AGENDA

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE

Meeting Date: October 11, 2012
Time: 12:30 PM
Location: 125 Worth Street, Room 532

BOARD OF DIRECTORS

CALL TO ORDER — **DR. STOCKER**

ADOPTION OF MINUTES
-September 20, 2012

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

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

METROPLUS HEALTH PLAN — **DR. SAPERSTEIN**

ACTION ITEM:

1. Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and execute a renewal and amendment to the contract with SunGard Availability Services (SunGard) for an alternate data center for disaster recovery, business continuity and associated professional services. Funding for the four-year renewal term per the Corporation's exercise of its renewal options under the existing contract shall not exceed $25,550,000 (which includes a 20% contingency of $4,262,480). — **MR. ROBLES/ MR. CUSH**

INFORMATION ITEM:

1. **Patient Satisfaction** — **MS. JOHNSTON/ DR. WILSON**

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

MINUTES

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE BOARD OF DIRECTORS

Meeting Date: September 20, 2012

ATTENDEES

COMMITTEE MEMBERS:

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

OTHER BOARD MEMBERS PRESENT:

Ian Hartman O'Connell (representing Linda Gibbs, Deputy Mayor)

HHC CENTRAL OFFICE STAFF:

Donna Benjamin, Restructuring Project Manager
Sima Bruk, Systems and Programming, IT
Deborah Cates, Chief of Staff, Board Affairs
Louis Capponi, MD, Chief Medical Informatics Officer
Christina Coiro, Director, Office of Research Management
Paul Contino, Chief Technology Officer
Barbara DeIorio, Senior Director, Office of Special Projects
Nancy Doyle, Assistant Vice President, Workforce Planning & Development
Al Garofalo, Senior Director, Clinical IS
Marisa Salamone-Greason, Assistant Vice President, EITS
Mark Guillaume, Senior Consultant, Clinical IS
Lauren Johnston, Senior Assistant Vice President/Chief Nursing Officer, Patient Centered Care
Victor Kim, Senior Director, Corporate Planning Services
Mei Kong, Assistant Vice President, Patient Safety
Robert Kurtz, MD, Senior Clinical Advisor, Office of Health Care Improvement
JoAnn Liburd, Senior Director, Accreditation & Regulatory Services
Patricia Lockhart, Secretary to the Corporation
MaryBeth Maginn, Project Manager, Clinical IS
Agustin Manaloto, Assistant Director, Nursing, Bellevue Hospital Center
Nini Mar, Director, Corporate Reimbursement
Ana Marengo, Senior Vice President, Communications & Marketing
Antonio D. Martin, Executive Vice President/Corporate Chief Operating Officer
Chanty McCaskey, Coordinating Manager, IT
Susan Meehan, Assistant Vice President, Medical & Professional Affairs
Angela Minielli, Assistant Director, EITS
John Morley, MD, Deputy Chief Medical Officer
Charlotte Neuhaus, Senior Management Consultant, Corporate Planning Services
Deidre Newton, Senior Counsel, Legal Affairs

HHC CENTRAL OFFICE STAFF (cont'd):

Bert Robles, Chief Information Officer
Salvatore Russo, Senior Vice President & General Counsel, Legal Affairs
Ramon Sanchez, Senior Consultant, Clinical IS
Julio Santos, Senior Director, EITS
Joan Schiller, Senior Director, Clinical Information Services
David Stevens, MD, Senior Director, Health Care Improvement
Manasses Williams, Assistant Vice President, AA/EEO
Marlene Zurack, Senior Vice President & Chief Financial Officer

FACILITY STAFF:

Abha Agrawal, MD, Medical Director, Kings County Hospital Center
Maria Aguero-Rosenfeld, Director, Clinical Pathology, Bellevue Hospital Center
Ernest Baptiste, Executive Director, King County Hospital Center
Yolanda Bruno, MD, Medical Director, Coler-Goldwater
Lebby Delgado, Associate Executive Director, Generations+/Northern Manhattan Network
Warren Lakoff, Director, Pharmacy, Coney Island Hospital
John Maese, MD, Chief Medical Office, Coney Island Hospital
George Proctor, Senior Vice President, Central & Northern Brooklyn Network
Arnold Saperstein, Executive Director, MetroPlus Health Plan, Inc.
Melissa Schorri, MD, Medical Director, Lincoln Medical and Mental Health Center
Vincent Smith, Network Chief Information Officer, Queens Health Network
Denise Soares, Executive Director, Harlem Hospital Center
Arthur Wagner, Senior Vice President, Southern Brooklyn/SI Network
William Walsh, Senior Vice President, North Bronx Healthcare Network
Maurice Wright, MD, Medical Director, Harlem Hospital Center

OTHERS PRESENT:

Moira Dolan, Senior Assistant Director, DC 37, Research & Negotiations Department
Carl Dvorak, Executive Vice President, Epic Systems Corporation
Melissa Dubowski, Analyst, Office of Management and Budget
Scott Hill, Account Executive, QuadraMed Corp.
Richard McIntyre, Key Account Executive, Siemens
Megan Meagher, Analyst, Office of Management and Budget
Ellen White, Sr. Sales Executive, Epic Systems Corporation

**MEDICAL AND PROFESSIONAL AFFAIRS/
INFORMATION TECHNOLOGY COMMITTEE
Thursday, September 20, 2012**

Michael A. Stocker, MD, Chairman of the Board, called the meeting to order at 10:09 A.M. The minutes of the July 19, 2012 Medical & Professional Affairs/IT Committee meeting were adopted.

CHIEF MEDICAL OFFICER REPORT:

John Morley, MD, Deputy Chief Medical Officer reported on the following initiatives:

1. Radiology 24 x 7 x 365

In early 2011 an adverse event occurred that resulted, in part, from a delay in interpretation of imaging studies performed during "off hours". As a result the Corporation has committed to providing real time (within 30 minutes) interpretation of CT images done on a 24 x 7 x 365 basis by an attending radiologist with privileges to provide final interpretations and to be available for discussion of the case after providing the interpretation.

Several of our acute care facilities already provide this coverage but we are in the final stages of having the same level of care at all 11 hospitals. Harlem Hospital Center will have the new schedule in effect by October 1st and the North Bronx Network will be in place in October. At that point all 11 hospitals will have a final interpretation of CT scans and chest radiographs and the treating physicians will be able to discuss any questions with the interpreting radiologist.

Most hospitals have chosen to outsource this service for night time/weekend reading but at least one hospital has chosen to provide the coverage with their own staff extending their work schedules. The two (2) vendors HHC hospitals are contracting with for night time and weekend services are vRad and NexxRad (Coney Island Hospital).

2. Patient Centered Medical Home (PCMH) Practices

PCMH practices at each of our facilities have been working over the past few months to ensure that all primary care patients are linked to primary care providers and that this relationship is monitored and sustained overtime. HHC IT developed and launched the Patient Panel Management System (PAMS) early this summer to support the monitoring of the patient assignment activity, and has trained primary care front-line and management staff to work with PAMS to manage patient assignment protocols. Through these efforts, HHC PCMH practices have successfully assigned 82% of primary care patients to PCPs/care teams in FY 2012, an improvement of 11.4% since January 2012.

3. Hospital-Medical Home (H-MH) Demonstration Project

HHC submitted applications for the New York State Department of Health Hospital-Medical Home (H-MH) Demonstration Program on behalf of our 11 hospitals on July 2, 2012. The H-MH Demonstration Program will make up to $250 million available over the next three years to NYS teaching hospitals to support transition of their outpatient training sites to Patient-Centered Medical Home (PCMH). If successful, HHC is estimated to receive approximately $28 million of the $102 million to be disbursed in the first year of the demonstration, based on a formula derived from Medicaid volume and number of primary care residents receiving training at our facilities. Award notifications are expected sometime in September and successful applicants will then be required to submit a work-plan describing selected resident training continuity of care enhancements, care integration initiatives with focus on primary care and behavioral health integration, and

inpatient safety projects. Continued funding will be dependent upon meeting certain performance milestones, including achieving Level 2 or 3 NCQA PCMH re-certification by December 2013.

4. The New York City Health and Hospitals Corporation ACO (HHC ACO)

The HHC ACO has filed an application to operate as a Medicare Accountable Care Organization (ACO), an initiative established by the federal Affordable Care Act that creates a new model of providing Medicare beneficiaries with higher quality care while reducing costs through of more efficient, better integrated care. The HHC ACO is specifically seeking to participate in the Medicare Shared Savings Program, a payment model that aligns payment rewards with performance based on quality, process and cost-reduction targets. The HHC ACO arrangement is a collaborative venture among HHC, its employed physicians, and a number of physician affiliate organizations, including Mt. Sinai School of Medicine, New York University School of Medicine and the Physician Affiliate Group of New York (PAGNY). To receive incentive payments, HHC ACO participants will have to measurably improve the health status of patients, adopt evidence-based clinical practices, and lower spending for the Medicare program by reducing unnecessary hospitalizations, readmissions and emergency room visits for designated patients. The HHC ACO application to the Medicare Shared Savings Program is expected to be reviewed by CMS in the next few months. If approved, HHC ACO will begin operations in January 2013.

5. The Ambulatory Care Leadership (ACL) Council,

The Ambulatory Care Leadership (ACL) Council, whose members represent the ambulatory care leadership at HHC acute care facilities and Diagnostic and Treatment Centers, has ratified its new charter and mission whose aim is to advise and lead the strategic and operational changes in the delivery of ambulatory services at HHC so that it can function as an accountable care organization and deliver the *Triple Aim*. The Council, assisted by its three co-chairs, representing medical, nursing and administrative leadership, has selected as its initial focus, to establish action plans for arriving at a package of recommendations for ambulatory care governance, collaborative care model adoption and improving access to ambulatory care services.

6. Dialysis Transition Task Force

A team of representatives from each site impacted (Bellevue Hospital Center and Elmhurst Hospital Center not involved) will be meeting monthly to design the transition to the vendor providing dialysis - topics will include the sequence and timeline for transition, reporting quality templates and formats, working closely with Labor for a smooth labor process, and related monitoring of the clinical contract parameters.

7. Nursing Excellence Awards

The Nursing Excellence awards ceremony will be held on October 16th from 2pm-4pm at Harlem's new mural gallery. Six (6) individual nurses will be honored along with one team from across the Corporation. The awards are for: 1) Volunteerism and Service; 2) Education and Mentorship; 3) Professional Management; 4) Excellence in Home; 5) Community and Ambulatory Care; 6) Excellence in Clinical Nursing, Advancing and Leading the Profession; and the 7) Team Award. The venue is planned for Harlem's new mural gallery.

8. Nurses Improving Care for Healthsystem Elders (NICHE)

Four new facilities are beginning the NICHE journey: Lincoln Medical and Mental Health Center, Elmhurst Hospital Center, Jacobi Medical Center and Coney Island Hospital. A grant was received from the Hartford

Institute for Elder Care based at NYU to support this program. Three facilities have already achieved NICHE status: Queens Hospital Center, Harlem Hospital Center and North Central Bronx Hospital.

9. HHC Plays Major Role in Statewide Behavioral Health Conference

This week the Office of Behavioral Health will make two separate presentations at the New York Association of Psychiatric Rehabilitation Services 30th annual conference, the largest mental health consumer attended conference in the State. The theme of the conference is "Keeping the Integrity in Integration." Joyce Wale, Senior AVP for Behavioral Health will be participating in a panel that will discuss what can be expected as the State moves toward managed behavioral healthcare. Marylee Burns, Senior Director for Mental Health Services, and Linda Richard, Consumer Affairs Coordinator will present on the importance of the use of peer health coaches in improving the health outcomes for people with mental illness.

10. Changes to the State's Managed Behavioral Healthcare Plan

In January 2011, Governor Cuomo created a Medicaid Redesign Team to find ways to increase quality and efficiency in the Medicaid program and to reduce costs. One of the recommendations enacted into law was the creation of Behavioral Health Organizations (BHOs) that would be responsible for paving the way for behavioral health to enter into managed care. The expectation was that through data collection on long-stay patients and those who were frequently readmitted to inpatient psychiatric or detox services, the BHOs would be able to advise the State on the types of service redesigns and enhancements that would need to occur to decrease length of stay (LOS) and improve community tenure and prepare the way for managed behavioral healthcare. However, the BHOs resulted in an increased administrative burden to hospitals without producing useful results. Effective October 1, 2012, the two state agencies who oversee BHO performance, the NYS Office of Mental Health, (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS) have reduced the burden by changing the reporting requirements to focus on the more complex, difficult-to-discharge and frequently readmitted patients. It is hoped that this will result in more useful data to move into the second phase of managed behavioral healthcare. It is further expected that the State will delay implementation of Phase Two until 2014.

11. IMSAL - Intern Orientation 2012

The IMSAL team embarked on its third year of delivering simulation training to incoming Emergency Medicine, Internal Medicine and Surgery Residents. Over the course of a 6 week period, approximately 500 interns were trained in Central Line placement utilizing the HHC Bundle System. The four hour hands-on course gives interns a chance to master the procedure using both the Internal Jugular and Subclavian Veins, as well as use of the HHC Bundle Kit and Ultrasound. Emergency Medicine residents were additionally trained in Basic Airway management, giving them a chance to practice BVM techniques, insertion of basic airway adjuncts and direct laryngoscopy. The residents also put their new "skills" to use in hi-fidelity scenarios. This year, over half of the residency programs elected to send their residents to IMSAL to be trained, which eliminated the cost of training incurred by the individual facilities, as well as increasing the number of residents IMSAL faculty could train. This year also marked the first year that guest facilitators from the local facilities joined IMSAL staff in delivering training: Dr. Nur-Ain Nadir, IMSAL's newest Simulation Fellow, Dr. Heather Mahoney from Bellevue Hospital Center, Drs. Nikita Joshi and Ian Julie from Kings County Hospital Center, and Dr. Nehad Shabareck from Lincoln Medical and Mental Health Center.



METROPLUS HEALTH PLAN, INC.

Dr. Arnold Saperstein, Executive Director, MetroPlus Health Plan, Inc. presented to the Committee. Dr. Saperstein informed the Committee that the total plan enrollment as of August 31, 2012 was 436,735. Breakdown of plan enrollment by line of business is as follows:

Medicaid	368,883
Child Health Plus	16,102
Family Health Plus	36,886
MetroPlus Gold	3,157
Partnership in Care (HIV/SNP)	5,810
Medicare	5,897

Dr. Saperstein informed the Committee that this month, MetroPlus added 921 members. Their largest growth was in our Medicaid line of business. MetroPlus added 92 new enrollees in Medicare.

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

In the month of August, MetroPlus lost 1,128 members to Fidelis Care and 1,101 members to Health First. After more research, it appears that the MetroPlus dental transition to Healthplex in July may have contributed to this loss.

The 2013 Medicare Bids were submitted to CMS in June and accepted in August. Due to rate cuts and very high drug costs, significant changes had to be made to the Partnership in Care Plan (HMO

SNP) for 2013. Monthly premiums increased from $0 to $23.70, copayments were increased and several benefits had to be cut from the package including hearing aids, transportation services, and vision services.

On September 1, 2012 the NYS 599 statute for Medicaid MCO's and FHP Plans' will commence requiring reimbursement to mental health clinics for services under the ambulatory patient group (APG) rate setting methodology. One challenge is that the 3M grouper for this change has not yet been released. The state has informed providers to hold their claims until the grouper is released. NYS will then only allow plans 2-3 days after the release to update their systems. An adjustment to premium rates for Mental Health APGs will be included in a July 2012 rate package and will be pro-rated for the implementation date. NYS indicated the impact for NYC is expected to be approximately $33,000,000.

The Affordable Care Act (ACA) included a provision to expand primary care access and address physician shortages through an increase to primary care physician Medicaid reimbursement to of 100% RBRVS - effective January of 2013. Eligible providers are those recognized by the American Board of Medical Specialties as: Family Medicine, General Internal Medicine, Pediatric Medicine, and recognized Sub-specialties.

MetroPlus continues to work very closely with HHC towards the successful implementation of the HHC Health Home. Membership outreach commenced on July 16, 2012. MetroPlus sent the initial mailing to eligible members and has routed care management calls to HHC for handling. The Health Home contract has been executed between MetroPlus and HHC. Enrollment is very slow so far. There are only 15 MetroPlus members in the HHC Health Home.

Mandatory enrollment for Managed Long Term Care (MLTC) began on July 2, 2012. The MetroPlus application for a MLTC License was completed, submitted and approved. MetroPlus has been granted a Provider ID. MetroPlus has started testing our systems with the NYS enrollment broker, Maximus as of August 24, 2012. MetroPlus is still waiting for their formal contract and license.

In 2011, NYS approved a mandate for coverage of autism services. This legislation will now be enacted and is effective November 1, 2012. The Mandate applies to all policies and contracts issued, or renewed, modified, altered or amended on or after November 1, 2012 and will affect approximately 14,000 MetroPlus Child Health Plus members. Every policy that includes coverage of physician services, medical, major medical or similar comprehensive-type coverage must provide coverage for autism screening, diagnosis, and treatment. There are no age limits or limits to visits that are solely applied to the treatment of autism spectrum disorder. Coverage is subject to a maximum benefit of $45,000 per year per covered individual.

Medicaid Redesign Team Managed Care Benefit and Population Expansion changes continue to occur as MetroPlus moves to the end of 2012.

Effective October 1, 2012, Consumer Directed Personal Care (CDPAP) will be carved into the MetroPlus benefit package. CDPAP provides services to chronically ill or physically disabled individuals who have a medical need for help with activities of daily living or skilled nursing services. Services can include any of the services provided by a personal care aide, home health aide, or nurse. Recipients have flexibility and freedom in choosing their caregivers. The consumer or the person acting on the consumer's behalf (such as the parent of a disabled or chronically ill child) assumes full responsibility for hiring, training, supervising, and – if necessary– terminating the employment of persons providing the services. MetroPlus is in the process of securing a fiscal intermediary to provide paperwork facilitation, payroll, and benefits administration for this benefit.

Finally, effective January 1, 2013, New York State will transition the management of all non-emergency medical transportation services for enrollees in a managed care plan to LogistiCare, a regional

transportation company. For the last six months, all Medicaid fee-for-service enrollees have been using this provider.

ACTION ITEM:

1. Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and execute a contract with Epic Systems Corporation for an Enterprise-Wide Electronic Medical Record (EMR) System including the software license, installation, training and maintenance to be used throughout the Corporation's facilities. The contract will be for an initial term of ten years, with an additional five-year renewal option, exercisable solely by the Corporation, in an amount not to exceed $302,807,986.

Presenting to the Committee was Bert Robles, Chief Information Officer, Dr. Louis Capponi, Chief Medical Informatics Officer, Marlene Zurack, Chief Financial Officer, and from Epic Systems Corporation, Carl Dvorak, Executive Vice President, Ellen White, Sr. Sales Executive.

Over its twenty-year life span, the current electronic medical record has enabled HHC to maintain operations and even improve in some areas. However, over the next 20 years with many upcoming changes in the health care industry around home care and HHC's Accountable Care Organization (ACO) status, an entirely new paradigm shift must be made in the way we manage the organization as we now require. The current system has old functionality, such as clinical documentation and a decision support engine, which have not changed significantly for over 20 years. Other areas where the current EMR lacks functionality include the emergency department, operating room, long term care, behavioral health, patient portals, and mobile access. The system also lacks the agility to support our complex integrated delivery system. HHC's ACO's will require a highly developed Electronic Medical Record Systems to support complex care management and patient centered medical homes, manage cost, and eliminate waste while maintaining the best medical practice – in other words, to achieve the triple aim.

Dr. Stocker asked Dr. Capponi to describe the relationship with the current vendor. Dr. Capponi responded that the current EMR product that HHC uses has had four changes in ownership, with the current vendor being the fifth (QuadraMed). QuadraMed has been keeping the software as up-to-date as possible, meeting our minimum requirements from the regulatory perspective, and we were able to meet Meaningful Use Stage I and we are working collaboratively on Stage II. There are significant areas where we do not see development in their particular software and we need software that is focused on large, complex integrated delivery systems like HHC. Dr. Capponi stated that he does believe that there will be a collegial relationship with QuadraMed during the transition period to the new software.

Dr. Capponi illustrated a case study that demonstrated the extensive coordination necessary to help Ms. Jones through one care process. Complex processes like this happen at HHC 100's of times each day. Older Electronic Health Records can't help HHC manage this complexity. HHC needs an Electronic Medical Record System to manage our integrated delivery system. To put the need for a complex integrated EMR in perspective, consider the case of Ms. Christie Jones. Ms. Jones is a 68-year-old female with a history of hypertension and angina who has recently suffered a small stroke. Previous to iCIS, the medical information regarding the care of Ms. Jones was contained in multiple systems making coordination of care difficult and validating the accuracy of her healthcare laborious. With iCIS, all of Ms. Jones' medical care will be captured within a single, robust, integrated EMR – from her arrival to the Emergency Department, admission as an Inpatient, and subsequent discharge, followed by care within the home and through the ambulatory care services, iCIS will allow all her medications, diagnostics and laboratory tests and clinical documentation to be readily available across HHC. Ms. Jones is just one representation of the 1.2 million patients, often with even more complex medical conditions, who will benefit from the integrated EMR.

The selection process was extensive and inclusive. The Selection Committee members was comprised of three Corporate Officers; Sr. Clinical Leadership representing Nursing, Medicine, Psychiatry, Long Term Care, Emergency Department, Informatics, and Pharmacy; along with the President's Chief of Staff, the Sr. Assistant Vice President of Finance and HHC's Chief Medical Officer). Expert Workgroups were interdisciplinary teams including service line managers, IT technicians, lab technicians etc. The key to our success in the selection process was the extensive involvement by clinical staffs and highly detailed review of the vendor product. Early on, HHC conducted ten full days of scripted demonstrations. These demonstrations showed how the system would be used to care for patients specific conditions across multiple care settings. The same five scenarios were given to each vendor to see how their systems functionality could handle our demands and needs. The review included over 100 review sessions, nine site visits, three system scalability tests in a test labs, and six executive visits. Overall, 312 HHC staff contributed input during the selection and review process.

The Expert Workgroups started with over 4,000 functional requirements within the request for full proposals. Expert Workgroups provided their observations of each vendor's strengths and weaknesses through formal presentations to the selection committee. In addition to attending vendor demonstrations, these groups conducted additional product reviews, attended site visits and participated in reference calls. Expert Workgroups provided their impressions of system functionality to the Selection Committee for review, including any significant concerns. In June 2011 five vendors were then selected and invited to a two-day clinical and technical session so that we could review the functionalities of their EMR systems, which then resulted in narrowing the list of potential vendors to three (Allscripts, Cerner and Epic). From September 2011 to March 2012, members from HHC's Expert Workgroups conducted 33 additional review sessions with each finalist to evaluate their system on a more detailed granular level.

In addition, the selection process assessed three areas: 1) Strategic Business Partner- is the company solid, has the same values as HHC, ability to handle our size and complexity; 2) Proposed System Solution – meets our integrated functionality requirements, supports patient focused care, provides 24/7 access to data, satisfies regulatory requirements, safeguards patient data privacy, supports health information exchange and vendor has no failed implementations; and 3) Operational & Financial Impact - software licensing & maintenance, hardware & technical infrastructure, implementation staging & resources, and total cost of ownership.

Epic Systems Corporation was selected as the preferred vendor. Epic will help us achieve in areas that we have struggled with such as extending the electronic health record (EHR) into Behavioral Health, Anesthesia/Operating Room, the Emergency Department, and Long Term Care. It is an integrated system hence; it will be able to integrate with the Soarian financial system. Epic is a very strong company and is a privately held corporation with substantial growth and little debt. Epic's product is used by large and complicated healthcare systems across the United States and they have high ratings in the marketplace.

Dr. Stocker inquired as to whether we are clear that the new system will integrate with Soarian and that has been tested. Dr. Capponi responded yes, and we reviewed Epic's integration components in terms of the key information that needs to be shared between both systems. In addition Epic has integrated with the Soarian product along with other vendor financial systems.

Dr. Stocker stated that given our experience with current vendor changing ownership during the long term relationship he wondered what Epic's stand is. Carl Dvorak, Executive Vice President, Epic Systems Corporation responded that they structured Epic's corporation to specifically not be acquired in the long term future. We have arranged the stock and stock control such that the company cannot go public, cannot be acquired by another organization. We felt that in the long term it would be to our strategic advantage to stay mission focused. Dr. Stocker stated that there is generally not a lot of information available on privately

owned companies and inquired about how many investors Epic has. Mr. Dvorak informed the Committee that all shareholders are employees of Epic or previous employees (original founders), there are no out-side investors, and no shareholder has a controlling interest. Marlene Zurack, Chief Financial Officer, informed the Committee that Epic did provide HHC with two years of their audited financial statements and they are financially solid.

Epic is highly rated in the industry as illustrated by the following three industry corporate leaders in analytics around health care technology. Gartner, one of the world's top information technology research and advisory companies, consistently rates Epic as a leader. Epic is the highest rated (rated #1) integrated EMR in the marketplace by KLAS, an industry authority on Health Information Technology. The Health Information Management System Society (HIMSS) provides global leadership on the optimal use of Healthcare Technology. Stage 7 is their highest level of HIT achievement. Hospitals with greater HIT investment do better financially. More customers achieve stage 7 using Epic than all other vendors combined. Dr. Capponi provided the Committee with a slide that listed all the large hospital systems and safety net members of the National Association of Public Hospitals & Health Systems.

Dr. Stocker noted that two of HHC's major affiliates (Mt. Sinai and NYU) use Epic and inquired at to what the doctors think about the system and whether the utility of their system will be similar to ours for ease of use and transition. Dr. Capponi responded that there were members of the HHC affiliation staff who participated in the evaluation process. We did not do a formal survey of those individuals but did do site visits to both the affiliates. The fact that more people will be using Epic particularly more trainees across the affiliates and HHC facilities versus attendings, and having them familiar with the software products is a huge advantage with respect to training. Dr. Stocker inquired about a trainee trained on the Mt. Sinai system versus this system for HHC, will the two systems be identical. Dr. Capponi responded that the HHC system will not be identical but will be very similar to the point that the amount of training will be reduced.

As noted in the resolution, the contract will be for an initial term of ten years, with an additional five-year renewal option, in an amount not to exceed $302,807,986. Payments are fixed for the enterprise software licenses, milestone based for software maintenance, time-and-materials for professional services and training. Software license costs are $60 M which includes the Perpetual Enterprise Licenses for all modules and Third Party Licenses for the Cache Database and the Pharmacy Database. Professional services for the implementation support and training costs equals $23.8 M. Software maintenance, annual maintenance for modules will be paid as implemented at a total cost of $204 M, and there is a contingency of $15 M built into the cost.

The total 15 year cost to migrate from the current trajectory to Epic is $1.4B, which includes both new costs and the cost to maintain existing systems during the transition. A breakdown of the costs is below.

Component	**Description**	**15-year Cost (in millions)**
1. EPIC Contract	Today's 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 (e.g., biomedical devices; disaster plan)	$157
6. Implementation Support*	Vendors to be identified through RFP, Includes cost of non IT Staff participation, training & clinical staff coverage.	$203
7. Application Support Team	New and Existing HHC Staff to be used through the implementation and maintenance period	$ 357
	Total	$1,435

*Future contracts to be presented to the Board of Directors.

Compared to the fifteen-year total cost of ownership of the current system, implementing the new Epic system results in a net cost of $157 million. This net increase is primarily due to implementation costs as well as the cost involved with transitioning from one system to another. The bulk of this cost difference can be funded by the CMS meaningful use incentive, which totals $125M.

Dr. Stocker noted that Epic has been awarded numerous contracts recently and inquired as to whether they felt confident in their ability to service HHC's contract specifically during the implementation process. Mr. Dvorak responded that over 300 customers and noted that they have successfully implemented the system at not only at smaller systems but at larger ones such as Kaiser Permanente. Mr. Robles reinforced that Epic has a proven track record of being able to handle large organizations like HHC. Ms. Zurack stated that they visited Epic's headquarters and found it to be very impressive and scaled with staff to accommodate the needs of users and user groups. Mr. Dvorak noted that they have over 6,000 staff members' to-date and recently held a conference for end-users of which over 7,000 attended to share techniques and best practices. Dr. Stocker inquired if there is a difference in implementation risk with organization's that already have an EMR versus organizations that are implementing an EMR for the first time. Mr. Dvorak responded that there is less implementation risk in a system that already has expertise, moving from a collection of systems to a single system versus someone coming in from scratch. Mr. Robles added that today we do manage over 300 interfaces so there is a lot of experience in that area. Dr. Stocker asked for information about who does the training and installation.

Dr. Capponi responded that one of the many reasons Epic was chosen was their business model is currently aligned with our strategic model which is to depend less on outside staff and develop in-house staff expertise to be successful during implementation and but also be independent during the maintenance period. During the implementation there are peaks because you have a very large bolus of training and coordination of the logistics of moving from the current state to Epic. Consultants will be engaged mainly in the area of project management, technical and analyst areas.

Dr. Parsons noted that there has been reference to Epic's installation – difficulty in implementing the product design because of the variable infrastructure Epic has around product design as Epic tends to not "tweak" things on the fly, which could be sometimes good for the customer or bad for the overall long term integrity of the product. Given that, and given that New York State has pretty progressive agenda with respect to things like health information exchange, the Statewide Health Information Network of New York **(**SHINY) and multi-state collaboratives to advance standards – do we have a guarantee from Epic that they will be able to build the interface we need for the SHINY even though they may not be used – what is the commitment for making it work in New York State and multi-state collaboratives. Mr. Dvorak responded that they choose

the more structured rigorous approach during installation and implementation at new sites and because of that they get excellent outcomes and results, however, the perception it generates is not truly valid because after training and experience and skills needed are obtained we do give them wings and they fly in all different directions. We feel our structured approach ensures that people do not stumble and trip along the way and to have the freedom for variation afterwards. He further stated that they handle over 70 million Americans and exchange over 2 million health records per month as patients move from one system to another at Epic sites as well as the VA and DOD, therefore well versed and experienced in health information exchange systems and interfaces.

Dr. Capponi concluded the presentation by noting that the time line for full conversion will take six years. As part of the Business Intelligence Program, legacy data will be normalized and then integrated into the Epic system over the next one year to eighteen months in a parallel system with the ability to pull historical information as needed, however, certain data such as lab test results will be brought into Epic.

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

There being no further business the meeting adjourned at 11:46 A.M.

Bert Robles
Senior Vice President, Information Technology Services
Report to the M&PA/IT Committee to the Board
Thursday, October 11, 2012 – 12:30 PM

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

1. <u>Electronic Medical Record- Next Steps:</u>

At the September 27th Board meeting, HHC's Board of Directors unanimously voted to approve a resolution authorizing HHC to contract with the EPIC Corporation to provide HHC with a new Electronic Medical Record System. However, this decision is contingent upon review by the Procurement Review Board following a complaint issued by Allscripts.

Notwithstanding this review, Enterprise IT Services (EITS) is moving aggressively with the planning process. As outlined to this committee and to the full Board last month, several additional contracts will be presented to the Board of Directors through the course of the implementation. We anticipate early on that there will be a sole source contract for Electronic Prescribing Provider estimated at $5 million; Device Integration Software and related services estimated at $32 million; initial hardware installation estimated at $68 million; Medical library references (also due for renewal) of $10 million; and a requirements contract for Professional Services to support implementation estimated at $40 million/year over five years. In addition, additional space will be required to house new staff specifically hired for the EMR implementation.

2. Soarian Go-Live at Coney Island Hospital:

I am pleased to report that Soarian went live at Coney Island Hospital on Monday, September 24th.

This implementation was the culmination of months of preparation which included training staff, building scheduling templates, working on PC configuration and connectivity issues. Over 250 users at the facility were trained along with an off-site vendor that does scheduling for some clinics, and the number of users continues to grow daily. Overall, the transition proved to be very smooth and users are scheduling appointments without disruption.

A team of Siemens project/support staff along with Revenue Management was on site for the week to resolve any issues encountered by the CIH staff. As with any implementation, some of the challenges identified either prior or during the go-live have been resolved while others continue to be worked on.

Following the Coney Island go-live, Gouverneur is scheduled next on October 15th followed by Bellevue on October 29th and Metropolitan on November 12th.
A full Soarian update will be presented to this Committee at the November 20th meeting.

3. Meaningful Use (MU) –Year 2 of Stage 1:

HHC is in Year 2 of Stage I of Meaningful Use and will continue to maintain MU measures for the next twelve (12) months. HHC has already achieved $17million of $30 million incentive dollars for the first year. However, in order to qualify for all of the incentive money, HHC must meet all nineteen (19) objectives for the

entire year. We continue to work to actively meet the Stage 2 requirements in the latter part of calendar year 2013.

We will keep the Board apprised of our progress.

4. EITS Workforce Development-Roll-Out of SkillSoft On-Line Training:

As part of the overall Corporate Workforce Development initiative, EITS implemented an IT Training and Professional Development program for its 600+ full time staff located at Central Office and all HHC facilities.

The program includes foundational and advanced courses, aimed at further developing core competencies needed to support HHC's strategic goals and was designed to help individuals build technical, desktop, business and professional development skills. As the program matures instructor-led courses will be developed and offered to employees as well.

SkillSoft was selected as EITS' e-learning vendor, providing more than 2600 courses, including various certification tracks. As part of the program, EITS employees are also eligible to use SkillSoft's Books 24x7, which provides online access to thousands of digital titles on a variety of useful topics. Staff can access the Skillsoft courses and Books 24x7 either at work or from home. All EITS staff was provided an overview of the program at their specific sites as well as a one (1) hour introductory session on how to access the on-line program.

Deployment of this program to HHC Central Office and facilities began in early May 2012 and was completed on August 31st.

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

MetroPlus Health Plan, Inc.
Report to the
HHC Medical and Professional Affairs Committee
October 11, 2012

Total plan enrollment as of September 27, 2012 was 435,564. Breakdown of plan enrollment by line of business is as follows:

Medicaid	369,107
Child Health Plus	15,383
Family Health Plus	36,267
MetroPlus Gold	3,087
Partnership in Care (HIV/SNP)	5,766
Medicare	5,954

This month, we lost 2,546 members. Our largest loss was in our Medicaid line of business. MetroPlus lost 15 Medicare enrollees.

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

In the last two months, we lost 2,018 members to Fidelis Care and 2,076 members to Health First. This month, our loss decreased slightly from last month; 890 members to Fidelis Care and 975 members to Health First. After more research, while it appears that the MetroPlus dental transition to Healthplex in July may have been a contributing factor, we are still working to identify other potential causes for these significant losses. The losses are not focused at any particular provider site.

At the end of August, MetroPlus completed a telephone survey to assess the disenrollment reasons for the initial loss of membership to Health First and Fidelis Care. A segment of our disenrolled members were successfully contacted. Approximately half of the members that we contacted that disenrolled to Fidelis Care stated that they left MetroPlus because their dentist was not in the Healthplex network. Approximately one-third the members that we contacted that disenrolled to Health First stated they left MetroPlus because their dentist was not in the Healthplex network. Our hope is that the losses due to dental will now subside in the 4th month after transitioning to Healthplex.

MetroPlus continues to work to meet the HHC Enterprise goal of doubling the current Medicare membership. To date, MetroPlus' Medicare growth has been modest and we are currently implementing strategies to increase our membership. This Fall, in addition to MetroPlus' usual print ad campaigns in newspapers and subway advertisements, we will be launching a Spanish language television campaign on Telemundo and Univision. The television ads will run for 11 weeks, airing for 4 weeks this Fall and resuming in late Winter/early Spring 2013.

Industry-wide, it has been proven that member retention and member satisfaction in Medicare markets are closely tied to constant 'touches' to the membership. The MetroPlus retention

department will be increasing the number of ‘touches’ to our Medicare membership this open enrollment season.

Additionally, the MetroPlus Medicare marketing team will be offering lunch and learn activities in HHC facilities to increase referrals of dual eligible members. HHC data shows that there are approximately 20,000 dual-eligible members receiving services at HHC that are eligible to join MetroPlus. These lunch and learn activities are designed to educate the staff about MetroPlus and its relationship to HHC and institute referral processes to allow MetroPlus marketing staff to educate this eligible membership on their options. This Fall, the HHC facilities will be sending a mailing to the same dual eligible members signed by the facility Chief Medical Officers encouraging them to explore their options for joining a Medicare managed care plan.

Each year before a CMS Medicare bid is submitted, MetroPlus completes a detailed analysis of the benefit packages offered by competitive managed care plans in our market. For 2013, our benefit package is competitive to others in the market.

Each year, CMS posts quality ratings of Medicare Advantage Programs based on a star scale to provide Medicare beneficiaries information about plans offered in their area. MetroPlus has just been certified as a 3-star plan for 2013. In general, we scored well on the measures related to clinical care, but scored poorly on measures related to access. In 2013, we will receive 3.0% Quality Bonus Payment and 58.3% rebate percentage. The rebate amount decreased from 2012 where MetroPlus received a 66.7% rebate percentage. MetroPlus must be certified as a 4 –star plan in 2015 in order to receive a Quality Bonus Payment. Plans with less than 4- stars will not receive a Quality Bonus Payment.

MetroPlus continues to work very closely with HHC towards the successful implementation of the HHC Health Home. To date, there are 29 MetroPlus members in the HHC Health Home. We have 15 members which are billable to the state. The remaining 14 members are in CIDP/COBRA case management programs, which are billed directly by HHC. We expect to increase MetroPlus membership in the HHC Health Home in the coming months.

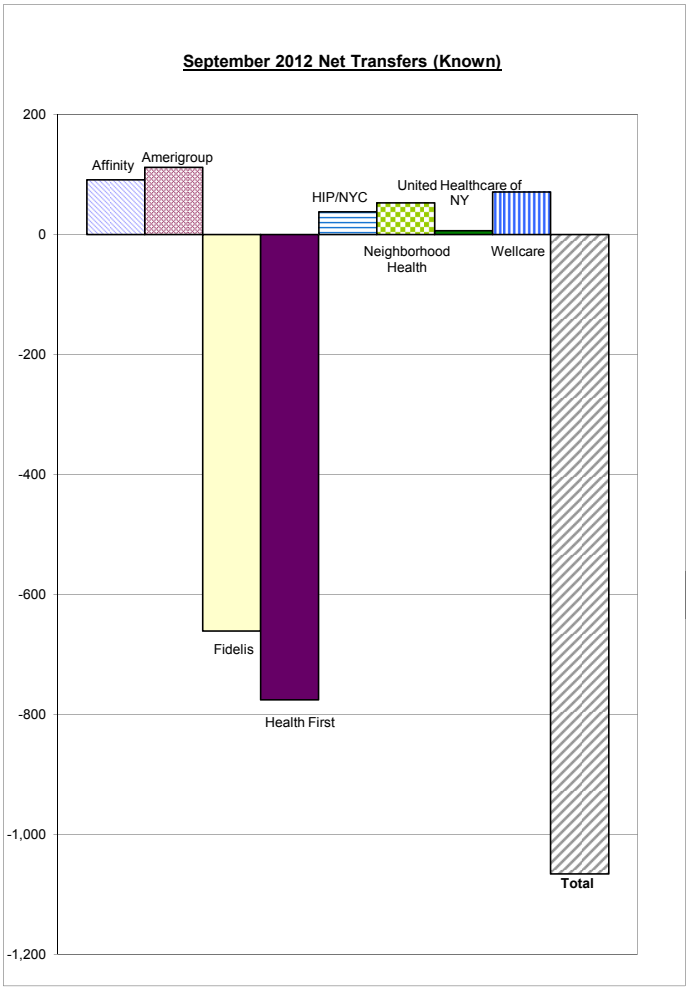
I am happy to report that MetroPlus has executed a contract with the state to initiate a Managed Long Term Care plan. We will begin educating the public of this new benefit immediately and will begin enrollment on November 1, 2012.

Disenrollments TO Other Plans		Sep-12			Oct-11 to Sep-12		
		FHP	MCAD	Total	FHP	MCAD	Total
	INVOL.	0	0	0	0	1	1
	VOL.	11	133	144	151	1,365	1,516
Affinity Health Plan	TOTAL	11	133	144	151	1,366	1,517
	INVOL.	1	3	4	4	31	35
	VOL.	11	236	247	237	2,626	2,863
Amerigroup/Health Plus/CarePlus	TOTAL	12	239	251	241	2,657	2,898
	INVOL.	0	0	0	1	15	16
	VOL.	99	791	890	555	4,444	4,999
Fidelis Care	TOTAL	99	791	890	556	4,459	5,015
	INVOL.	0	0	0	3	26	29
	VOL.	69	906	975	637	7,121	7,758
Health First	TOTAL	69	906	975	640	7,148	7,788
	INVOL.	0	0	0	0	2	2
	VOL.	10	88	98	133	1,010	1,143
HIP/NYC	TOTAL	10	88	98	135	1,013	1,148
	INVOL.	0	0	0	0	8	8
	VOL.	13	133	146	160	1,410	1,570
Neighborhood Health	TOTAL	13	133	146	160	1,419	1,579
	INVOL.	0	0	0	0	11	11
	VOL.	11	89	100	143	1,001	1,144
United Healthcare of NY	TOTAL	11	89	100	143	1,012	1,155
	INVOL.	0	0	0	2	10	12
	VOL.	3	30	33	28	271	299
Wellcare of NY	TOTAL	3	30	33	30	281	311
	INVOL.	1	3	4	10	104	114
	VOL.	227	2,406	2,633	2,044	19,248	21,292
Disenrolled Plan Transfers:	TOTAL	228	2,409	2,637	2,056	19,355	21,411
	INVOL.	2	9	11	61	474	535
	VOL.	16	75	91	183	929	1,112
Disenrolled Unknown Plan Transfers:	TOTAL	18	84	102	244	1,404	1,648
	INVOL.	1,221	10,580	11,801	13,424	120,617	134,041
	UNK.	1	3	4	31	85	116
	VOL.	0	23	23	345	1,908	2,253
Non-Transfer Disenroll Total:	TOTAL	1,222	10,606	11,828	13,800	122,610	136,410
	INVOL.	1,224	10,592	11,816	13,495	121,195	134,690
	UNK.	1	3	4	33	89	122
	VOL.	243	2,504	2,747	2,572	22,085	24,657
Total MetroPlus Disenrollment:	**TOTAL**	**1,468**	**13,099**	**14,567**	**16,100**	**143,369**	**159,469**

Disenrollments FROM Other Plans	Sep-12			Oct-11 to Sep-12		
	FHP	MCAD	Total	FHP	MCAD	Total
Affinity Health Plan	23	212	235	272	2,586	2,858
Amerigroup/Health Plus/CarePlus	30	333	363	634	5,295	5,929
Fidelis Care	14	215	229	201	2,395	2,596
Health First	22	177	199	219	2,511	2,730
HIP/NYC	8	128	136	90	1,327	1,417
Neighborhood Health	13	186	199	257	2,202	2,459
United Healthcare of NY	14	92	106	117	1,290	1,407
Wellcare of NY	13	91	104	254	1,562	1,816
Total	137	1,434	1,571	2,044	19,168	21,212
Unknown (not in total)	1,691	10,660	12,351	24,563	142,792	167,355

Data Source: RDS Report 1268a&c Updated 09/18/2012

Net Difference	Sep-12			Oct-11 to Sep-12		
	FHP	MCAD	Total	FHP	MCAD	Total
Affinity Health Plan	12	79	91	121	1,220	1,341
Amerigroup/Health Plus/CarePlus	18	94	112	393	2,638	3,031
Fidelis Care	-85	-576	-661	-355	-2,064	-2,419
Health First	-47	-729	-776	-421	-4,637	-5,058
HIP/NYC	-2	40	38	-45	314	269
Neighborhood Health	0	53	53	97	783	880
United Healthcare of NY	3	3	6	-26	278	252
Wellcare of NY	10	61	71	224	1,281	1,505
Total	-91	-975	-1,066	-12	-187	-199



MetroPlus Health Plan

New Member Transfer From Other Plans

	2011_10		2011_11		2011_12		2012_01		2012_02		2012_03		2012_04		2012_05		2012_06		2012_07		2012_08		2012_09		TOTAL
	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
Affinity Health Plan	20	173	22	203	17	189	13	207	19	191	20	254	30	242	38	296	26	239	21	180	23	200	23	212	2,858
Amerigroup/Health Plus/CarePlus	61	388	60	427	40	418	39	445	43	347	55	559	63	494	77	614	74	553	45	373	47	344	30	333	5,929
Fidelis Care	24	173	19	232	18	216	17	183	10	171	16	209	17	190	27	225	11	200	6	159	22	222	14	215	2,596
Health First	14	184	26	213	13	198	22	164	8	188	17	250	20	214	19	253	25	213	13	213	20	244	22	177	2,730
HIP/NYC	6	94	7	102	5	104	11	97	8	89	10	128	7	118	5	130	7	130	9	95	7	112	8	128	1,417
Neighborhood Health Provider PHPS	25	149	23	169	29	125	16	205	18	166	18	234	22	191	30	251	32	201	15	140	16	185	13	186	2,459
United Healthcare of NY	6	72	8	101	10	121	8	100	14	90	10	126	10	90	11	162	10	144	10	96	6	96	14	92	1,407
Unknown PLan	1,929	9,394	2,191	12,793	1,822	11,464	2,161	11,747	2,154	13,041	2,066	11,410	1,914	10,652	2,476	14,769	2,180	12,013	1,950	11,512	2,029	13,337	1,691	10,660	167,355
Wellcare of NY	19	146	27	142	15	125	19	138	14	99	31	122	23	146	15	185	27	147	19	84	32	137	13	91	1,816
TOTAL	2,104	10,773	2,383	14,382	1,969	12,960	2,306	13,286	2,288	14,382	2,243	13,292	2,106	12,337	2,698	16,885	2,392	13,840	2,088	12,852	2,202	14,877	1,828	12,094	188,567

Report ID: MHP1268C
Report Run Date: 9/17/2012

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 09/14/2012

Other Plan Name	Category	2011_10		2011_11		2011_12		2012_01		2012_02		2012_03		2012_04		2012_05		2012_06		2012_07		2012_08		2012_09		TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
Affinity Health Plan	INVOLUNTARY	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
	VOLUNTARY	10	138	22	124	19	99	10	109	15	90	6	71	7	130	14	128	13	117	10	112	14	114	11	133	1,516
	TOTAL	10	138	22	124	19	99	10	109	15	90	6	71	7	130	14	129	13	117	10	112	14	114	11	133	1,517
Amerigroup/ Health Plus/CarePlus	INVOLUNTARY	0	0	2	9	0	1	0	2	0	1	0	2	0	3	0	2	1	5	0	1	0	2	1	3	35
	VOLUNTARY	23	170	28	259	27	230	10	203	18	266	14	128	20	197	33	187	23	267	11	243	19	240	11	236	2,863
	TOTAL	23	170	30	268	27	231	10	205	18	267	14	130	20	200	33	189	24	272	11	244	19	242	12	239	2,898
Fidelis Care	INVOLUNTARY	1	1	0	1	0	0	0	1	0	2	0	0	0	1	0	1	0	1	0	4	0	3	0	0	16
	VOLUNTARY	22	202	28	256	27	234	25	222	33	266	17	144	22	264	28	273	26	240	77	563	151	989	99	791	4,999
	TOTAL	23	203	28	257	27	234	25	223	33	268	17	144	22	265	28	274	26	241	77	567	151	992	99	791	5,015
Health First	INVOLUNTARY	0	1	0	2	0	0	1	5	0	1	1	0	1	3	0	3	0	3	0	5	0	3	0	0	29
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1
	VOLUNTARY	38	407	44	488	39	462	26	515	42	551	29	300	53	479	61	635	45	601	76	780	115	997	69	906	7,758
	TOTAL	38	408	44	490	39	462	27	520	42	552	30	300	54	482	61	638	45	604	76	786	115	1,000	69	906	7,788
HIP/NYC	INVOLUNTARY	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	2
	UNKNOWN	0	0	0	0	0	0	0	0	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
	VOLUNTARY	11	55	12	78	12	87	11	92	8	93	9	54	14	113	13	99	15	83	11	83	7	85	10	88	1,143
	TOTAL	11	55	12	78	12	87	11	92	10	95	9	54	14	114	13	99	15	83	11	83	7	85	10	88	1,148
Neighborhood Health Provider PHPS	INVOLUNTARY	0	0	0	2	0	1	0	2	0	1	0	0	0	1	0	0	0	0	0	0	0	1	0	0	8
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
	VOLUNTARY	8	114	15	144	14	130	16	96	11	122	9	75	14	94	12	138	17	106	8	118	23	140	13	133	1,570

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 09/14/2012

		2011_10		2011_11		2011_12		2012_01		2012_02		2012_03		2012_04		2012_05		2012_06		2012_07		2012_08		2012_09		TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
Neighborhood	TOTAL	8	114	15	146	14	131	16	98	11	123	9	76	14	95	12	138	17	106	8	118	23	141	13	133	1,579
United Healthcare of NY	INVOLUNTARY	0	0	0	1	0	0	0	1	0	0	0	1	0	1	0	0	0	3	0	1	0	3	0	0	11
	VOLUNTARY	7	48	18	110	16	76	14	70	8	82	7	49	8	68	12	102	11	69	13	109	18	129	11	89	1,144
	TOTAL	7	48	18	111	16	76	14	71	8	82	7	50	8	69	12	102	11	72	13	110	18	132	11	89	1,155
Wellcare of NY	INVOLUNTARY	0	0	0	0	0	0	0	1	0	0	0	0	0	1	2	5	0	0	0	2	0	1	0	0	12
	VOLUNTARY	8	18	0	10	2	29	0	20	2	25	2	13	1	17	3	27	1	30	4	14	2	38	3	30	299
	TOTAL	8	18	0	10	2	29	0	21	2	25	2	13	1	18	5	32	1	30	4	16	2	39	3	30	311
Disenrolled Plan Transfers	INVOLUNTARY	1	2	2	15	0	2	1	12	0	6	1	3	1	11	2	12	1	12	0	13	0	13	1	3	114
	UNKNOWN	0	0	0	0	0	0	0	0	2	1	0	1	0	0	0	0	0	0	0	1	0	0	0	0	5
	VOLUNTARY	127	1,152	167	1,469	156	1,347	112	1,327	137	1,495	93	834	139	1,362	176	1,589	151	1,513	210	2,022	349	2,732	227	2,406	21,292
	TOTAL	128	1,154	169	1,484	156	1,349	113	1,339	139	1,502	94	838	140	1,373	178	1,601	152	1,525	210	2,036	349	2,745	228	2,409	21,411
Disenrolled Unknown Plan Transfers	INVOLUNTARY	7	53	5	36	3	27	3	43	3	35	6	31	7	84	8	59	3	33	11	34	3	30	2	9	535
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
	VOLUNTARY	4	51	18	96	17	113	8	52	8	76	17	71	27	74	8	42	33	102	10	74	17	103	16	75	1,112
	TOTAL	11	104	23	132	20	140	11	95	11	111	23	103	34	158	16	101	36	135	21	108	20	133	18	84	1,648
Non-Transfer Disenroll Total	INVOLUNTARY	1,011	9,917	1,023	9,743	1,155	10,165	1,161	10,307	1,019	10,238	1,252	10,186	1,062	9,786	1,077	9,303	1,272	10,952	973	9,723	1,198	9,717	1,221	10,580	134,041
	UNKNOWN	1	3	1	5	1	6	1	5	1	14	2	13	2	15	3	9	5	5	8	6	5	1	1	3	116
	VOLUNTARY	1	55	252	386	2	60	2	82	1	63	78	781	2	98	7	132	0	92	0	73	0	63	0	23	2,253
	TOTAL	1,013	9,975	1,276	10,134	1,158	10,231	1,164	10,394	1,021	10,315	1,332	10,980	1,066	9,899	1,087	9,444	1,277	11,049	981	9,802	1,203	9,781	1,222	10,606	136,410
Total MetroPl	INVOLUNTARY	1,019	9,972	1,030	9,794	1,158	10,194	1,165	10,362	1,022	10,279	1,259	10,220	1,070	9,881	1,087	9,374	1,276	10,997	984	9,770	1,201	9,760	1,224	10,592	134,690

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 09/14/2012

		2011_10		2011_11		2011_12		2012_01		2012_02		2012_03		2012_04		2012_05		2012_06		2012_07		2012_08		2012_09		TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
Total MetroPlus Disenrollment	**UNKNOWN**	1	3	1	5	1	6	1	5	3	15	2	15	2	15	3	9	5	5	8	7	5	1	1	3	122
	VOLUNTARY	132	1,258	437	1,951	175	1,520	122	1,461	146	1,634	188	1,686	168	1,534	191	1,763	184	1,707	220	2,169	366	2,898	243	2,504	24,657
	TOTAL	1,152	11,233	1,468	11,750	1,334	11,720	1,288	11,828	1,171	11,928	1,449	11,921	1,240	11,430	1,281	11,146	1,465	12,709	1,212	11,946	1,572	12,659	1,468	13,099	159,469

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

September-2012

		Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12
Total Members	Prior Month	427,016	428,157	428,756	434,660	435,777	436,883	438,110
	New Member	17,422	16,376	21,454	18,231	16,992	18,329	14,583
	Voluntary Disenroll	2,031	1,886	2,137	2,053	2,588	3,464	2,969
	Involuntary Disenroll	14,250	13,891	13,413	15,061	13,298	13,638	14,160
	Adjusted	-14	-23	-43	-36	149	1,339	0
	Net Change	1,141	599	5,904	1,117	1,106	1,227	-2,546
	Current Month	428,157	428,756	434,660	435,777	436,883	438,110	435,564
Medicaid	Prior Month	358,448	359,892	360,874	366,577	367,851	369,033	370,885
	New Member	14,303	13,357	17,831	14,969	13,994	15,414	12,036
	Voluntary Disenroll	1,686	1,534	1,763	1,707	2,170	2,898	2,504
	Involuntary Disenroll	11,173	10,841	10,365	11,988	10,642	10,664	11,310
	Adjusted	-17	-25	-37	-28	150	1,354	0
	Net Change	1,444	982	5,703	1,274	1,182	1,852	-1,778
	Current Month	359,892	360,874	366,577	367,851	369,033	370,885	369,107
Child Health Plus	Prior Month	17,801	17,519	17,129	16,700	16,342	16,092	15,692
	New Member	526	514	503	420	452	399	437
	Voluntary Disenroll	29	28	24	22	38	53	33
	Involuntary Disenroll	779	876	908	756	664	746	713
	Adjusted	-2	-3	-5	-7	-10	-20	0
	Net Change	-282	-390	-429	-358	-250	-400	-309
	Current Month	17,519	17,129	16,700	16,342	16,092	15,692	15,383
Family Health Plus	Prior Month	36,274	36,209	36,298	36,813	36,823	36,886	36,658
	New Member	2,232	2,095	2,667	2,354	2,075	2,171	1,810
	Voluntary Disenroll	188	168	191	184	220	366	243
	Involuntary Disenroll	2,109	1,838	1,961	2,160	1,792	2,033	1,958
	Adjusted	0	2	0	1	0	5	0
	Net Change	-65	89	515	10	63	-228	-391
	Current Month	36,209	36,298	36,813	36,823	36,886	36,658	36,267

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

September-2012

		Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12
HHC	Prior Month	3,126	3,113	3,131	3,134	3,136	3,173	3,112
	New Member	31	33	27	15	65	10	4
	Voluntary Disenroll	0	0	1	0	0	0	2
	Involuntary Disenroll	44	15	23	13	28	71	27
	Adjusted	3	3	1	1	16	16	0
	Net Change	-13	18	3	2	37	-61	-25
	Current Month	3,113	3,131	3,134	3,136	3,173	3,112	3,087
SNP	Prior Month	5,721	5,724	5,742	5,786	5,820	5,805	5,794
	New Member	135	133	178	178	134	111	84
	Voluntary Disenroll	28	42	44	37	49	41	34
	Involuntary Disenroll	104	73	90	107	100	81	78
	Adjusted	1	-1	-3	-4	-5	-13	0
	Net Change	3	18	44	34	-15	-11	-28
	Current Month	5,724	5,742	5,786	5,820	5,805	5,794	5,766
Medicare	Prior Month	5,646	5,700	5,582	5,650	5,805	5,894	5,969
	New Member	195	244	248	295	272	224	212
	Voluntary Disenroll	100	114	114	103	111	106	153
	Involuntary Disenroll	41	248	66	37	72	43	74
	Adjusted	1	1	1	1	-2	-3	0
	Net Change	54	-118	68	155	89	75	-15
	Current Month	5,700	5,582	5,650	5,805	5,894	5,969	5,954

Resolution

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and execute a renewal and amendment to the contract with SunGard Availability Services (SunGard) for an alternate data center for disaster recovery, business continuity and associated professional services. Funding for the four-year renewal term per the Corporation's exercise of its renewal options under the existing contract is $5,321,880 annually, for a total amount not to exceed $25,550,000 which includes a 20% contingency of $4,262,480.

WHEREAS, the Corporation currently uses SunGard as its alternate data center under an existing contract originally awarded via a Greater New York Hospital Association (GNYHA) contract; and

WHEREAS, SunGard has hosted mission critical servers and computer systems and has provided customized solutions for the Corporation for the last five years without any service interruption; and

WHEREAS, given the anticipated costs of building a replacement alternate data center with a new vendor and migrating off the current alternate data center to a new facility, and the need for additional power for new Information Technology capital projects including the Electronic Medical Record (EMR), renewing the SunGard contract is in the best interests of the Corporation; and

WHEREAS, the contract will be managed and monitored under the direction of the Senior Vice President/ Corporate Chief Information Officer.

NOW, THEREFORE, be it:

RESOLVED, THAT THE President of New York City Health and Hospitals Corporation be and hereby is authorized negotiate and execute a renewal and amendment to the contract with SunGard Availability Services (SunGard) for an alternate data center for disaster recovery, business continuity and associated professional services. Funding for the four-year renewal term per the Corporation's exercise of its renewal options under the existing contract is $5,321,880 annually, for a total amount not to exceed $25,550,000 which includes a 20% contingency of $4,262,480.

Executive Summary –
Alternate Data Center (Business Continuity/Disaster Recovery)

The accompanying resolution requests approval to negotiate and execute a renewal and amendment to the contract with SunGard Availability Services (SunGard) for an alternate data center for disaster recovery and business continuity including cabinet space, caged cabinets, power, cabling, and professional services. Funding for the four-year renewal term per the Corporation's exercise of its renewal options under the existing contract is $5,321,880 annually, for a total amount not to exceed $25,550,000 which includes a 20% contingency of $4,262,480. The contingency is needed if the Corporation requires additional power and space to support growth, and in the event of an emergency, to enable the Corporation to secure managed services for disaster recovery.

The Corporation currently uses SunGard as its alternate data center under an existing contract originally awarded via a Greater New York Hospital Association (GNYHA) contract. SunGard hosts mission critical servers and computer systems for the Corporation. It is a Tier 4 Backup Data Center. Data center tier standards measure the quality and reliability of a data center's server hosting ability. Tier 4 data centers are considered the most robust and are less prone to failures. SunGard has provided customized solutions for the Corporation for the last five years without any service interruption.

The proposed pricing under the new contract is approximately 20% less than the annual costs that the Corporation currently pays SunGard. The proposed contract includes 193kW of power needed for the Electronic Medical Record (EMR) and new IT Capital Projects for the Corporation. After factoring the cost of the additional power, the Corporation will save approximately $20.28 million under the new contract. Furthermore, this contract includes additional savings of approximately $71,800 per month, *if additional* power is needed when compared to the current contract rate. These additional savings are for additional blocks of 100kW of power.

It will cost approximately $43 million to build a replacement data center and migrate the current data center to a new facility. Such a migration would take between eighteen months to two years to complete. The cost to migrate to another existing data center site versus building a new data center would be approximately $26 million. Not securing a contract with the existing back up site data center would also present a potential financial risk up to $60 million in lost Federal incentives stemming from the Electronic Medical Record program.

Due to the cost to build a replacement Tier 4 Backup Data Center, the cost to migrate off the current SunGard Tier 4 Backup Data Center to a new facility, and the need for additional power for new Information Technology capital projects including the Electronic Medical Record (EMR), renewing the SunGard contract is in the best interests of the Corporation.

CONTRACT FACT SHEET
New York City Health and Hospitals Corporation

Contract Title: SunGard Disaster Recovery Data Center

Project Title & Number: Alternate Data Center (Business Continuity/Disaster Recovery)

Project Location: SunGard Data Center, New Jersey

Requesting Dept.: Enterprise IT Services

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

Successful Respondent: SunGard Availability Services

Contract Term: **4 Year Contract Term**

Contract Amount: **$**5,321,880 annually for a total amount not to exceed $25,550,000

which includes a 20% contingency of $4,262,480

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

Range of Proposals: $ to $

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

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

Method of Payment: Lump Sum Per Diem Time and Rate
Other: explain Monthly Payments

EEO Analysis: Conditionally Approved; SunGard has been requested to appear before the 10/16/12 EEO Committee

Compliance with HHC's McBride Principles? Yes No

Vendex Clearance Yes No N/A (Pending)

(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 Corporation utilizes SunGard Availability Services as an alternate data center to backup and replicate applications, data and services which reside at the Jacobi Data Center in the Bronx. The Corporation currently uses SunGard under an existing contract that was originally awarded via a Greater New York Hospital Association (GNYHA) contract. The Corporation's contract with SunGard expires on October 31, 2012. The accompanying resolution requests approval to negotiate and execute a renewal and amendment to the contract. Funding for the four-year renewal term per the Corporation's exercise of its renewal options under the existing contract is $5,321,880 annually for a total amount not to exceed $25,550,000 which includes a 20% contingency of $4,262,480.

Enterprise Information Technology Services (EITS) estimates it will take between eighteen months to two years to complete a move from the SunGard Data Center to a new data center and cost approximately $43 million to build a replacement data center and migrate the current data center to a new facility. The cost to migrate to another existing data center site versus building a new data center would be approximately $26 million. It also would present a potential financial risk of up to $60 million in lost Federal incentives stemming from the Electronic Medical Record program.

SunGard provides space, power and environmentals to the Corporation. SunGard provides disaster recovery services, managed IT services and information availability consulting services. In addition, SunGard assists the Corporation with conducting annual disaster recovery mainframe planning and testing

SunGard has provided customized solutions for the Corporation for the last five years without any service interruption.

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

September 19, 2012

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

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):*

Not Applicable. This is a renewal of an existing contract.

Scope of work and timetable:

SunGard provides space, power and environmentals to the Corporation. The contract scope includes cabinet space, caged cabinets, power, cabling, and professional services. SunGard also provides disaster recovery services, managed IT services and information availability consulting services. In addition, SunGard assists the Corporation with conducting annual disaster recovery mainframe planning and testing. Costs are billed monthly.

The current contract with SunGard expires on October 31, 2012. Following approval of this renewal and amendment from the Contract Review Committee and the Board of Directors, the anticipated start date of the renewal is November 1, 2012.

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

Enterprise Information Technology Services (EITS) estimates it will take between eighteen months to two years to complete a move from the SunGard Data Center to a new data center and cost approximately $43 million to build a replacement data center and migrate the current data center to a new facility. The cost to migrate to another existing data center site versus building a new data center would be approximately $26 million. It also would present a potential financial risk of up to $60 million in lost Federal incentives stemming from the Electronic Medical Records program.

In addition, the proposed pricing under the new contract is approximately 20% less than the current annual costs that the Corporation pays SunGard. As illustrated in the table below, the Corporation currently pays SunGard approximately $6.65 million an annual basis. This annual cost will decrease to approximately $5.32 million under the new contract, and also includes an additional 193kW of power needed for the Electronic Medical Record (EMR) and new IT Capital Projects for the Corporation.

If Corporation were to pay SunGard for the additional 193kW of power at the current contract rates, the annual contract cost to the Corporation would increase to $10.39 million a year. This represents savings of over $5.07 million a year ($10.39 million - $5.32 million = $5.07 million). Over the course of the four year contract term, this totals $20.28 million in savings ($5.07 million x 4 years = $20.28 million).

This contract includes additional savings of approximately $71,800 per month, if additional power is needed when compared to the current contract rate. These additional savings are for additional blocks of 100kW of power.

Table: Costs/Savings Analysis of the Services

Cost Analysis	NO Power Increase	With Capital Project and EMR Power Increases		
	Current Contract Rate	Using SunGard Current Contract Rate (A)	Using SunGard Proposed New Contract (B)	Savings (C = A - B)
Usage	343	536	536	
Cost per kW	$1,616	$1,616	$827	**$788**
Monthly Cost	$554,230	$866,085	$443,490	**$422,595**
Annual Cost	$6,650,760	$10,393,024	$5,321,880	**$5,071,144**
Cost Over 4 Years	$26,603,040	$41,572,097.49	$21,287,520	**$20,284,577.49**

Cost Analysis	Additional Blocks of 100kW Power BEYOND 536kW		Additional Savings	
	Using SunGard Current Contract Rate	Using SunGard Proposed New Contract		
	=$1,616 * 100kW	=$898 * 100kW	Additional Blocks of 100kW @ $898 Per kW Versus Current Rate (Per Month, IF NEEDED)	$71,783
	$161,600	$89,800		

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

FY09: $5,176,454
FY10: $5,700,092
FY11: $6,075,505
FY12: $7,277,256*

The above amounts represent cash expenditures.
*Includes consulting services for a Risk Assessment and Business Impact Analysis.

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

This contract submission is for the Tier 4 Backup Data Center for the Jacobi Data Center. Data center tier standards exist to measure the quality and reliability of a data center's server hosting ability. The Uptime Institute uses a 4-Tier ranking system as a benchmark to determining the dependability of a data center.

Tier 4 data centers are considered the most robust and are less prone to failures. They are designed to host mission critical servers and computer systems, with fully redundant subsystems (cooling, power, network links and storage) and compartmentalized security zones controlled by biometric access controls methods. All cooling equipment is independently dual-

powered, including chillers and heating, ventilating and air-conditioning (HVAC) systems guaranteeing 99.995% availability.

HHC currently does not have the ability to provide for this internally.

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

No artistic/creative/intellectual property will be produced from this contract. All data stored at the SunGard facility will be owned by HHC and secured by SunGard using HHC requirements. All installed equipment at the SunGard facility will be owned by HHC.

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

Bert Robles
Senior Vice President/Corporate Chief Information Officer

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

Received By E.E.O. August 2012

Analysis Completed By E.E.O. 9/17/12

Manasses Williams
Name

SunGard received EEO approval for its Carlstadt, NJ location, which is where the Corporation's data center is located. SunGard received a conditional approval for it Wayne, PA location. SunGard has been requested to appear before the EEO Committee on October 16, 2012.

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
nyc.gov/hhc
346 Broadway • Room 500B • New York, NY 10013 • Tel: 212-788-3380 • Fax: 212-788-3689

Manasses C. Williams
Assistant Vice President
Affirmative Action/EEO
manasses.williams@nychhc.org

TO: Afshan Syed
Office of Information Services (CIS)

FROM: Manasses C. Williams

DATE: September 17, 2012

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor/consultant, **Sungard Availability Services, LP**, has submitted to the Affirmative Action Office a completed Contract Compliance Questionnaire and the appropriate EEO documents.

This company is a:

[ ] Minority Business Enterprise [ ] Woman Business Enterprise [X] Non-M/WBE

Project Location(s): Central Office

Contract Number: _____ Project: Alternate Data Center

Submitted by: Office of Information Services

EEO STATUS:

1. [ ] Approved

2. [ ] Approved with follow-up review and monitoring

3. [ ] Not approved

4. [X] Subject to EEO Committee Review

COMMENTS:

MCW:srf

SunGard Disaster Recovery/Business Continuity Alternate Data Center

Presentation Summary- October 11, 2012

The Corporation currently uses SunGard as its alternate data center under an existing contract originally awarded via a Greater New York Hospital Association (GNYHA) contract. SunGard hosts mission critical servers and computer systems for the Corporation. It is a Tier 4 Backup Data Center. Data center tier standards measure the quality and reliability of a data center's server hosting ability. Tier 4 data centers are considered the most robust and are less prone to failures. SunGard has provided customized solutions for the Corporation for the last five years without any service interruption.

It will cost approximately $43 million to build a replacement data center and migrate the current data center to a new facility. Such a migration would take between eighteen months to two years to complete. The cost to migrate to another existing data center site versus building a new data center would be approximately $26 million. Not securing a contract with the existing back up site data center would also present a potential financial risk up to $60 million in lost Federal incentives stemming from the Electronic Medical Record program.

Due to the cost to build a replacement Tier 4 Backup Data Center, the cost to migrate off the current SunGard Tier 4 Backup Data Center to a new facility, and the need for additional power for new Information Technology capital projects including the Electronic Medical Record (EMR), renewing the SunGard contract is in the best interests of the Corporation.

This presentation and the accompanying resolution requests approval to negotiate and execute a renewal and amendment to the contract with SunGard Availability Services (SunGard) for an alternate data center for disaster recovery and business continuity including cabinet space, caged cabinets, power, cabling, and professional services. Funding for the four-year renewal term per the Corporation's exercise of its renewal options under the existing contract is $5,321,880 annually, for a total amount not to exceed $25,550,000 which includes a 20% contingency of $4,262,480.

The contingency is needed if the Corporation requires additional power and space to support growth, and in the event of an emergency, to enable the Corporation to secure managed services for disaster recovery.

SunGard Disaster Recovery / Business Continuity
Alternate Data Center

Bert Robles, SVP/Corporate CIO
Corey K. Cush, AVP

October 11, 2012

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

nyc.gov/hhc

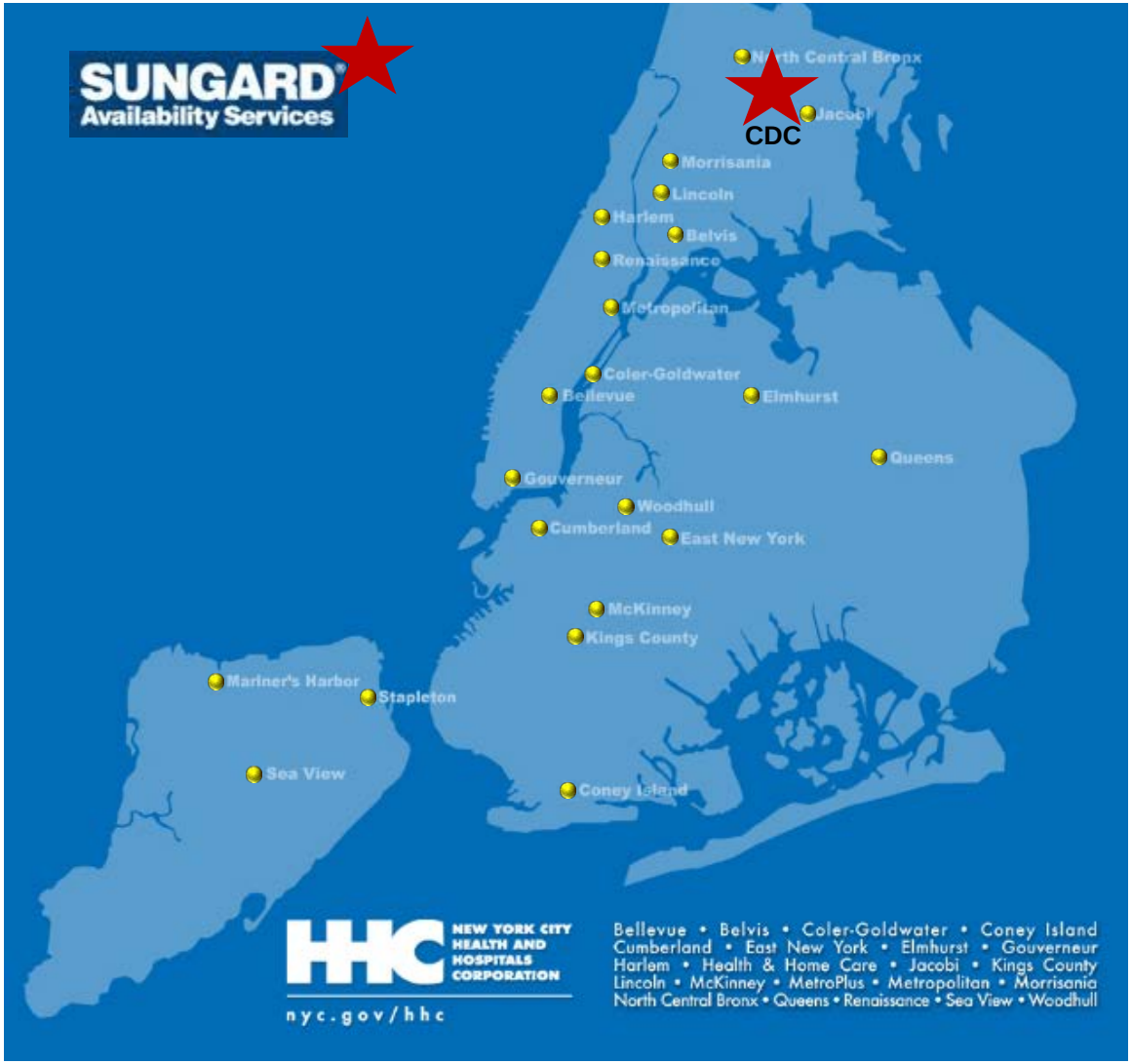
EXECUTIVE SUMMARY

A data center or computer center(also datacenter) is a facility used to house computer systems and associated components, such as telecommunications, servers, networking equipment and storage systems. It generally includes redundant or backup power supplies, redundant data communications connections, environmental controls (e.g., air conditioning, fire suppression) and security devices.

The most stringent level is a Tier 4 data center, which is designed to host mission critical computer systems, with fully redundant subsystems and compartmentalized security zones controlled by biometric access controls methods.

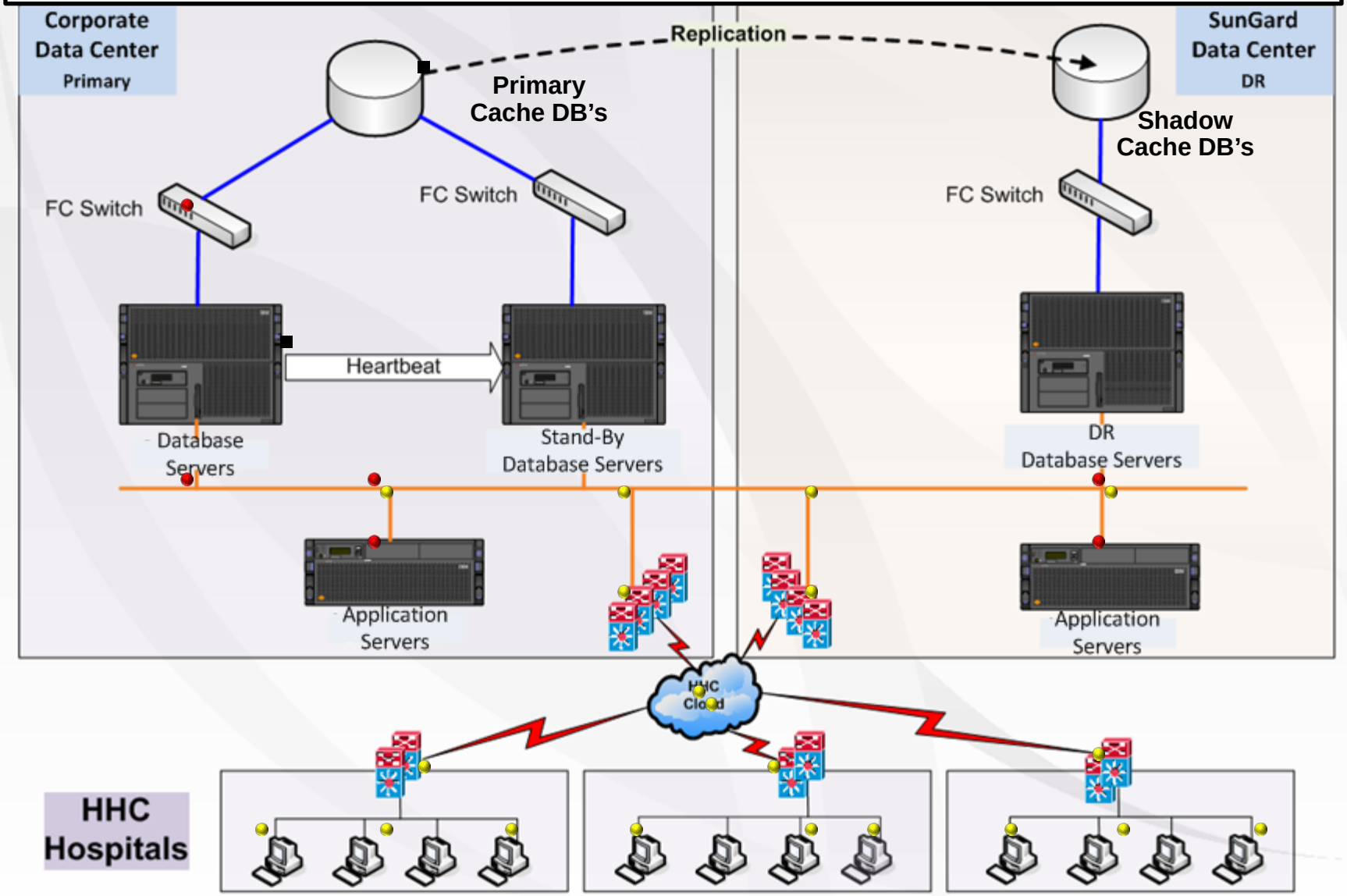
Tier Level	Requirements
1	• Single non-redundant distribution path serving the IT equipment • Non-redundant capacity components • Basic site infrastructure with expected availability of 99.671%
2	• Meets or exceeds all Tier 1 requirements • Redundant site infrastructure capacity components with expected availability of 99.741%
3	• Meets or exceeds all Tier 1 and Tier 2 requirements • Multiple independent distribution paths serving the IT equipment • All IT equipment must be dual-powered and fully compatible with the topology of a site's architecture • Concurrently maintainable site infrastructure with expected availability of 99.982%
4	• Meets or exceeds all Tier 1, Tier 2 and Tier 3 requirements • All cooling equipment is independently dual-powered, including chillers and heating, ventilating and air-conditioning (HVAC) systems • Fault-tolerant site infrastructure with electrical power storage and distribution facilities with expected availability of 99.995%

Enterprise Wide Data Communication and Redundancy



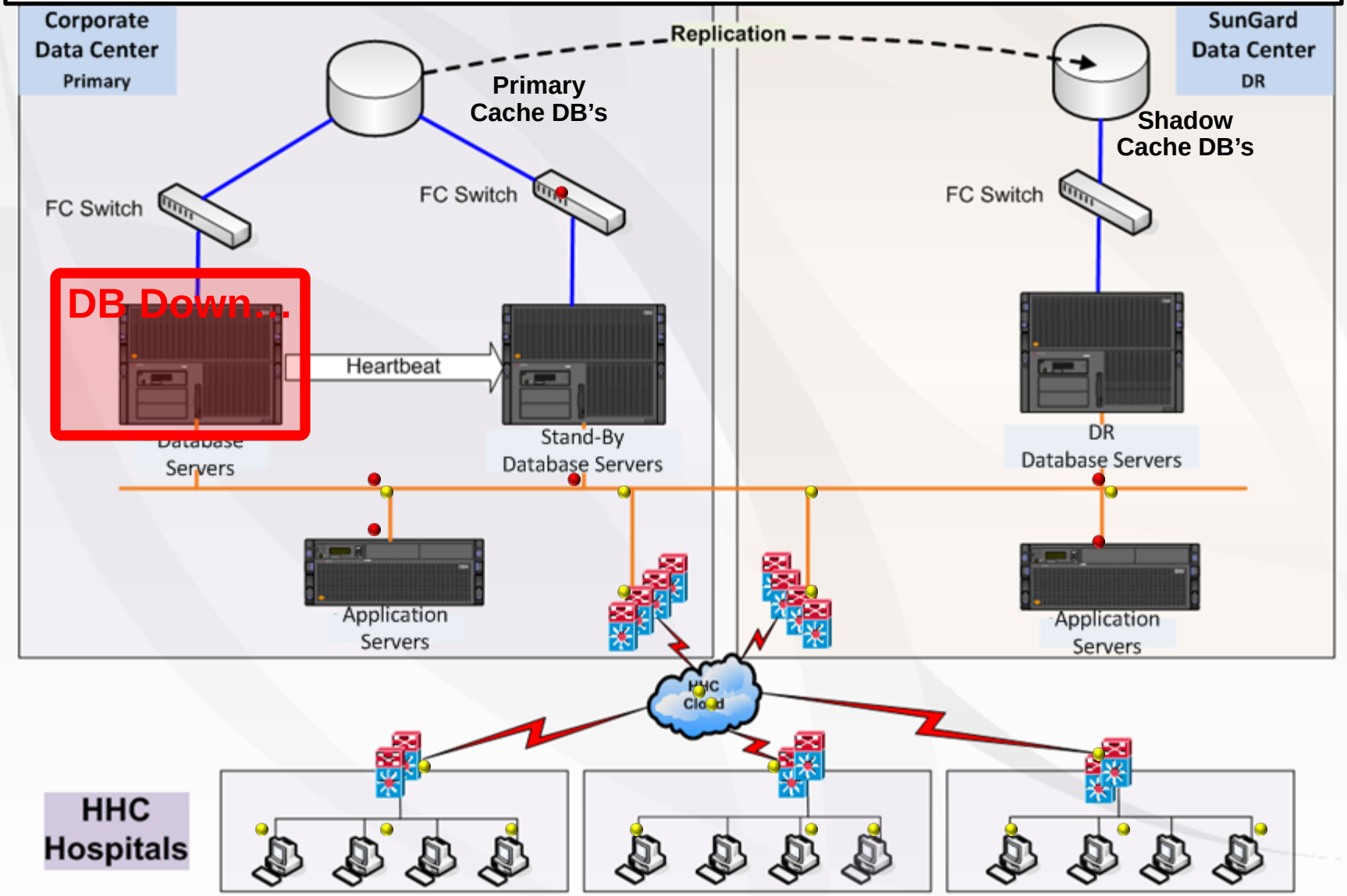
Existing SunGard Availability Services

Normal operation: Application Servers communicate with primary databases at CDC



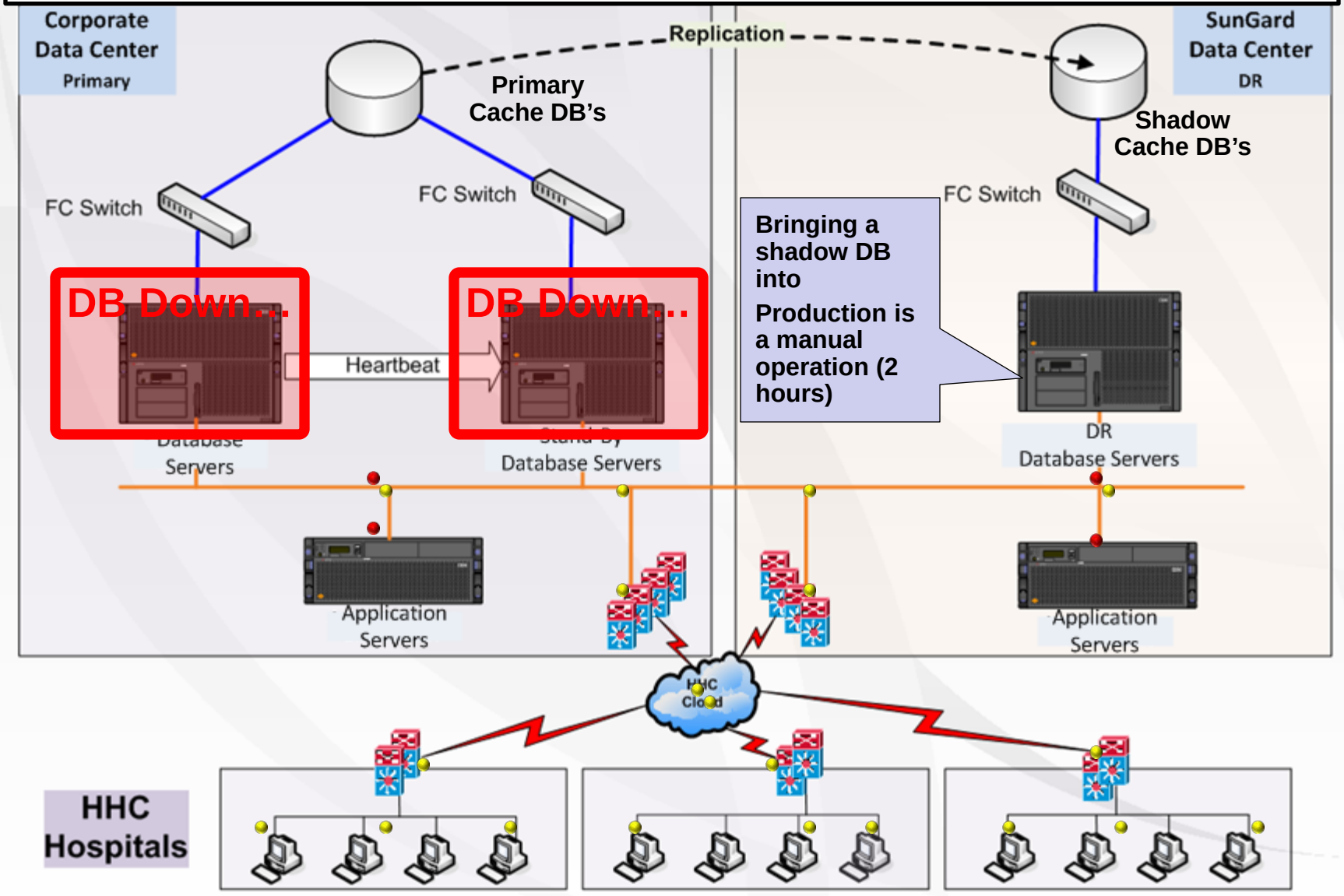
Existing SunGard Availability Services

Primary DB down: Application Servers communicate with secondary database servers at CDC



Existing SunGard Availability Services

CDC down: Application Servers communicate with DR databases at SDC



SunGard Contract Information

- Current contract rate is $6.7 million annually
- Proposed contract rate is $5.3 million annually includes additional power

Cost Analysis	NO Power Increase	With Capital Project and EMR Power Increases		
	Current Contract Rate	Using SunGard Current Contract Rate (A)	Using SunGard Proposed New Contract (B)	Savings (C = A - B)
Usage	343	536	536	
Cost per kW	$1,616	$1,616	$827	**$788**
Monthly Cost	$554,230	$866,085	$443,490	**$422,595**
Annual Cost	$6,650,760	$10,393,024	$5,321,880	**$5,071,144**
Cost Over 4 Years	$26,603,040	$41,572,097.49	$21,287,520	**$20,284,577.49**

Cost Analysis	Additional Blocks of 100kW Power BEYOND 536kW		Additional Savings	
	Using SunGard Current Contract Rate	Using SunGard Proposed New Contract		
	=$1,616 * 100kW	=$898 * 100kW	Additional Blocks of 100kW @ $898 Per kW Versus Current Rate (Per Month, IF NEEDED)	$71,783
	$161,600	$89,800		

SunGard Contract Information

- Approximate cost to relocate to a new Data Center - **$43 million**
- Approximate cost to use another existing Data Center - **$26 million**
- Approximate time to relocate to another Data Center – 18-24 months
- Potential financial risk - $60 million in lost Federal Incentives stemming from the Electronic Medical Records Program (Meaningful Use)
- Total savings with new SunGard contract is **$20.3 million** over 4 years

Questions

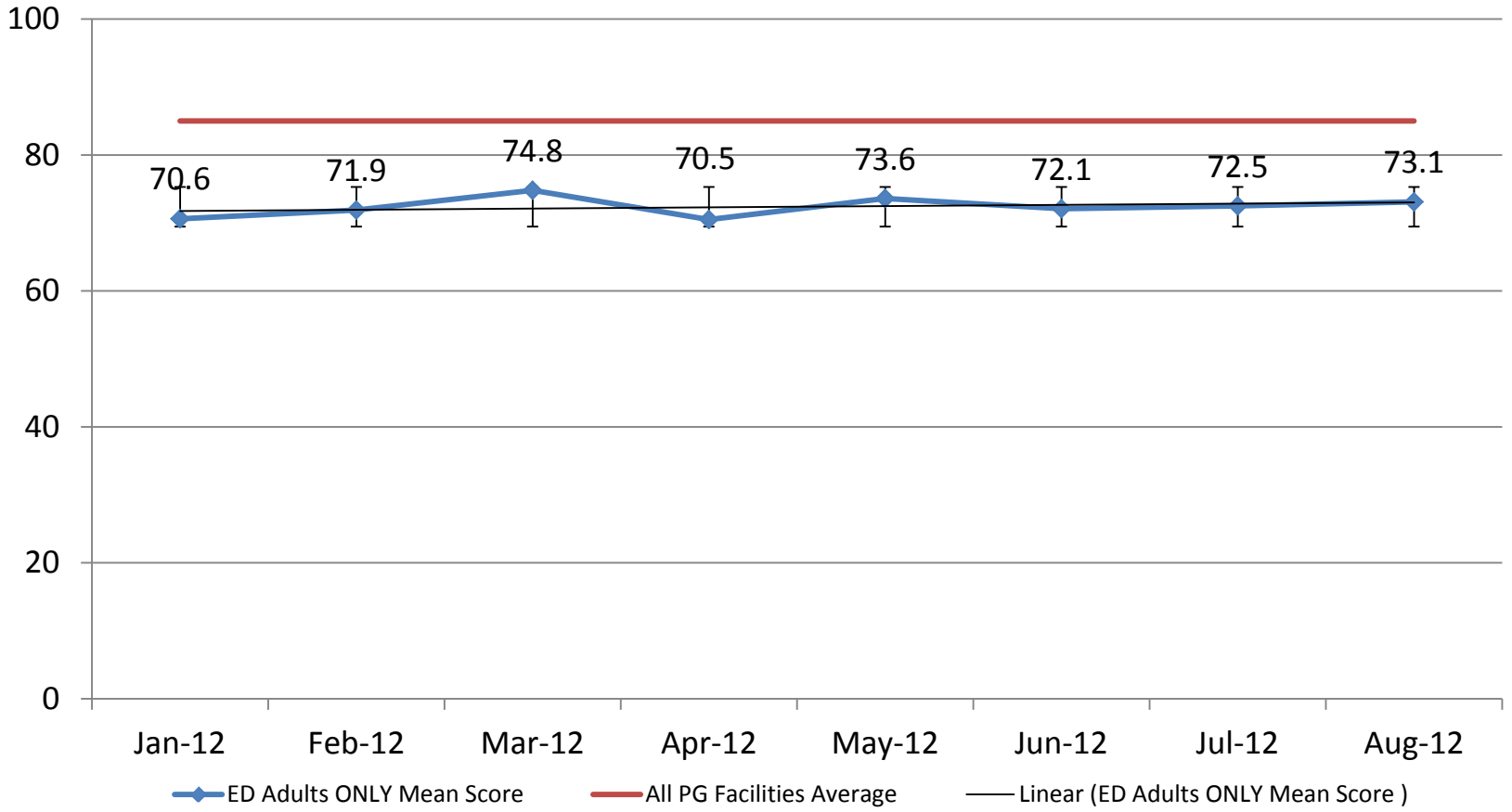
HHC Patient Satisfaction

Medical and Professional Affairs Committee, HHC Board
October 11, 2012

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
nyc.gov/hhc

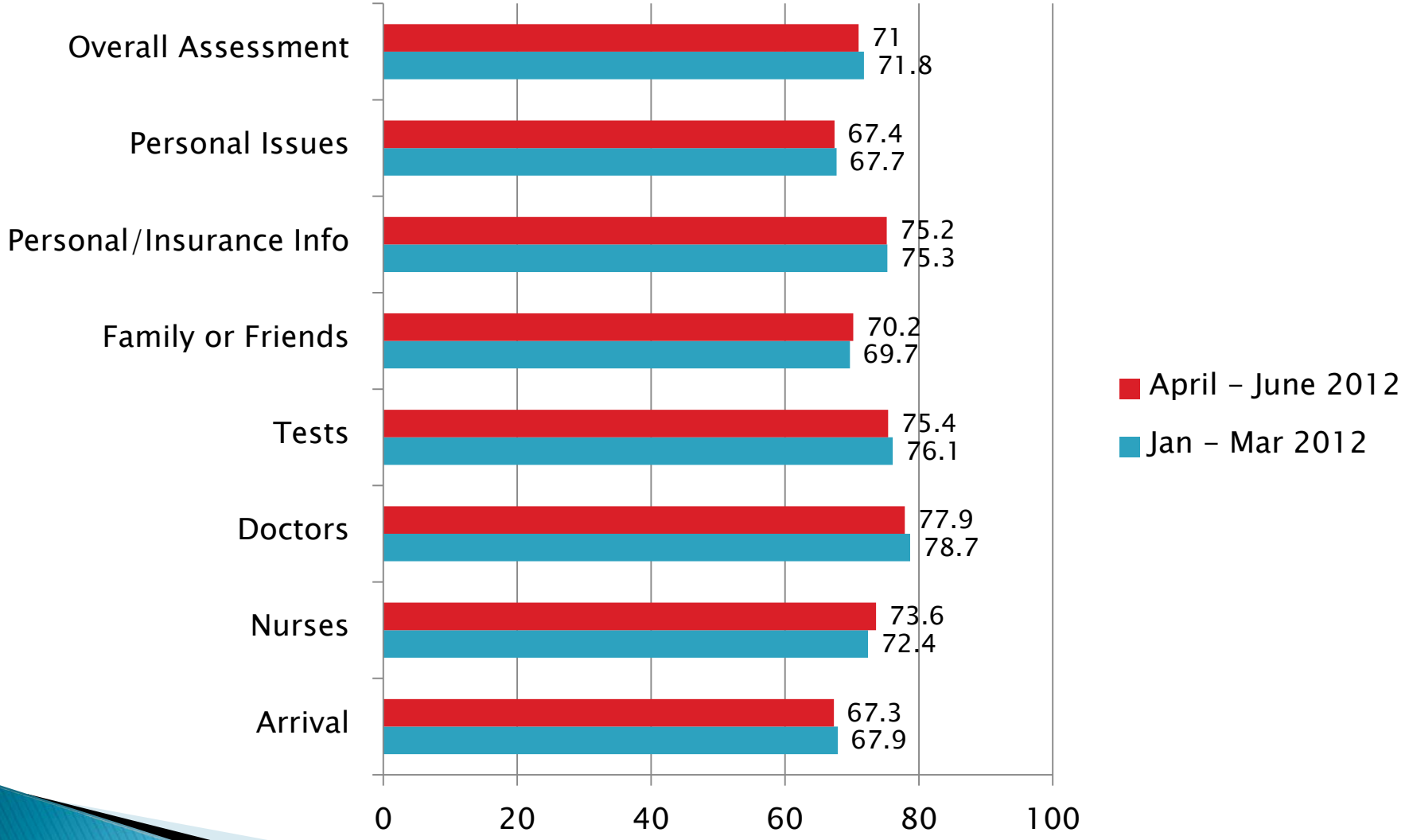
ED Overall Patient Satisfaction

Corporate-wide



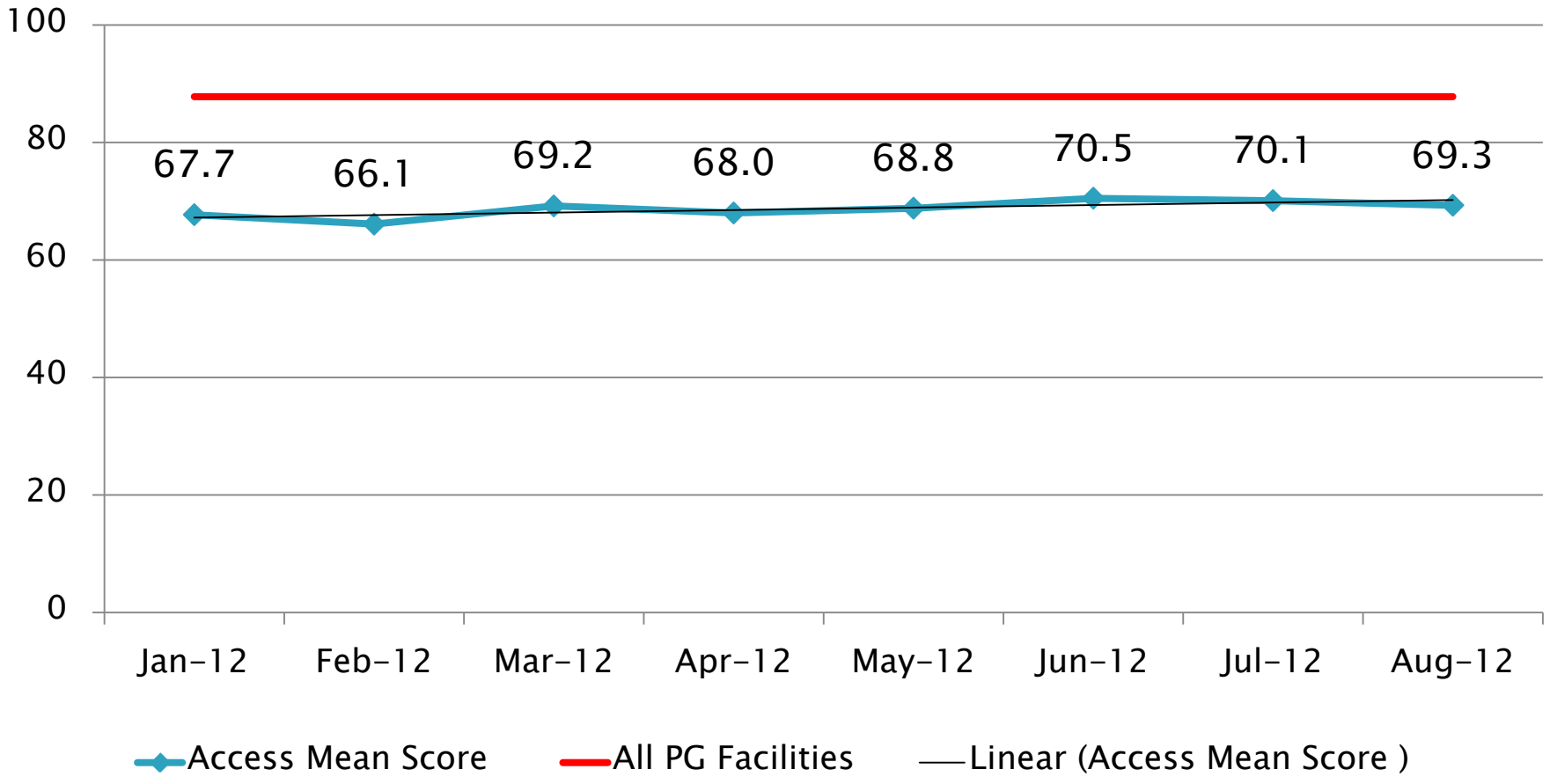
**Adult Patients Only*
**Data displayed by Discharge Date*
**YTD 2012 as of August 31, 2012*
**All PG Facilities represents [illegible] facilities throughout the US who use Press Ga[illegible]*

ED Patient Satisfaction – HHC Mean Score



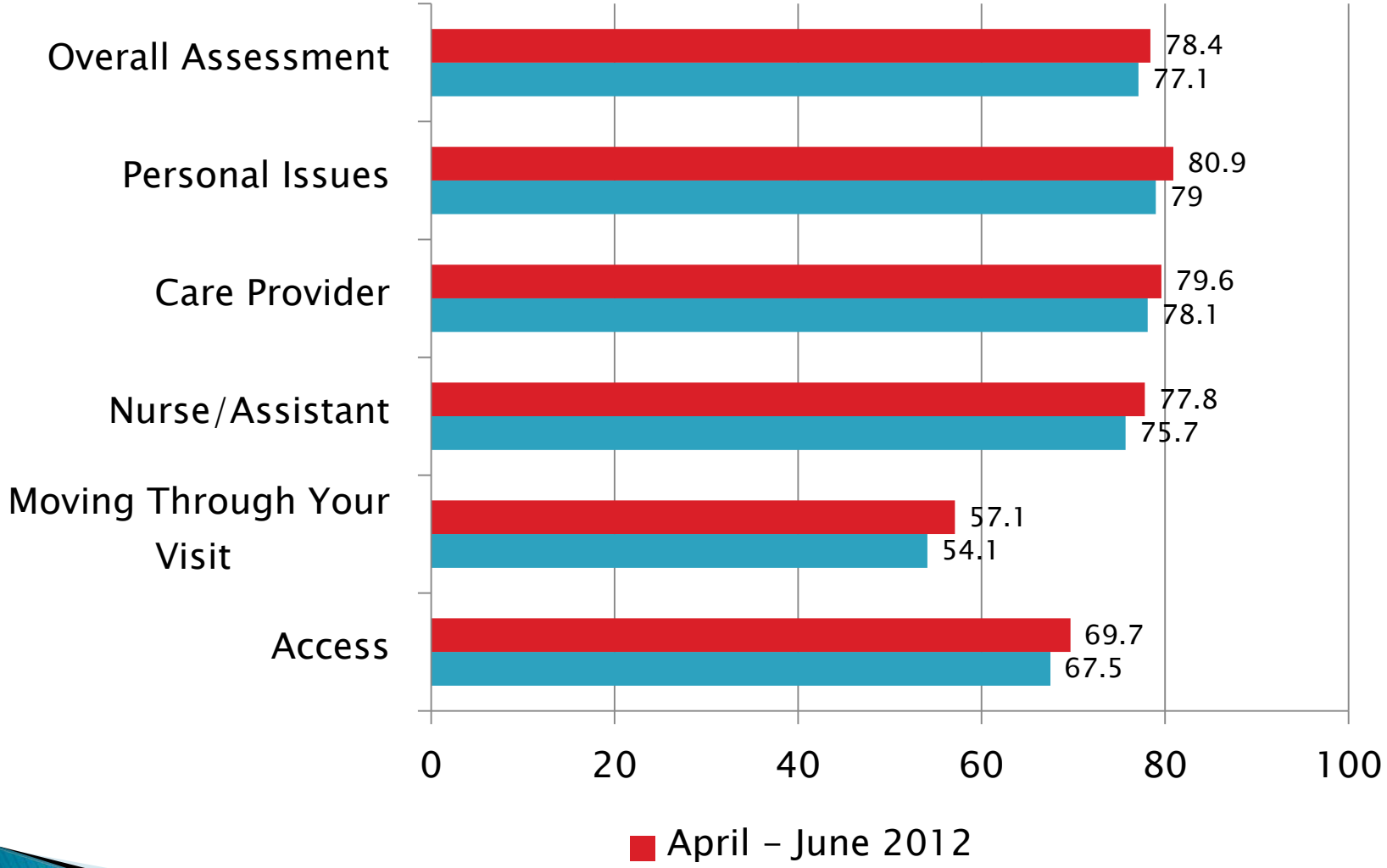
*Adult Patients Only
*Data displayed by Discharge Date

HHC Outpatient Access



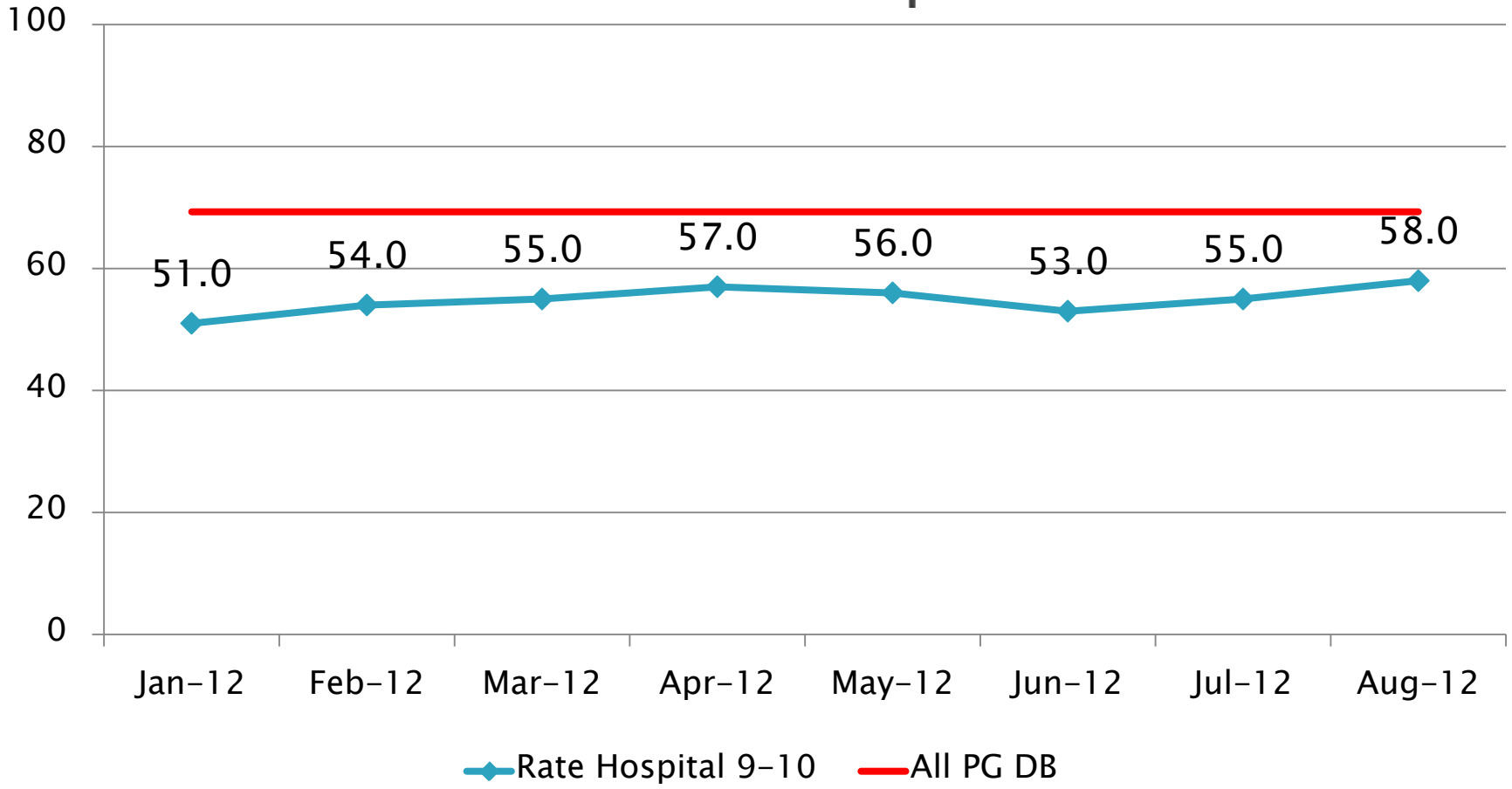
**Data displayed by Date of Visit*
**YTD 2012 as of August 31, 2012*
**All PG Facilities represents facilities throughout the US who use Press*

Outpatient Satisfaction – Mean Score



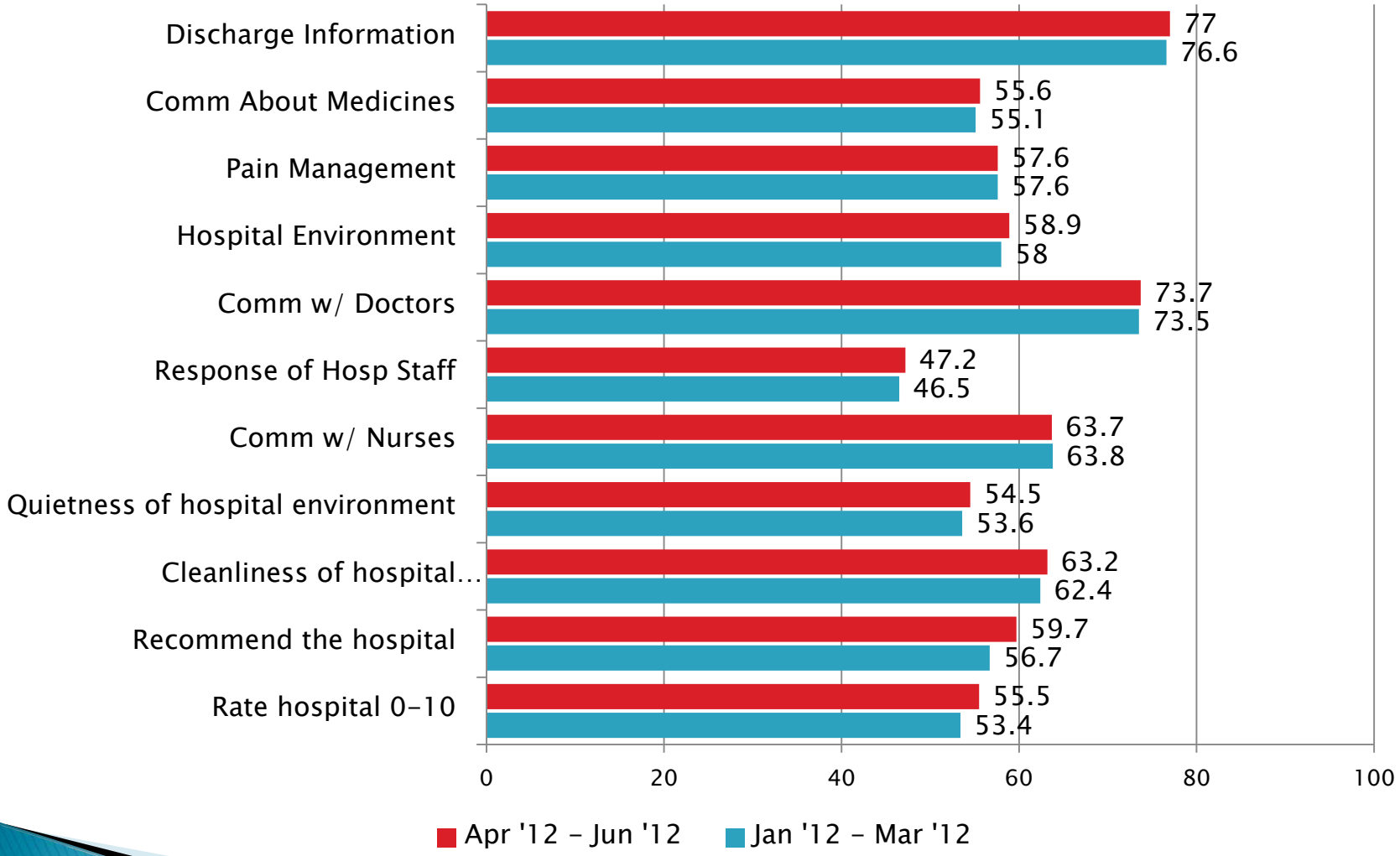
*Data displayed by Date of Visit
*YTD 2012 as of August 31, 2012

Inpatient Satisfaction
HCAHPS – Rate Hospital 9-10



**Data displayed by Discharge Date*
**YTD 2012 as of August 31, 2012*
**All PG DB represents hospitals throughout the US who use Press Ganey*

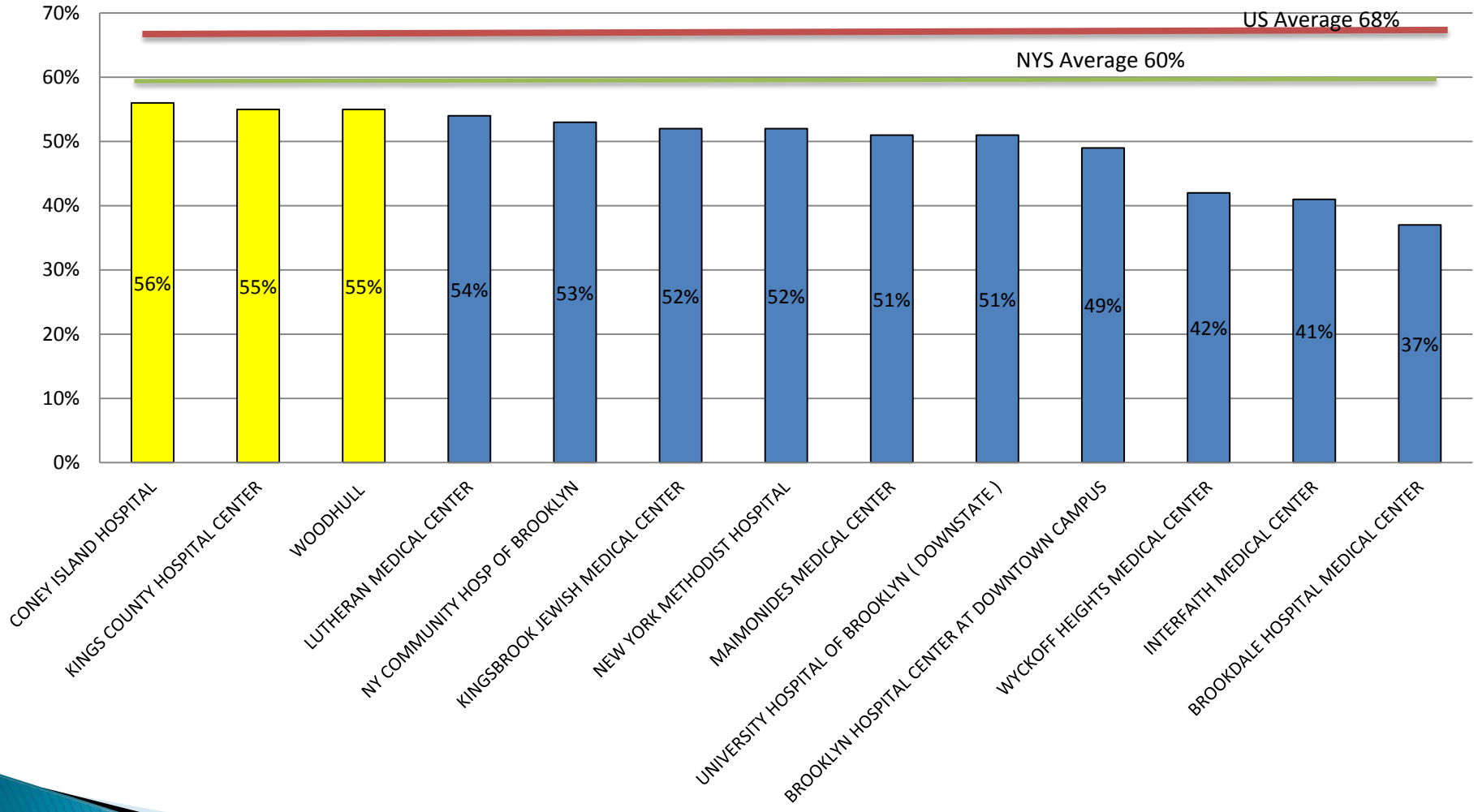
Inpatient Satisfaction
HCAHPS Top Box – All Domains



*Data displayed by Discharge Date
*YTD 2012 as of August 31, 2012

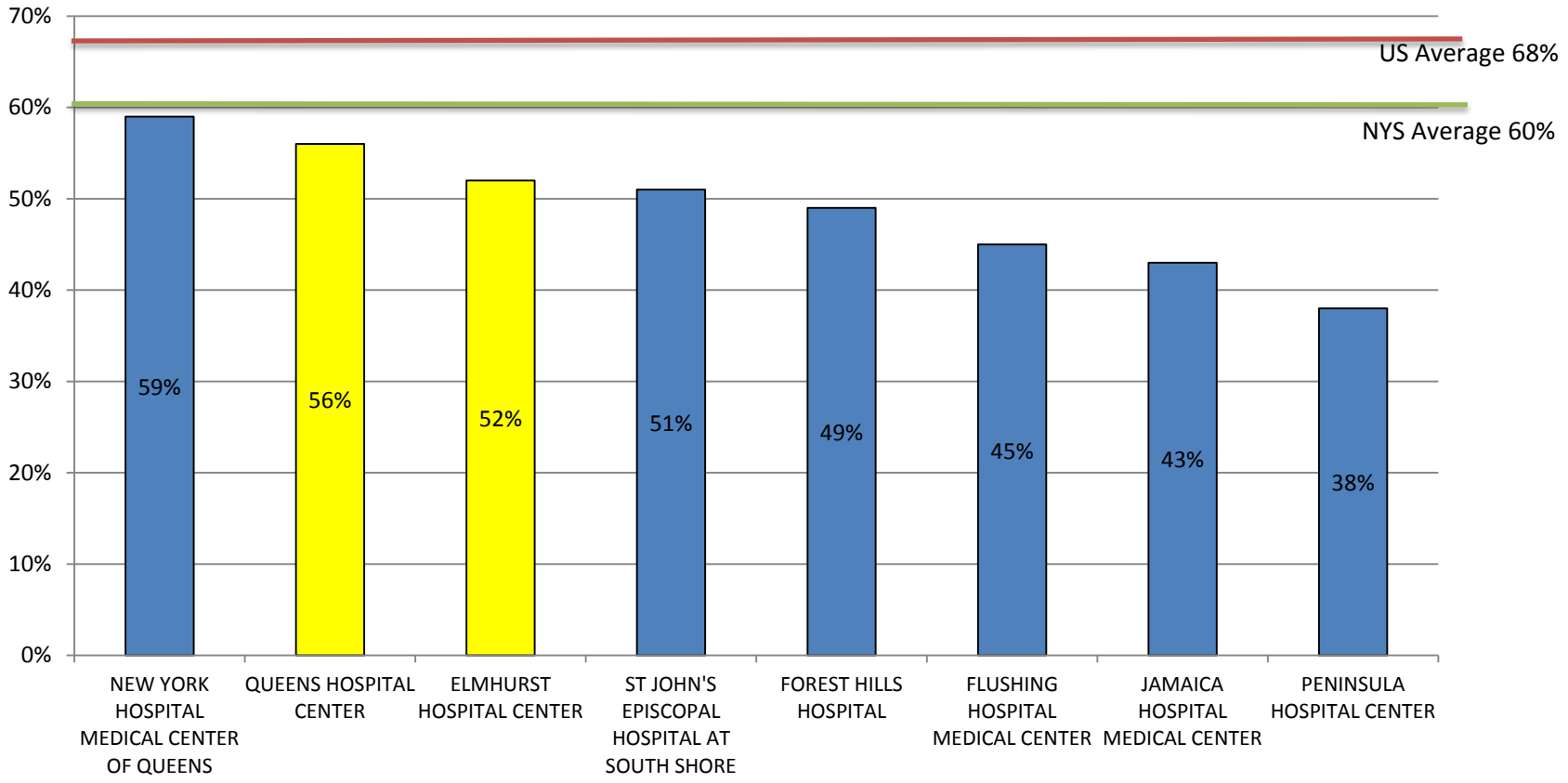
Brooklyn Hospitals

-overall HCAHPS ratings



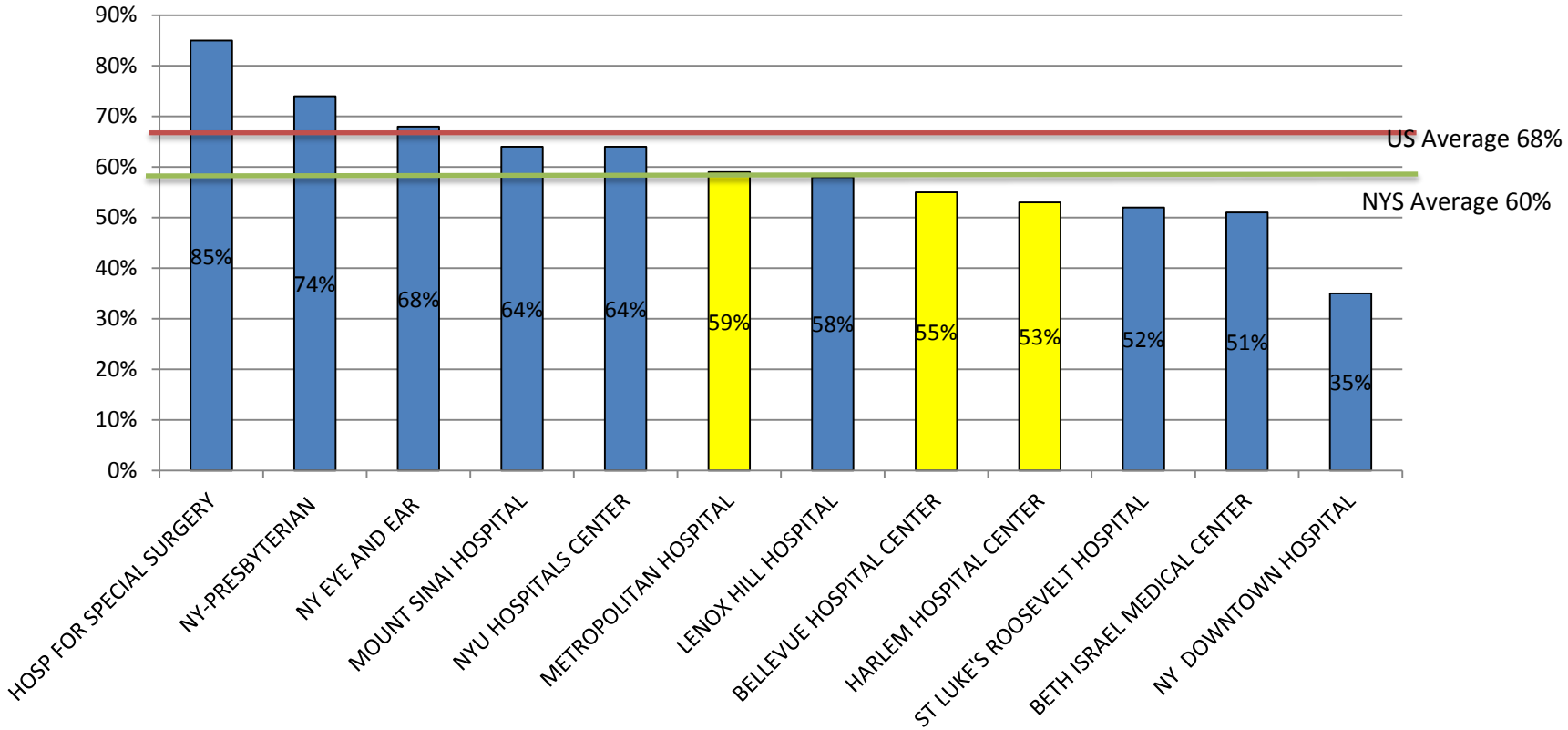
CMS Public Data : 10/1/10-9/30/11

Hospitals in the Borough of Queens
-overall HCAHPS rating



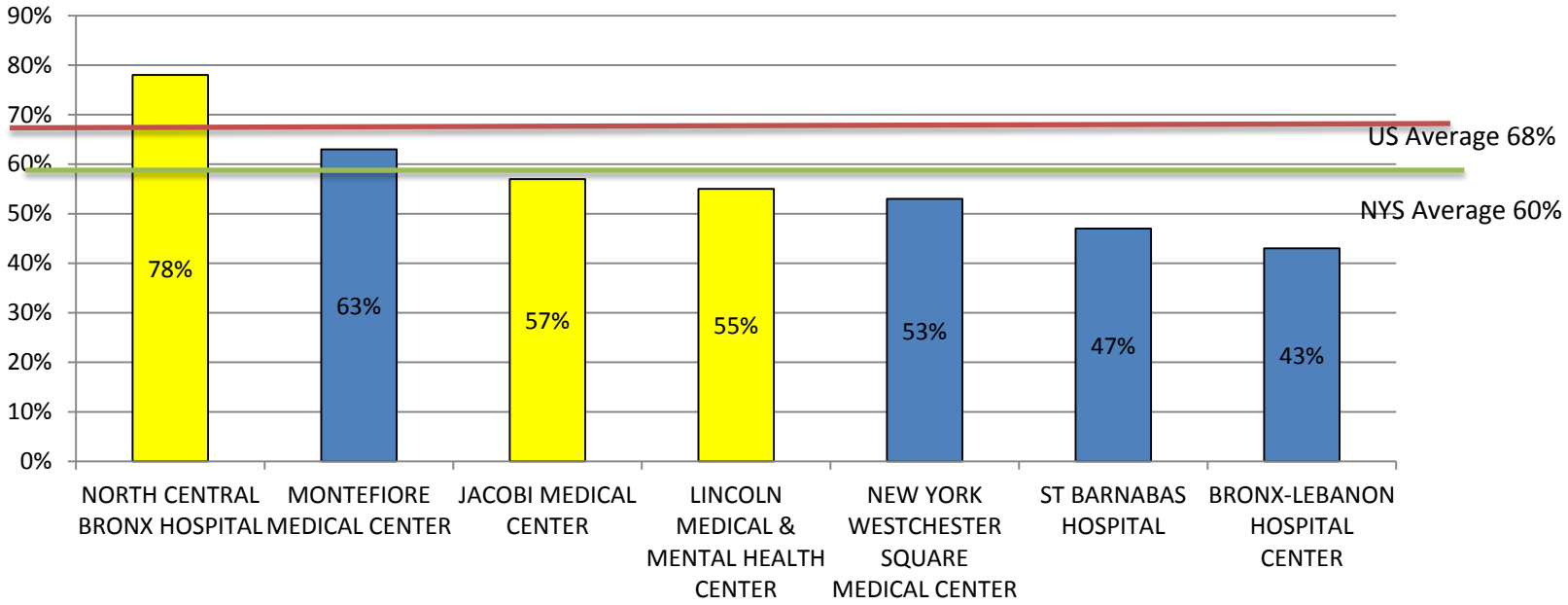
CMS Public Data : 10/1/10-9/30/11

Manhattan Hospitals
– overall HCAHPS rating



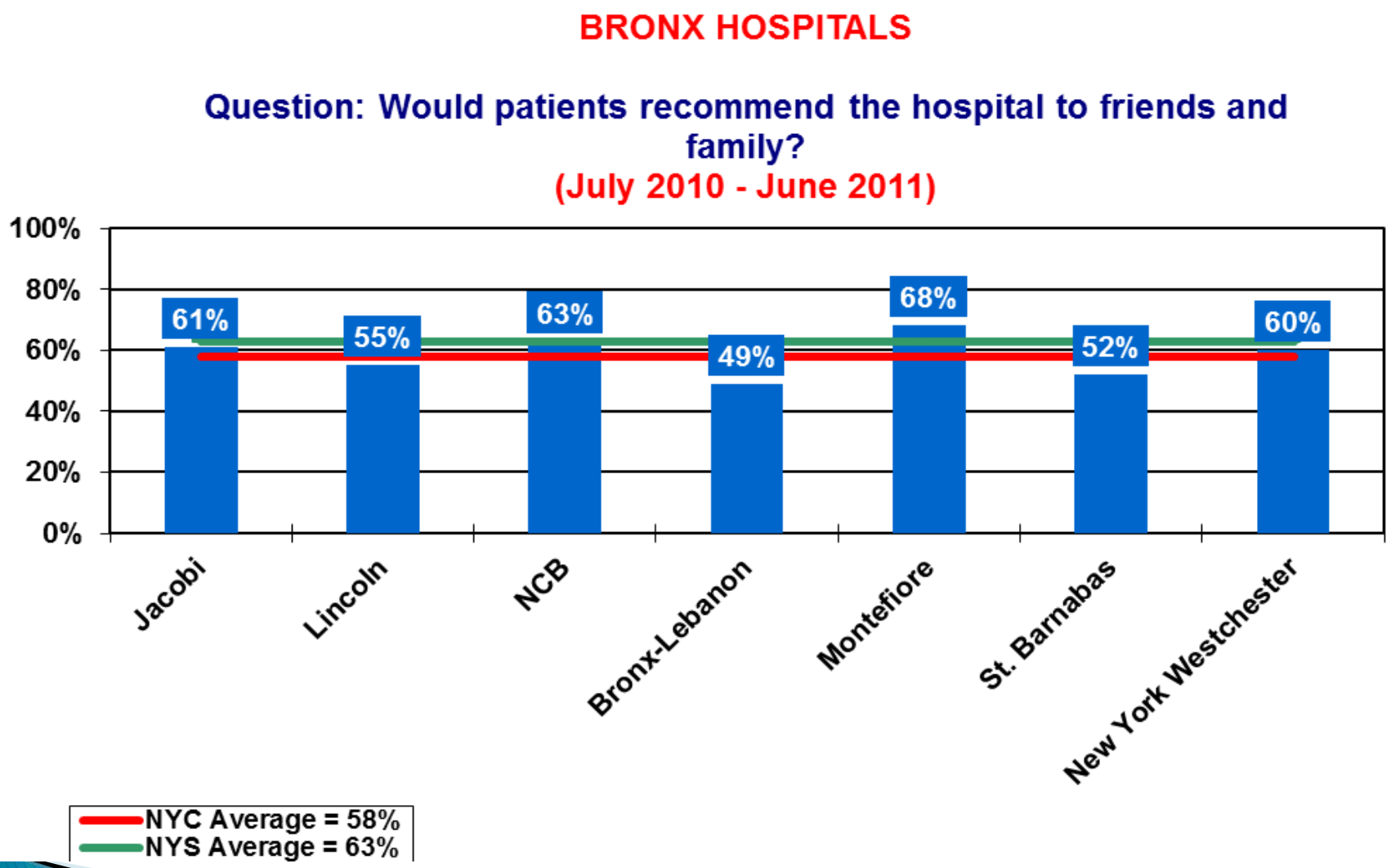
CMS Public Data : 10/1/10-9/30/11

Hospitals in the Borough of the Bronx
-overall HCAHPS rating



CMS Public Data : 10/1/10-9/30/11

Bronx HCAHPS : Recommend vs Rating



2012 – 2013 Action Plan Update

- Selection and engagement of new patient experience survey vendor (December 2011)
- Review and revise the parameters for surveying patients (January 2012)
- Expand the number of languages in which surveys will be offered to better meet the needs of patients (March 2012)
- Expand survey sample size
- Add Behavioral Health
- Leadership and staff education regarding patient centered care mission and newly available management tools available through new vendor (Began March 2012; In Progress)
- Dedicated HHC Press Ganey Improvement Advisor (April 2012)
- Review of baseline data (June 2012)
- Determination of 2013 goals and priority focus areas (September 2012)
- Determination of pilot facilities (Harlem and Metropolitan) for dedicated improvement work (September 2012)
- Launch of corporate wide leadership group to coordinate improvement activities and finalize an action plan

2013 Priority Focus Areas

INPATIENT

- Focus Question – '*Rate Hospital 9-10*'
- Goal – 50th Percentile All PG Database = 69.3 Top Box
- Key Drivers:
  - Nurse/MD Communication
  - Responsiveness of Hospital Staff

OUTPATIENT

- Focus Section – Access
- Goal – 50th Percentile All Facilities Database = 87.8 Mean Score
- Key Drivers:
  - East of getting through to the clinic on the phone
  - Ease of scheduling your appointment
  - Courtesy of staff in the registration area

2013 Priority Focus Areas (Cont.)

EMERGENCY DEPARTMENT

- Focus Section – Overall Assessment
- Goal – 50th Percentile All PG Database = 85 Mean Score
- Key Drivers:
  - Waiting time before staff noticed your arrival
  - Waiting time before you were brought to the treatment area
  - Waiting time in the treatment area before you were seen by a doctor
  - Information about waits and delays