Family Health Plus

- Medicaid:
  - Beginning January 1, 2014, all new Medicaid applications for MAGI populations have been processed by the Exchange.
    - Pregnant Women
    - Children
    - Parents/Caretaker Relatives
    - Adults under age 65, not on Medicare

New York Health Exchange
Impact on Medicaid and Family Health Plus

- FHP:
  - During 2014, existing FHP enrollees have been transitioned to Medicaid or a QHP, with the program ending at the end of 2014.
  - Beginning January 1, 2014, new applicants who were parents/caretakers with incomes between 138-150% of FPL and qualified for a QHP had their premium paid by the State if they enrolled in a silver plan.
  - Current FHP enrollees who, at renewal, are eligible for a QHP, also receive the premium wrap.

Current Exchange Membership

Metal Level	Benefit Type	0 to 19	20 to 35	36 to 49	50 to 59	60+	Total
Bronze	Non-Standard	0	9	5	1	0	15
Bronze	Standard	41	1,008	597	461	208	2315
Gold	Non-Standard	47	874	751	492	236	2400
Gold	Standard	20	203	186	129	63	601
Platinum	Non-Standard	74	1,310	1,326	1,016	499	4225
Platinum	Standard	67	232	251	208	97	855
Silver	Non-Standard	144	11,079	6,728	5,476	2,393	25820
Silver	Standard	89	2,543	1,701	1,512	725	6570
Total		482	17,258	11,545	9,295	4,221	42,801

Age		% of Membership
0-19	482	1.1%
20-35	17,258	40.2%
36-49	11,545	27%
50-59	9,295	21.8%
60+	4,221	9.9%
Total	42,801	**100%**

Benefit Type		% of Membership
Standard	10,341	24.2%
Non-Standard	32,460	75.8%
Total	42,801	**100%**

*non-standard products include the essential health benefits with the voluntary addition for dental and vision care

MetroPlus Health Plan

Health and Recovery Plan (HARP)

- Carve-in of Behavioral Health for SSI members (17,000)
- Creation of a Health and Recovery Plan (HARP) for the severely mentally ill population (13,000)
- At this time the State is still expressing a commitment that the HARP line of business will be implemented January 1, 2015.
- MetroPlus initiated an RFP to secure bids from behavioral health organizations to contract with to manage HARP membership. Beacon was awarded the contract (approved by the HHC Finance Committee and Board of Directors).
- Effective January 1, 2015 Beacon will manage the MetroPlus membership across all lines of business.
- Beacon is in the process of contracting for Behavioral Health and Substance Abuse services with HHC through HHC's Office of Managed Care.
- MetroPlus will submit a revised and enhanced version of the BH-QHP-MCO and BH HARP RFQ based on the State's letter of response.

Challenges

- Securing access for our new Exchange membership
  - 56% of Exchange members are assigned to HHC for Primary Care
  - HHC Access Project will help HHC absorb more members
- Managing utilization and costs in the Exchange products
  - Submitted 2015 rates prior to any utilization data being available; awaiting NYS approval of rates.
- State website does not allow applicants to choose a PCP, resulting in a high call volume to MetroPlus Customer Services.
- Highly competitive and rapidly changing healthcare landscape and market.
- Inadequate education of potential members on MetroPlus during their outpatient and inpatient visits at HHC.
- Beginning to see member loss due to non-payment.

Summary

- MetroPlus is a strong financial asset to HHC
- MetroPlus is challenged by the lack of access in the HHC facilities
- MetroPlus and HHC have many opportunities to strengthen their existing partnerships to ensure continued success
  - Medicare Enrollment
  - Access Improvement
  - Care Management Linkages
  - MLTC Referrals
  - FIDA Referrals
  - Coordination of Behavioral Health Care

Patient Safety Update 2014

Mei Kong, RN, MSN
Caroline M. Jacobs, MPH, MS.Ed.

M&PA IT Committee
Thursday, September 11, 2014

Patient Safety Update for FY 2014

- **Enterprise-wide strategic priorities**
  - Workforce development
    - TeamSTEPPS® engagement
  - Improving patient experience
- **2014 patient safety priorities**
  - Just Culture engagement
  - Medication safety
  - Patient Safety Culture Survey
- **Partnerships with external agencies and labor unions**
  - Committee of Interns and Residents - SEIU Healthcare (CIR/SEIU)
  - GNYHA and HANYS New York State Partnership For Patients (NYSPFP)
  - Agency for Healthcare Research and Quality (AHRQ)/Health Research and Educational Trust (HRET)/American Hospital Association (AHA)
- **Overview of other patient safety activities**

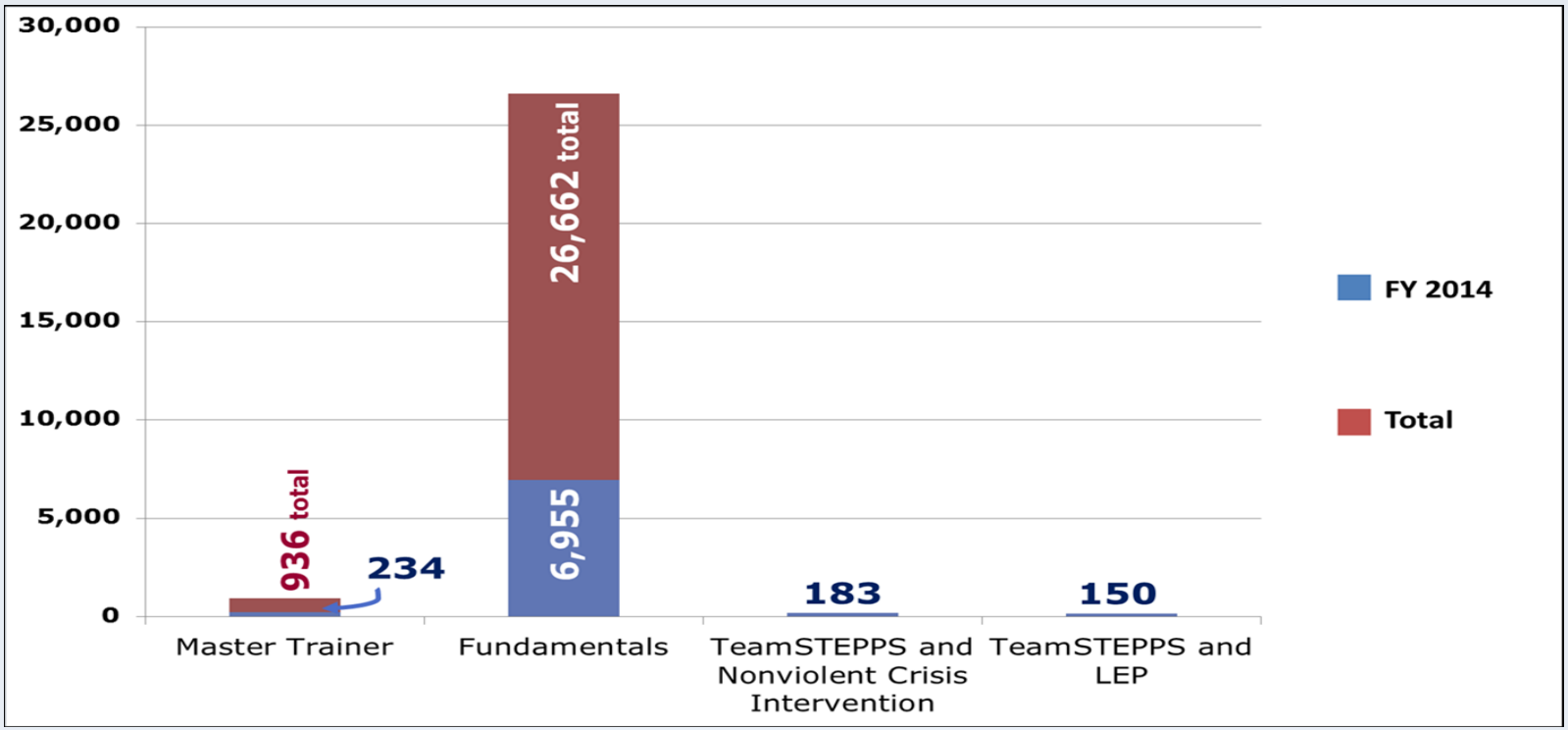
Enterprise-wide Strategic Priority

TeamSTEPPS® Engagement

TeamSTEPPS is an evidence-based framework to optimize team performance. It is comprised of four teachable - learnable skills:

TeamSTEPPS - Team Strategies and Tools to Enhance Performance and Patient Safety

TeamSTEPPS® Engagement FY14

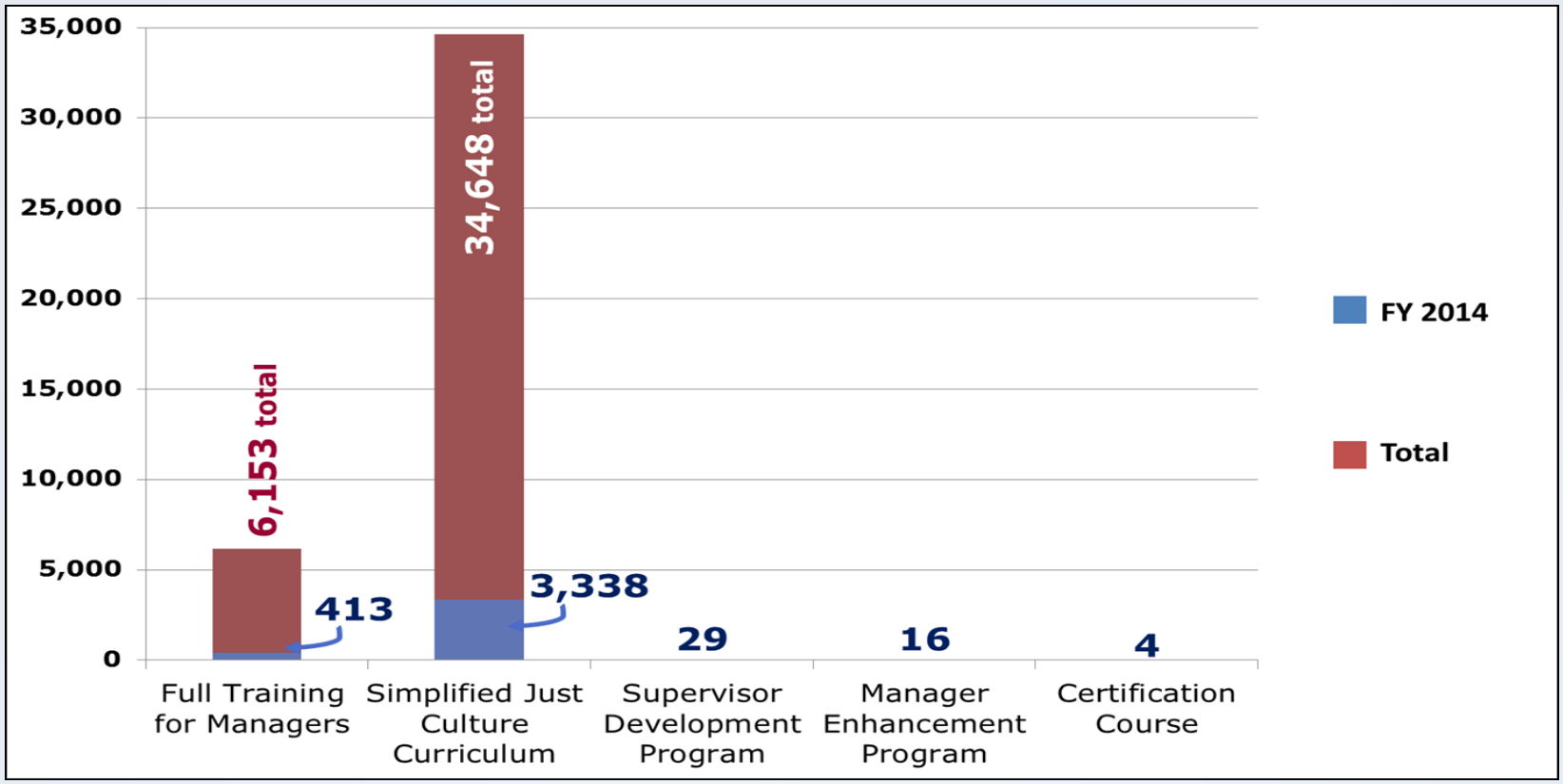


FY14 Hoshin Kanri employee engagement goal = Increase participation in TeamSTEPPS training by **10% or 1,416** employees.

TeamSTEPPS and Nonviolent Crisis Intervention is a new module added in FY 14.

TeamSTEPPS and Limited English Proficiency (LEP) is a new program funded by AHRQ/HRET/AHA. Will be made available across HHC in FY15.

Just Culture Engagement FY14



New Supervisor and New Manager Programs are 2 components of HHC's Workforce Development Program

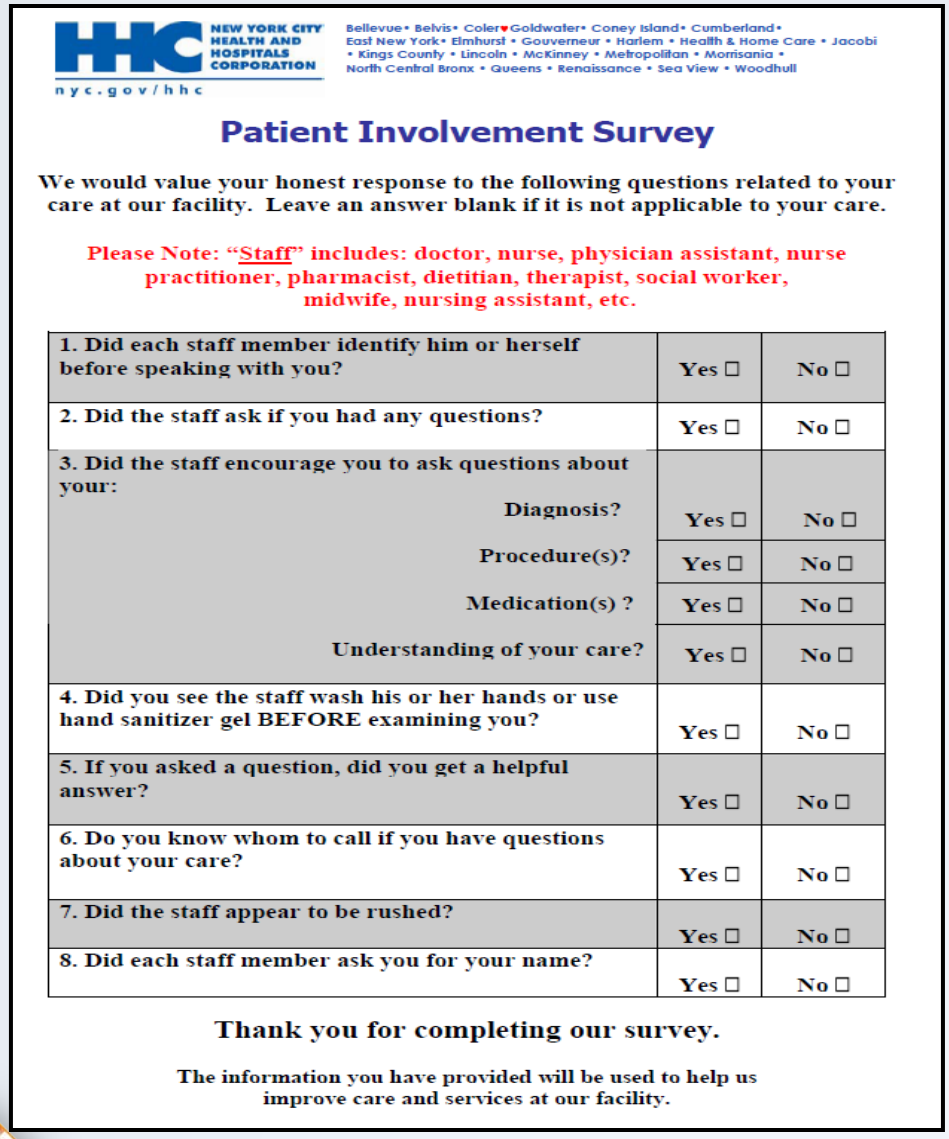
Two-day Just Culture Certification Course to be rolled out to 80 facility leaders in January 2015

Queens Health Network

Operationalizing TeamSTEPPS and "connecting the dots" with other strategic priorities

- Developed and launched a ***just-in-time TeamSTEPPS Breakthrough curriculum;*** delivered on day 1 of a Rapid Improvement Event (RIE) to improve team dynamics, communication and productivity of the event
- **100% Breakthrough Staff Master Trained on TeamSTEPPS**; resulting in the enhanced application of team training skills during Breakthrough Events organization-wide
- Collaborated with Breakthrough Value Stream Analysis (VSA) Owners to **identify and develop VSA-specific TeamSTEPPS Master Trainer champions.** The role of these Master Trainers includes supporting the active use of TeamSTEPPS strategies and skills into Breakthrough events
- Collaborated with the Journey to Excellence (JTE) staff to integrate TeamSTEPPS into JTE's Standards of Behavior

Improving Patient Experience



NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
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Patient Involvement Survey

We would value your honest response to the following questions related to your care at our facility. Leave an answer blank if it is not applicable to your care.

Please Note: "Staff" includes: doctor, nurse, physician assistant, nurse practitioner, pharmacist, dietitian, therapist, social worker, midwife, nursing assistant, etc.

1. Did each staff member identify him or herself before speaking with you?	Yes ☐	No ☐
2. Did the staff ask if you had any questions?	Yes ☐	No ☐
3. Did the staff encourage you to ask questions about your:		
Diagnosis?	Yes ☐	No ☐
Procedure(s)?	Yes ☐	No ☐
Medication(s) ?	Yes ☐	No ☐
Understanding of your care?	Yes ☐	No ☐
4. Did you see the staff wash his or her hands or use hand sanitizer gel BEFORE examining you?	Yes ☐	No ☐
5. If you asked a question, did you get a helpful answer?	Yes ☐	No ☐
6. Do you know whom to call if you have questions about your care?	Yes ☐	No ☐
7. Did the staff appear to be rushed?	Yes ☐	No ☐
8. Did each staff member ask you for your name?	Yes ☐	No ☐

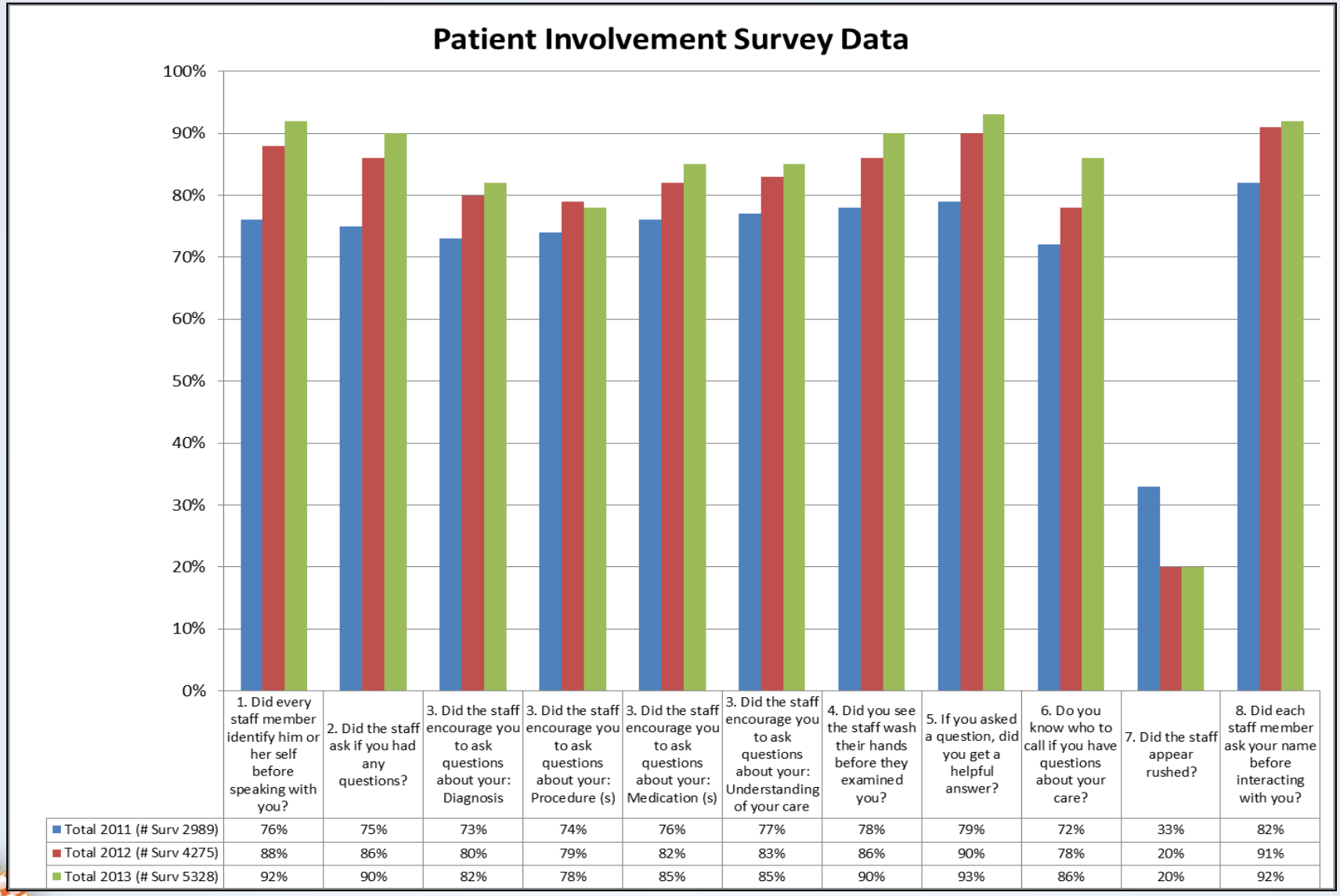
Thank you for completing our survey.

The information you have provided will be used to help us improve care and services at our facility.

Patient Involvement Survey

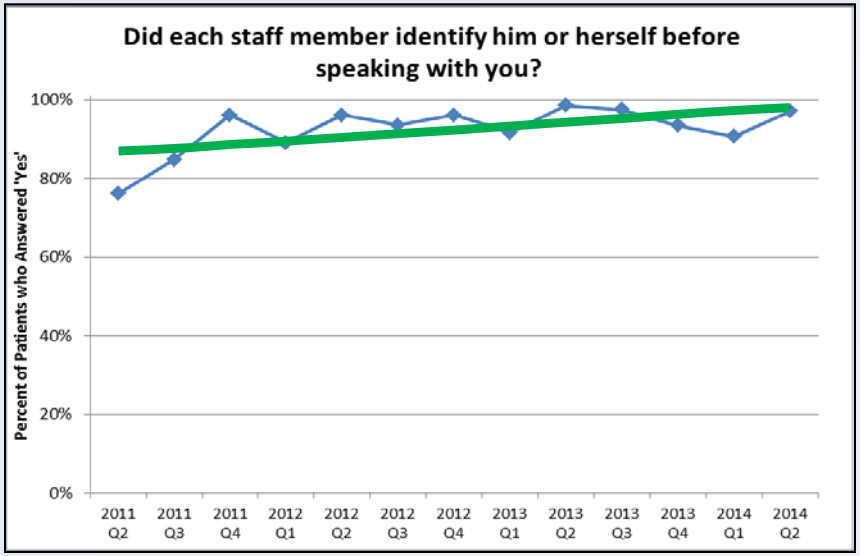
- "Just-in-time" tool to objectively assess patients' perception of involvement in their care
- Translated into 12 languages
- 5,328 surveys completed in CY 2013
- Next Step:
  - Evaluate impact on improvement in patient experience year over year (as measured by HCAHPS scores)

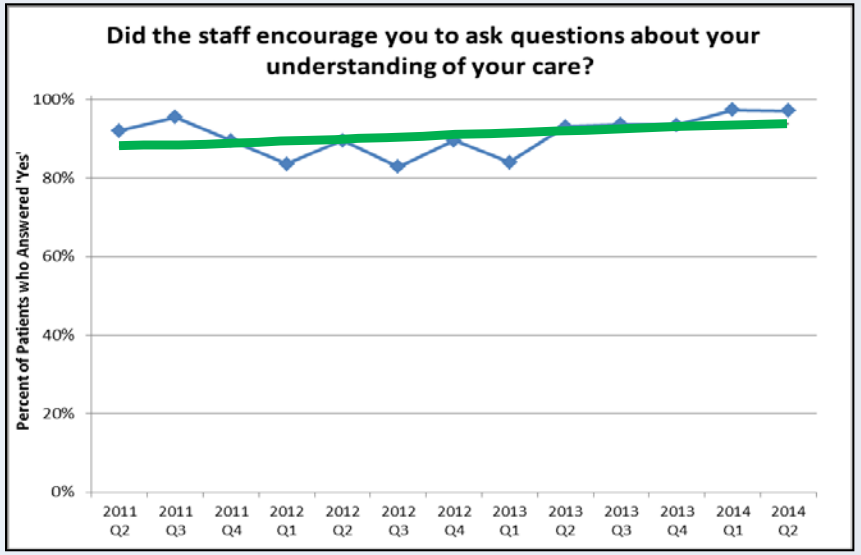
Patient Involvement

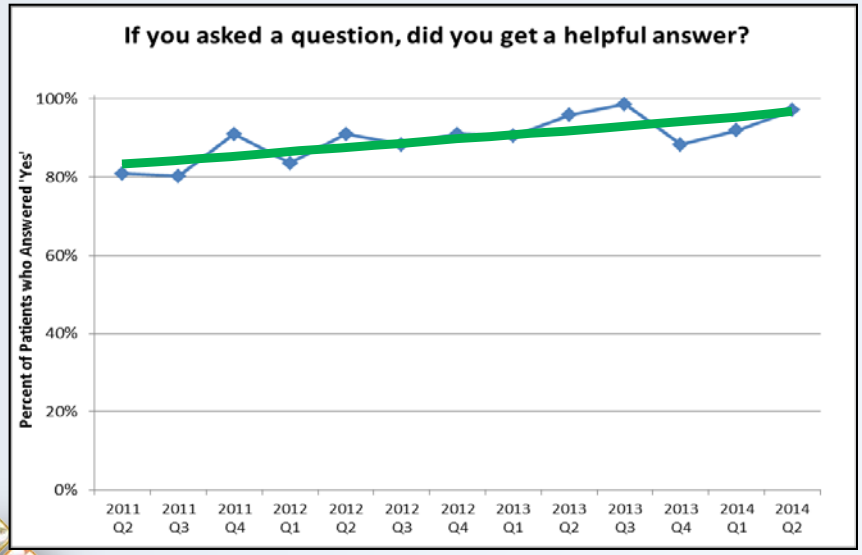


	1. Did every staff member identify him or her self before speaking with you?	2. Did the staff ask if you had any questions?	3. Did the staff encourage you to ask questions about your: Diagnosis	3. Did the staff encourage you to ask questions about your: Procedure (s)	3. Did the staff encourage you to ask questions about your: Medication (s)	3. Did the staff encourage you to ask questions about your: Understanding of your care	4. Did you see the staff wash their hands before they examined you?	5. If you asked a question, did you get a helpful answer?	6. Do you know who to call if you have questions about your care?	7. Did the staff appear rushed?	8. Did each staff member ask your name before interacting with you?
Total 2011 (# Surv 2989)	76%	75%	73%	74%	76%	77%	78%	79%	72%	33%	82%
Total 2012 (# Surv 4275)	88%	86%	80%	79%	82%	83%	86%	90%	78%	20%	91%
Total 2013 (# Surv 5328)	92%	90%	82%	78%	85%	85%	90%	93%	86%	20%	92%

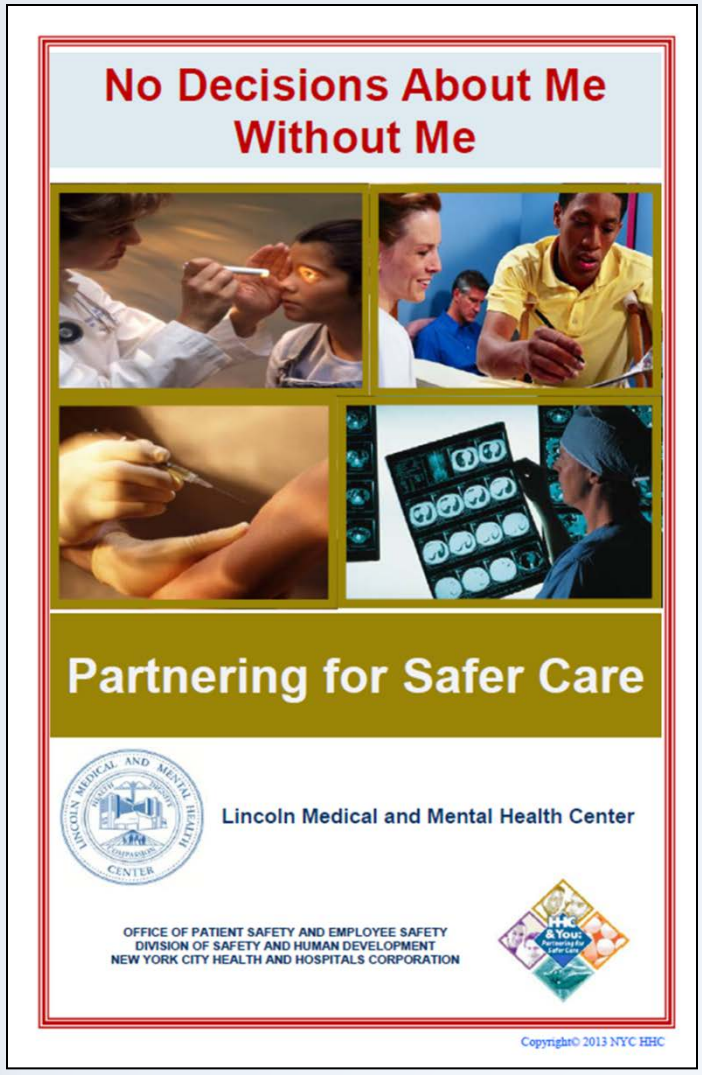
Elmhurst Hospital

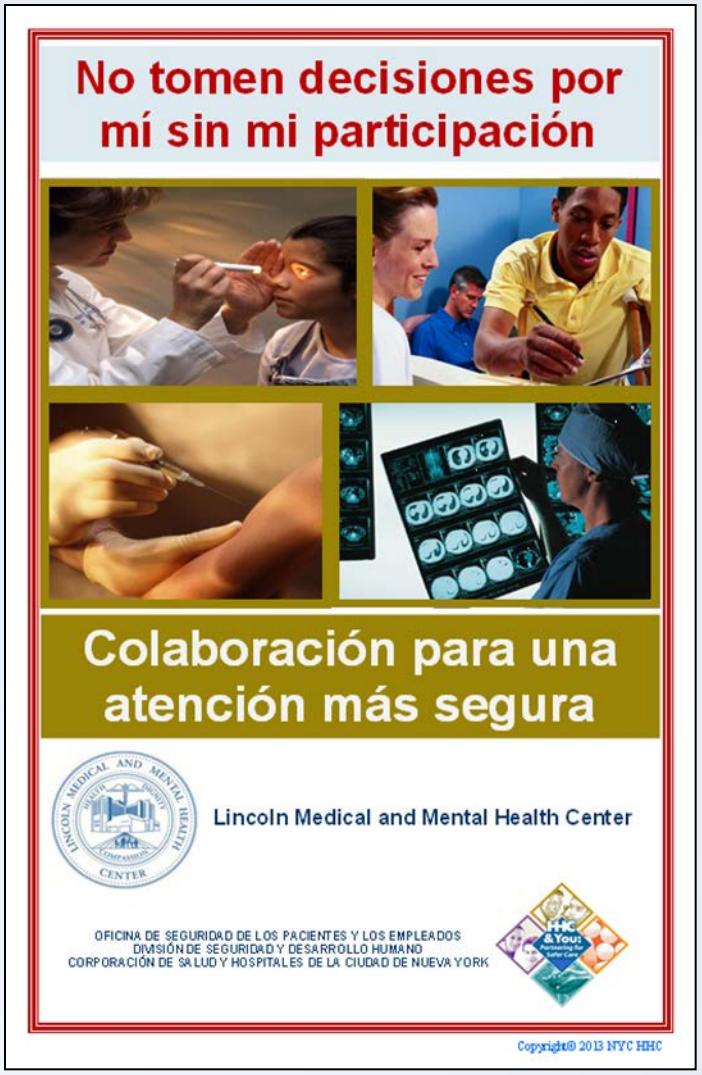






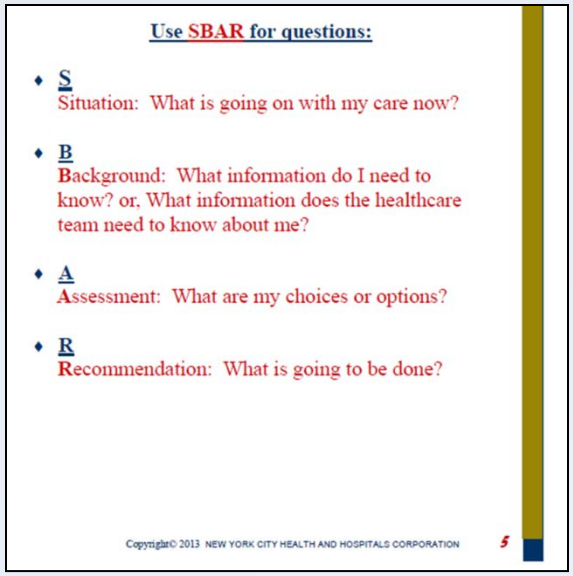
Patient Involvement

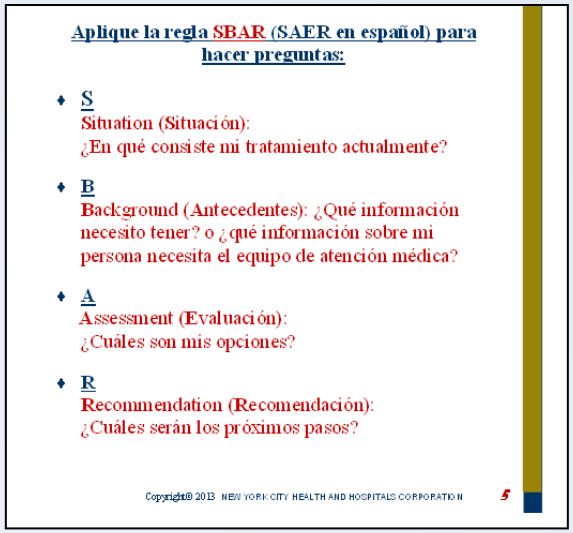


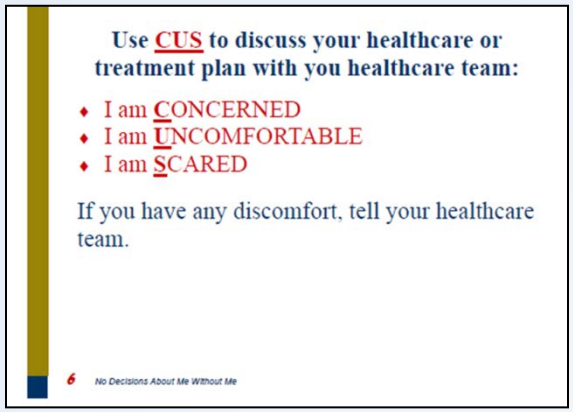


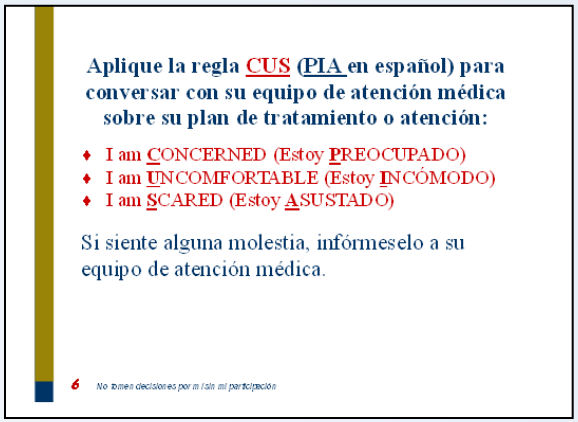
"No Decisions About Me Without Me"

Embedded TeamSTEPPS Tools to Engage Patients









Medication Safety

- **Enterprise Medication Safety Council**

  Purpose - improve medication processes to reduce errors and potential harm

  FY 2014 focus areas

  - **Improving collection of medication intervention data**
  - **Improving use of "high-alert" medications**
    - Anti-coagulants
    - Insulin
    - Opioids
  - **Improving medication reconciliation processes**
  - **Conducting Medication Safety Grand Rounds**
  - **Producing the Medication Safety Newsletter**

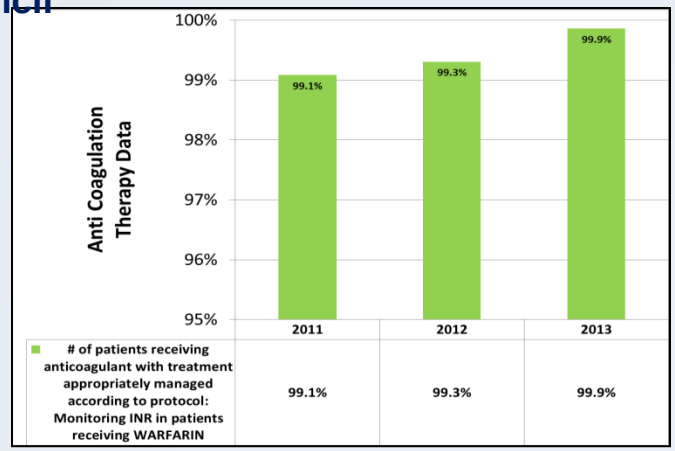
Medication Interventions

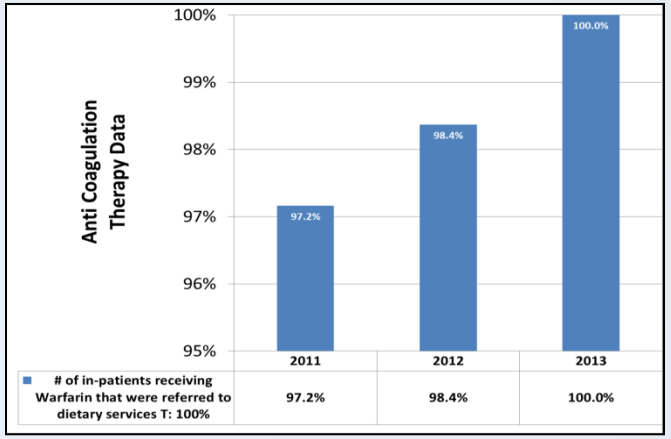
Top 5 Ranking Medications Requiring Pharmacy Intervention Across Facilities	
Vancomycin	2,670
Acetaminophen	811
Cefepime	547
Ciprofloxacin	530
Vancocin	345

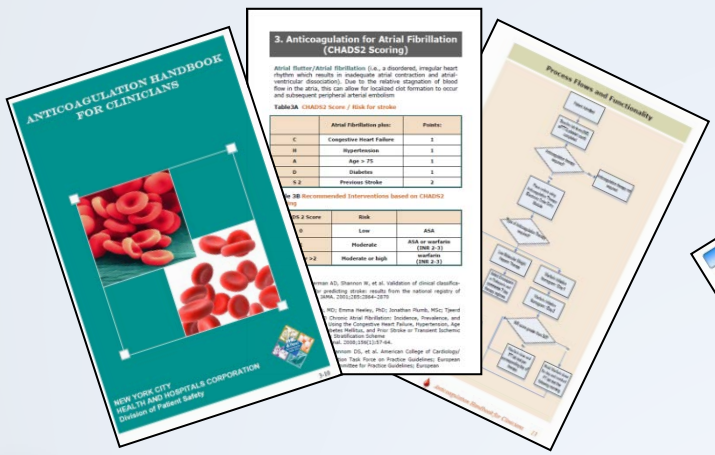
Medication Interventions (2013 = 58,687)	
Drug	15,713
Dose	8,249
Patient	65
Time	3,060
Route	1,399
Other	30,201

Improving Anticoagulation Therapy

- Ten facilities identified anticoagulants (Warfarin and Coumadin) as the medication with the largest number of adverse drug reactions in 2013
- Cases reviewed, lessons-learned discussed, and solutions identified by Medication Safety Council

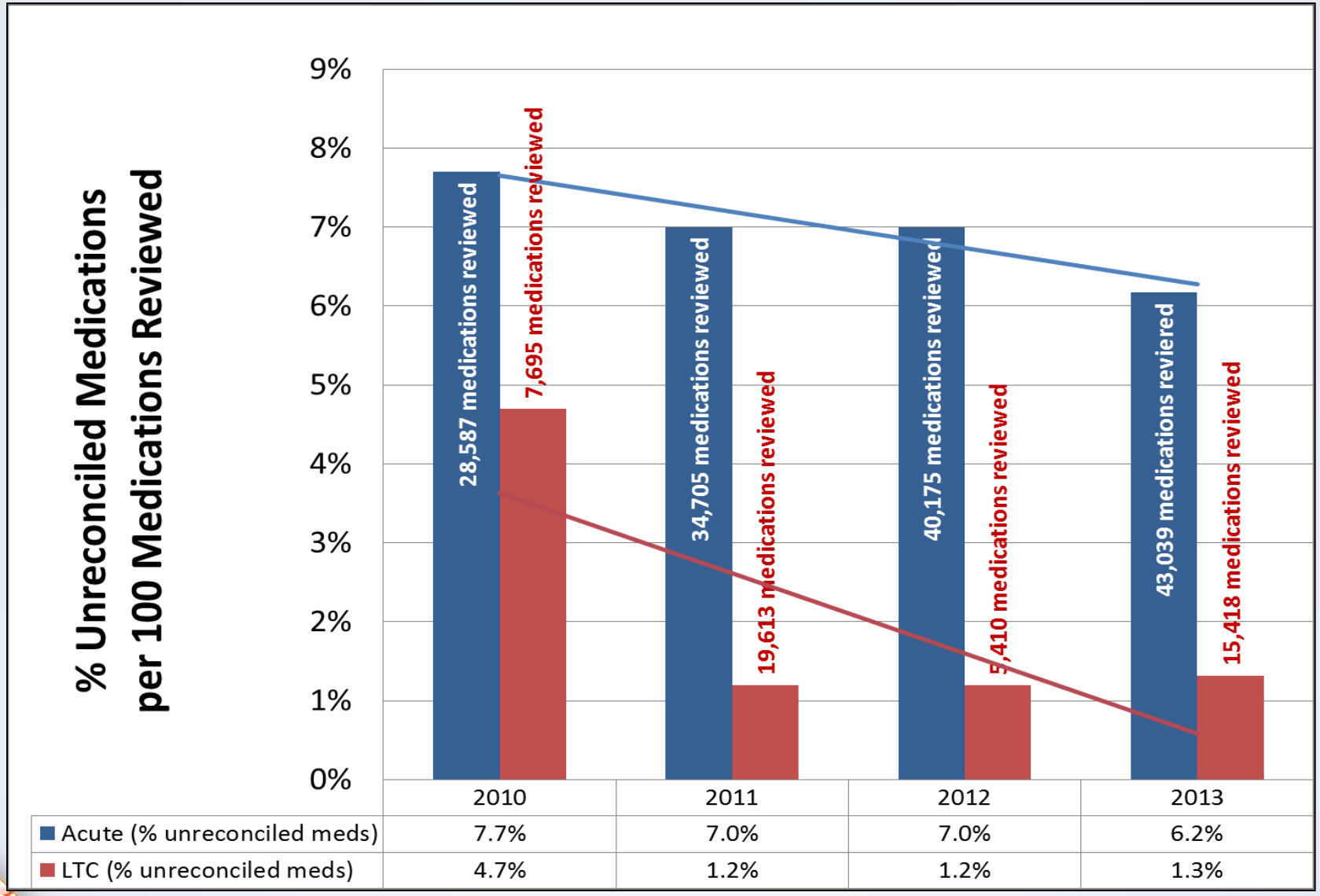






- Developed and disseminated Anticoagulation Handbook For Clinicians and Anticoagulation Therapy Guide for Patients (translated into 12 languages)

Medication Reconciliation



	2010	2011	2012	2013
Acute (% unreconciled meds)	7.7%	7.0%	7.0%	6.2%
LTC (% unreconciled meds)	4.7%	1.2%	1.2%	1.3%

Medication Safety Newsletter

Diabetes Mellitus and Insulin Therapy

All Employee Patient Safety Culture Survey – June 2014

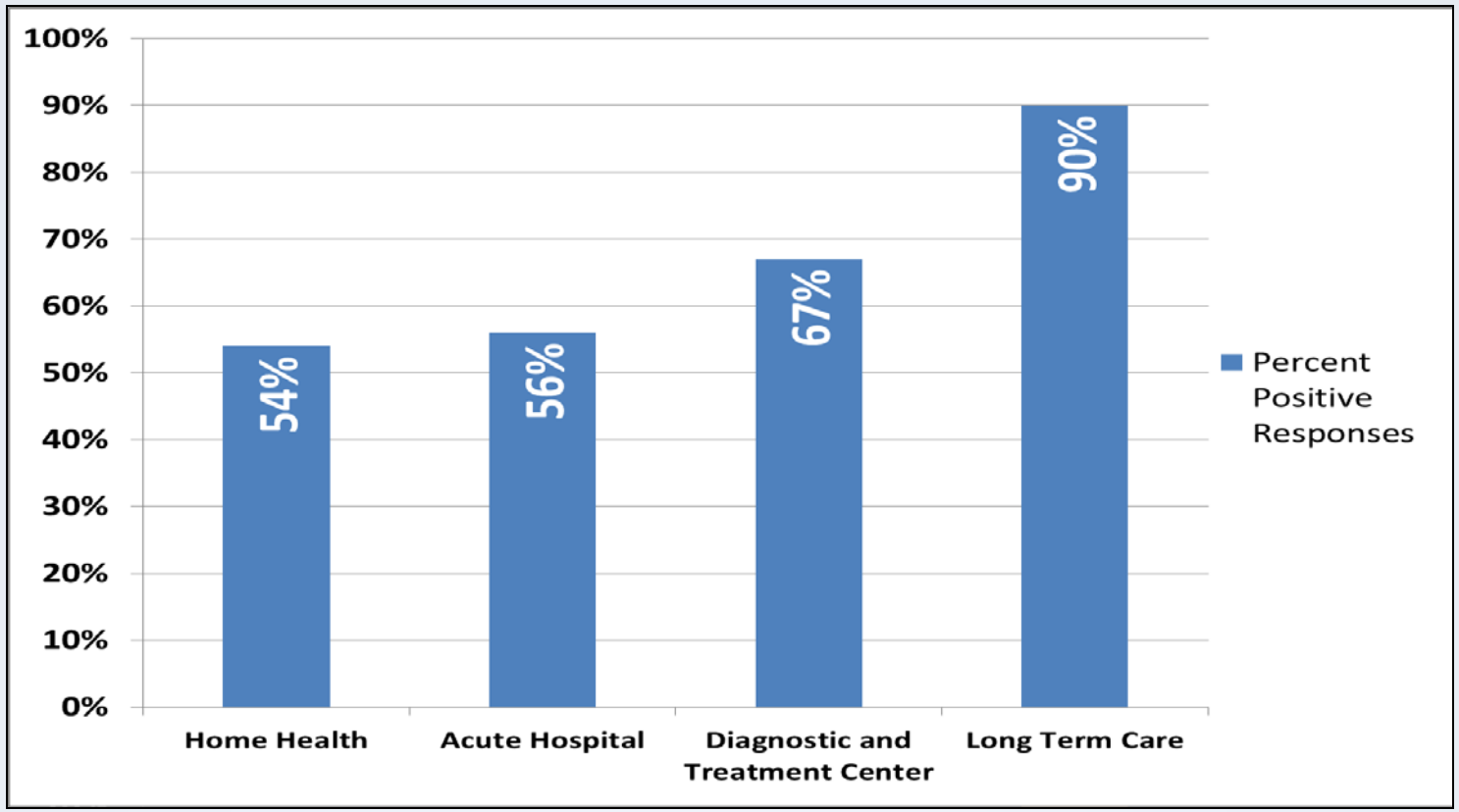
- **AHRQ Survey on Patient Safety Culture**
  - Evidence-based tool comprised of over 40 questions that assess employee opinions about patient safety issues, medical errors, and event reporting
  - All facility staff, medical staff, agency staff and volunteers invited to participate
- **Statistically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

Patient Safety Culture Survey

- **Enterprise-wide**
  - **Primary area of strength – Organizational learning/continuous improvement (National average 73% positive)**
    - The extent to which staff feel we are actively doing things to improve patient safety.
      - Aggregate % positive responses ranged from 70% (hospital and DTC) to 79% (LTC)
        - Employees with tenure of one year or less 82% positive
  - **Primary opportunity for improvement – Non-punitive response to error (National average 44% positive)**
    - The extent to which staff feel that their mistakes and event reports are not held against them, and that mistakes are not kept in their personnel file
      - % positive response rates ranged from 30% (hospitals) to 57% (LTC)

Patient Safety Culture Survey

Example of variability by level of care



Overall Perception of Safety - % of respondents who stated that the procedures and systems in the organization are good at preventing errors and that there is a lack of patient safety problems.

Patient Safety Culture Survey

- **Next steps**
  - Facilities engaged in “action planning”
  - Facility Patient Safety Officers will help us discern specific area(s) to focus on
  - Just Culture Certification course for 80 facility leaders
    - Help teams of staff learn how to effectively and consistently apply the Just Culture Algorithm and principles
  - Embed principles into policy and procedure and performance management processes

Partnerships: CIR and HHC Resident Patient Safety Survey

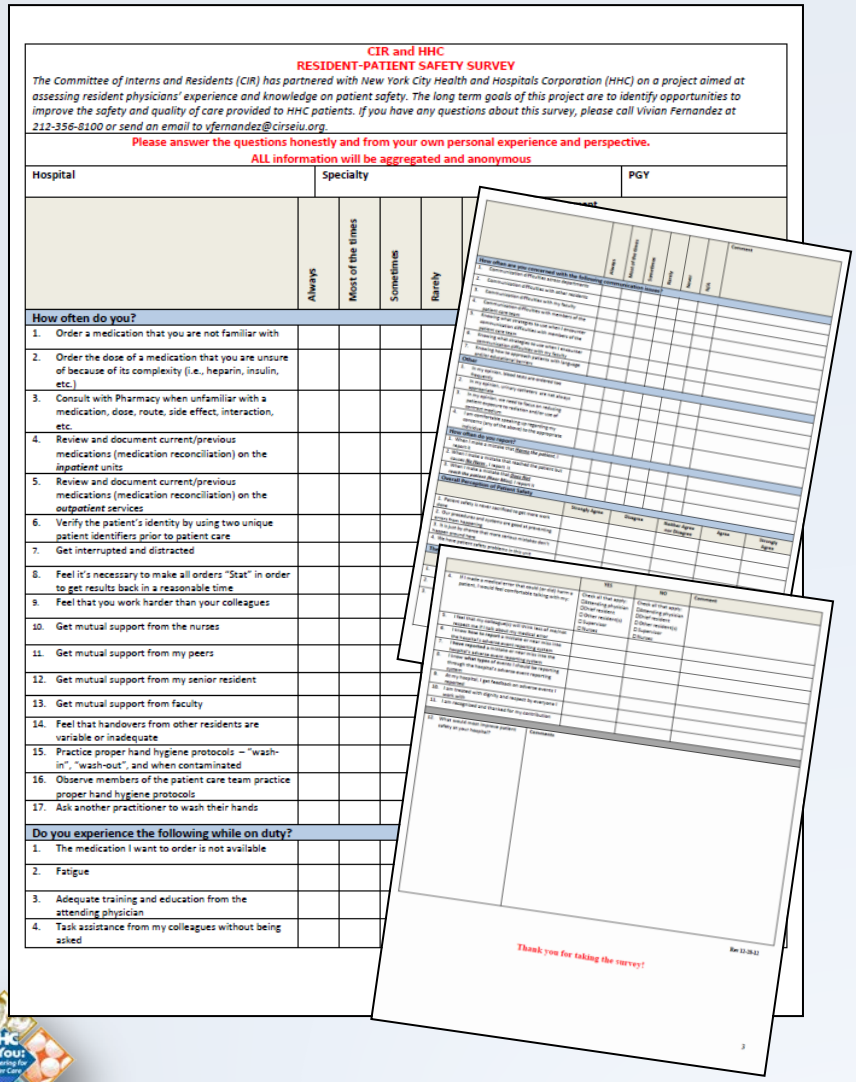
Background

- **HHC's Office of Patient Safety and CIR's Patient Safety Labor-Management Committee have collaborated for the last 6 years**
  - Annual patient safety conference
  - Conducted focus groups
  - Survey developed by HHC and CIR
  - Survey distributed by CIR team – over seven months

Method

- **"Top-down" and "bottom-up" methodologies were leveraged for participant recruitment**
  - A core group of resident leaders drove the project and recruited colleagues to participate
  - CIR contract organizers publicized the project interdepartmentally
- **Core patient safety team from HHC and CIR communicated to the facilities patient safety officer and associate, program director, and facility leaders to encourage participation**

CIR and HHC
Resident Patient Safety Survey



CIR and HHC
RESIDENT-PATIENT SAFETY SURVEY

The Committee of Interns and Residents (CIR) has partnered with New York City Health and Hospitals Corporation (HHC) on a project aimed at assessing resident physicians' experience and knowledge on patient safety. The long term goals of this project are to identify opportunities to improve the safety and quality of care provided to HHC patients. If you have any questions about this survey, please call Vivian Fernandez at 212-356-8100 or send an email to vfernandez@cirseiu.org.

Please answer the questions honestly and from your own personal experience and perspective.
ALL information will be aggregated and anonymous

Hospital | Specialty | PGY

	Always	Most of the times	Sometimes	Rarely
How often do you?				
1. Order a medication that you are not familiar with				
2. Order the dose of a medication that you are unsure of because of its complexity (i.e., heparin, insulin, etc.)				
3. Consult with Pharmacy when unfamiliar with a medication, dose, route, side effect, interaction, etc.				
4. Review and document current/previous medications (medication reconciliation) on the *inpatient* units				
5. Review and document current/previous medications (medication reconciliation) on the *outpatient* services				
6. Verify the patient's identity by using two unique patient identifiers prior to patient care				
7. Get interrupted and distracted				
8. Feel it's necessary to make all orders "Stat" in order to get results back in a reasonable time				
9. Feel that you work harder than your colleagues				
10. Get mutual support from the nurses				
11. Get mutual support from my peers				
12. Get mutual support from my senior resident				
13. Get mutual support from faculty				
14. Feel that handovers from other residents are variable or inadequate				
15. Practice proper hand hygiene protocols – "wash-in", "wash-out", and when contaminated				
16. Observe members of the patient care team practice proper hand hygiene protocols				
17. Ask another practitioner to wash their hands				
Do you experience the following while on duty?				
1. The medication I want to order is not available				
2. Fatigue				
3. Adequate training and education from the attending physician				
4. Task assistance from my colleagues without being asked				

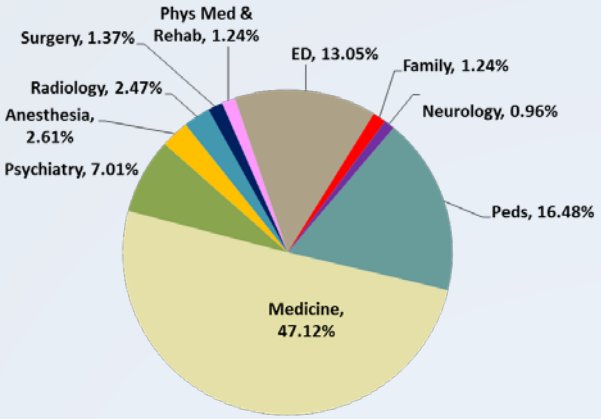
Thank you for taking the survey!

Purpose of Survey

- Identify what residents know about patient safety processes at HHC
- Evaluate residents' perception of, and experience with, patient safety
- Identify ways to improve the residency experience and to make their patient safety training more robust
- Align labor and management goals on patient safety
- Collaborate on efforts to improve patient safety for the population we serve

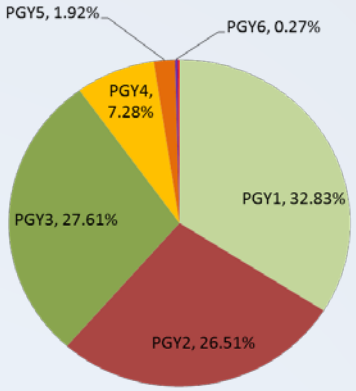
CIR and HHC
Resident Patient Safety Survey

Respondents by specialty



Respondents by PGY 1 to 7

N= 728



Opportunity identified	Improvement strategies
Teamwork and communication	TeamSTEPPS training emphasizing on handoffs across transitions
Transparency, accountability and perception of risks	Just Culture, near miss reporting and human factors training
Involvement in patient safety and quality	Opportunities through the housestaff union and patient safety forums and patient safety committees
Medication safety	Participation in medication safety councils and pharmacy led workgroups
Joy of work	Working with team members to value and recognize housestaff role

Patient Safety Alert

Patient Safety and Wrong Site Surgery

NYS Partnership for Patients

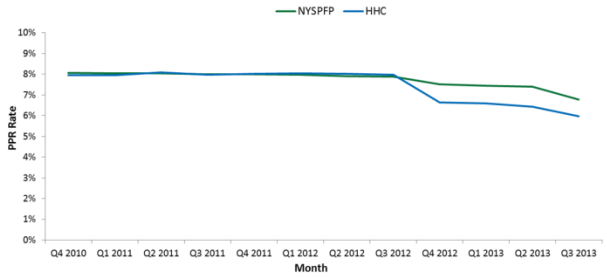
Comparison of HHC Performance to NYSPFP Statewide Averages

- CMS/HHS funded initiative
- Goals to achieve by December 2014
  - Reduce preventable harm (hospital acquired conditions) in the aggregate by 40%
  - Reduce preventable readmissions in the aggregate by 20%
- 170 participating hospitals state-wide
- 12 focus areas

Potentially Preventable Readmissions

NYSPFP	HHC
Baseline: 8.07% (n=141)	Baseline: 7.94% (n=11)
Comparison: 6.77% (n=142)	Comparison: 5.98% (n=11)
16% Improvement	25% Improvement

30-Day Potentially Preventable Readmission Rate (PPR)

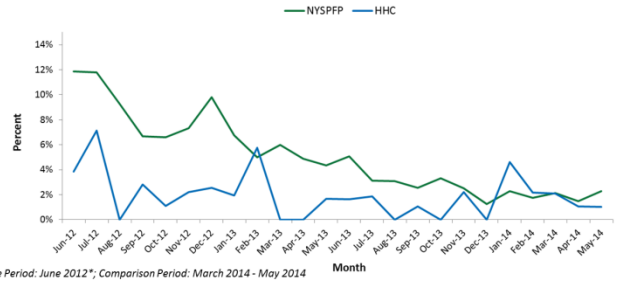


Baseline Period: Q4 2010; Comparison Period: Q3 2013**

Early Elective Deliveries

NYSPFP	HHC
Baseline: 11.85% (n=83)	Baseline: 3.85% (n=7)
Comparison: 1.98% (n=82)	Comparison: 1.40% (n=9)
83% Improvement	64% Improvement

Percent of all scheduled deliveries at 36 0/7 to 38 6/7 weeks gestation without documentation of listed maternal or fetal reason

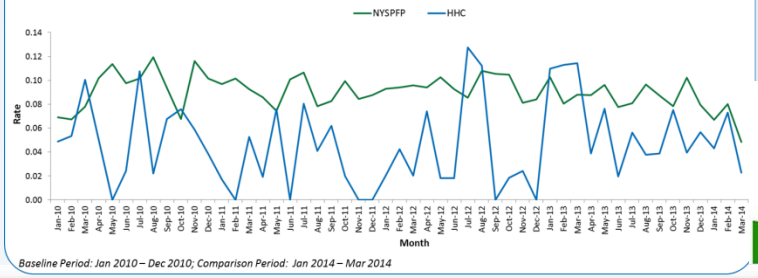


Baseline Period: June 2012; Comparison Period: March 2014 - May 2014*

Falls with Moderate or Greater Harm

NYSPFP	HHC
Baseline: .095 (n=85)	Baseline: .054 (n=11)
Comparison: .065 (n=121)	Comparison: .041 (n=9)
32% Improvement	24% Improvement

Rate of Falls with Moderate or Greater Harm Per 1,000 Patient Days



Baseline Period: Jan 2010 – Dec 2010; Comparison Period: Jan 2014 – Mar 2014

Other Patient Safety Activities

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

Other Patient Safety Activities

- **Sharing learnings and successes locally and nationally**
  - Presentations at
    - American Association of Critical Care Nurses – NYC Chapter
    - New York State Association of Nurse Anesthetists
    - National Patient Advocacy Conference
    - National Patient Safety Foundation Annual Congress
  - Faculty to AHRQ TeamSTEPPS Collaborative, NYSPFP, and America's Essential Hospitals
- **Developing and disseminating patient safety resources and tools**
- **FY 15 Action Planning**
  - Patient Safety Officer and Patient Safety Associate planning retreat to set agenda for FY 15 and 16

Division of Safety and Human Development, Office of Patient Safety and Employee Safety

http://patientsafety.nychhc.org/