AGENDA

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE	**Meeting Date: September 10, 2015** **Time: 9:00 AM** **Location: 125 Worth Street, Room 532**

BOARD OF DIRECTORS

CALL TO ORDER — **DR. CALAMIA**

ADOPTION OF MINUTES

July 16th, 2015

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

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

ACTION ITEM:

I. **Authorizing the New York City Health and Hospitals Corporation (HHC), through its President, to delegate to each acute care hospital's Grievance Committee responsibility for the prompt resolution of grievances and complaints from patients and/or their families. The activities of the Grievance Committees will be reviewed and reported through each hospital's Quality Assurance process to the Board of Directors.** — **MS. JACOBS**

II. **Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to enter into a sole source agreement With SURESCRIPTS, LLC for e-prescribing software and related services for an amount not to exceed $4,769,555 (which includes a contingency reserve of $229,817 for additional services that may be required) over a three-year term with up to two one-year renewal terms.** — **MR. GUIDO/ MS. BLACKBURN**

INFORMATION ITEM:

I.	**MetroPlus Annual Report**	**DR. SAPERSTEIN**
II.	**Patient Safety**	**MS. JACOBS/ MS. KONG**

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

MINUTES

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE BOARD OF DIRECTORS

Meeting Date: July 16, 2015

ATTENDEES

COMMITTEE MEMBERS
Vincent Calamia, MD, Committee Chair
Josephine Bolus, RN
Antonio Martin, (representing Dr. Ram Raju in voting capacity)
Hillary Kunins, MD (representing Dr. Gary Belkin in a voting capacity)

HHC CENTRAL OFFICE STAFF:
Machelle Allen, MD, Deputy Chief Medical Officer, Office of Health Care Improvement
Chalice Averett, Director, Office Audit Internal
Charles Barron, MD, Director of Psychiatry, Office of Behavioral Health
Janette Baxter, Senior Director, Risk Management
Donna Benjamin, Restructuring Project Management Officer
Nicholas Cagliuso, Sr., PhD, MPH, Assistant Vice President, Emergency Management
Deborah Cates, Chief of Staff, Board Affairs
Tammy Carlisle, Associate Executive Director, Corporate Planning
Megan Cunningham, Director, Accountable Care Organization
Carolyn Dunn, Senior Director, Marketing
Kenra Ford, Assistant Vice President Clinical Lab Operations/M&PA
Juliet Gaengan, Senior Director, Quality and Innovation
Alfred Garofalo, Senior Director, Enterprise Information Technology System
Sal Guido, Acting Chief Information Officer, Enterprise Information Technology System
Terry Hamilton, Assistant Vice President, Corporate Planning
Christina Jenkins, MD, Chief Executive Officer, OneCity Health
Lauren Johnston, Senior Assistant Vice President, Office of Patient Centered Care
John Jurenko, Senior Assistant Vice President, Intergovernmental Relations
Susan Kansagra, Assistant Vice President, Population Health
Barbara Keller, Deputy Counsel, Legal Affairs
Barbara Lederman, Senior Director, Enterprise Information Technology System
Patricia Lockhart, Secretary to the Corporation
Ana Marengo, Senior Vice President, Communications & Marketing
Randall Mark, Chief of Staff, President Office
Ian Michaels, Media Director, Communication and Marketing
Deirdre Newton, Senior Counsel, Legal Affairs
Darren Ng, Systems Analyst, Corporate Budget
Charlotte Nuehaus, Senior Management Consultant, Corporate Planning Services
Christopher Philippou, Assistant Director, Corporate Planning
Salvatore Russo, Senior Vice President & General Counsel, Legal Affairs
Lynnette Sainbert, Assistant Director, Board Affairs
Marisa Salamone Gleason, Assistant Vice President, Enterprise Information Technology System
Eli Tarlow, Enterprise Information Technology System

FACILITY STAFF:
Lillian Diaz, Chief Nurse Executive, Metropolitan Hospital Center
Seth Diamond, Chief Operating Officer, MetroPlus Health Plan, Inc.
John Maese, MD, Medical Director, Coney Island Hospital
Andreea Mera, Special Assistant to the President, MetroPlus Health Plan, Inc.
John T. Pellicone, Chief Medical Officer, Metropolitan Hospital Center
Denise Soares, Senior Vice President, Generation + Network

OTHERS PRESENT:
James Cassidy, Office of Management and Budget
Kent Cherny, Office of Management and Budget
Tyler DeRubis, Analyst, Office of Management and Budget
Mark Heron, Assistant Director, Director DC37
Scott Hill, Account Executive Quadramed
David N. Hoffman, Chief Compliance Officer, PAGNY
Kristyn Raffaele, Analyst, Office of Management and Budget

MEDICAL AND PROFESSIONAL AFFAIRS/
INFORMATION TECHNOLOGY COMMITTEE
Thursday, July 16, 2015

Dr. Vincent Calamia, Chair of the Committee, called the meeting to order at 9:00 AM. The minutes of the June 11th, 2015 Medical & Professional Affairs/IT Committee meeting were adopted.

CHIEF MEDICAL OFFICER REPORT

Machelle Allen, MD, Deputy Chief Medical Officer, reported on the following initiatives.

Office of Population Health

This summer, HHC will be participating in another season of the Fruit and Vegetable Prescription program in partnership with Wholesome Wave. The program supports overweight or obese children and their families with nutrition education and goal-setting on healthy eating. The program also provides families with a prescription for fruits and vegetables that can be redeemed for fresh produce at local farmers' markets.

Office of Behavioral Health

1. Transformation Project; Readiness for Managed Care:
   A learning session was held on June 23, 2015 which presented the results of the four pilot sites and presented the next step pilots for all HHC facilities. The conference was well attended and included several CEO's and CFO's of the facilities demonstrating the commitment of facility leadership to this process. Evaluation of the conference was very positive and attendees demonstrated high levels of enthusiasm and energy about the projects. The pilots that are planned for all facilities are the following:

- Increase Behavioral Health Access: by expansion of the current Access project;
- High Utilizer Data project: focusing on high utilizers of psychiatric emergency room services;
- Inpatient to Outpatient Bridging: using peers for transition;
- Outpatient Engagement: using community outreach to engage patients;
- Behavioral Health, Primary Care Integration: transition of identified stable patients from Behavioral Health clinics to Primary Care services.

An implementation plan for each facility has been developed for the Access and High Utilizer projects. Specific playbooks and implementation plans are being developed for the other projects and are scheduled for startup in September 2015.

2. Family Justice Center – Domestic Violence program:
   This is a potential program which establishes evaluation and short term treatment for victims of domestic violence which will be provided on site at the Family Justice Center program. A meeting has been scheduled with Dr. Catherine Monk who is the director of a similar program at Columbia University. We are in the process of developing a model for this program and a proposal will be finalized for review.

3. NYSOMH / OPWDD (Office of People with Developmental Disabilities) / HHC collaboration: This is a collaboration to explore and develop a specialized treatment program at one of our acute care facilities for people with both mental illness and developmental disabilities. Discussions with OMH are occurring now. We are awaiting utilization data and financial information from OMH. A next step evaluation meeting is to be scheduled.

4. HHC Behavioral Health Incident Review Committee:
This is a new committee established to meet the new requirement of the Justice Center. The committee is corporate wide and multidisciplinary and has been set up to review incident data in order to provide guidance to the corporation on trends and management issues. This committee meets every 2 months, the third meeting is scheduled for August.

Office of Patient Centered Care

1. The CNO's spent an entire day reviewing Epic and are quite pleased with the product. There are issues and processes that are being addressed after their input, but it was a positive experience for the nurses and the Epic team. There are additional meetings scheduled with the nurse educators, infection preventionists and Home Care.

2. HHC was awarded a grant from the Hartford Fund, the funding for which started on July 1st of this year. This grant will allow the enhancement of the role and expertise of registered nurses in the ambulatory Geriatric practices, leveraging NICHE (Nurses Improving Care for Healthsystem Elders), our PCMH and ACO experience.

3. The 2015 Nursing Excellence event will be held on October 27, 2015. Please save this date as all of our nurses always appreciate the participation of our leadership.

Accountable Care Organization

1. The ACO has convened internal management discussions and planning in preparation for reapplication to the Medicare Shared Savings Program for 2016. The ACO is also meeting with affiliates and HHC ACO Board of Directors in coming weeks to ensure satisfaction of CMS submission requirements by the August 7th deadline. The ACO is also exploring expansion of network partnerships to broaden primary care population and capacity in the next application cycle.

2. Roughly 20% of the ACO's overall population is publically housed in New York City Housing Authority (NYCHA) developments. NYCHA residents have access to various resources and services - crisis intervention, care management, education and counseling, home delivered meals, etc. - that help keep residents healthy in the community. Starting in June, the ACO began 'flagging' patients who reside in public housing. The goal in providing this information is to strengthen connections between HHC facilities, NYCHA, and the community-based organizations (CBOs) that provide services for NYCHA residents - particularly the elderly and disabled. This follows from a pilot with Dr. Judy Flores and the ACO team at Woodhull, who identified ACO patients from three NYCHA developments nearby, then connected ambulatory care/social work leadership with representatives from NYCHA and the CBOs in those locations. The ACO will continue to work to develop streamlined process for referrals and communication.

3. The ACO was recently featured in publications in Crain's New York and HHC Insider, highlighting the ACO's population management activities at HHC facilities and the ACO's policy perspective on changes to the Medicare ACO program structure.

Laboratory Service

HHC laboratories is participating in a 3 day Cerner event scheduled 14, 15 and 16th of July, 2015. The event includes review of the HHC Cerner build to date as well vendor training of HHC Super Users from Queens/Elmhurst, Jacobi and North Central Bronx laboratories. Laboratory Services continues to work closely with the EPIC team to insure a seamless communication between the laboratories and the clinical service providers.

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, 2015 was 473,905. Breakdown of plan enrollment by line of business is as follows:

Medicaid	415,887
Child Health Plus	13,309
MetroPlus Gold	3,526
Partnership in Care (HIV/SNP)	4,738
Medicare	8,446
MLTC	893
QHP	26,403
SHOP	601
FIDA	102

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.

NYS Department of Financial Services is continuing to review the 2016 Qualified Health Plan Rates we submitted in May. An answer is expected to be released in the first week of July.

New York Health Plan Alliance released a summary of the most common reasons for discrepancies between issuers (insurers), eMedNY (State enrollment database) and NYSoH (which contribute to member dissatisfaction and therefore potential disenrollment). MetroPlus is facing the same issues as the other participants, namely late renewals, the State's failure to process 834s, renewal date not available to plans, duplicate accounts, or the State's failure to submit effectuations.

The MetroPlus Quality Management department is working diligently to collect and submit the 2014 Medicare Star rating data. We predict our score to be the same as the past two years (3.5 stars).

In a previous report to this Committee I mentioned that our growth strategy includes expansion of our network into Staten Island. We have had discussions with the two hospitals in Staten Island – Staten Island University Hospital (SIUH) and Richmond University Medical Center (RUMC). We expect to finalize rates with RUMC this week. SIUH is more challenging due to its being part of the overall North Shore LIJ network. We are primarily targeting PCPs and high volume specialties. In addition, after mailing over 1,000

letters to Staten Island providers, we have almost 150 in the credentialing/contracting pipeline. SIUH Physicians and RUMC physician group (Amboy Medical PC) will both be contracted at the same time as the hospital agreements. This will provide over 500 physicians for the network. We also have a relationship with Advantage Care physicians through the Preferred Health Partners group in Brooklyn. They offer two sites in Staten Island with approximately 120 providers who are willing to contract. Pharmacy, Dental and Behavioral Health/Substance Abuse providers are all being addressed through our delegated vendors. We already meet network requirements for Staten Island in these areas.

As of the date of this report, we are undergoing the Onsite BH/HARP Readiness Review. The components of the onsite review are Program Operations (clinical program structure, clinical interviews with Utilization Management and Case Management staff, members services structure and protocols), Information Systems (claims, data warehouse, clinical and telephonic systems), and Document Review (sample of executed provider contracts and corresponding credentialing files, as well as resumes of plan staff participating in interviews). I will provide information about the outcome at the next meeting.

Since I have mentioned the HARP Readiness Review, I will inform you that MetroPlus is also scheduled to undergo the Article 44 Audit at the end of September 2015.

In looking at state-wide data on the Fully-Integrated Dual Advantage (FIDA) program, total enrollment in NYS as of June 2, 2015 was 4,407. There were 47,702 opt-outs. The passive enrollment schedule will enroll 3,908 individuals in July (effectuated June 1, 2015), and 5,584 in August (effectuated July 1, 2015) across the State. In addition, I would like to bring to this committee's attention that the three-way contract requires plans to move the provider payment agreements from fee-for-service to alternative payment arrangements. We are required to submit proposals for DOH review and approval by August 15, 2015.

Chief Information Officer Report:

Sal Guido, Acting Corporate Chief Information Officer, Enterprise Information Technology Services gave an update on the following: Epic is on time and on budget, ICD10 is on track for deployment on October 1st, and the exchanged email system are all on time.

ACTION ITEM:

Sal Guido, Acting Corporate Chief Information Officer, Enterprise Information Technology Services presented to the committee on the following resolution:

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to enter into multiple contracts to purchase health information related professional services for the Epic Electronic Medical Record program and Epic related Revenue Cycle modules as needed with 22 vendors (the "Contractors") through requirements contracts for a two year term with three one-year options to renew at the Corporation's exclusive option for an amount not to exceed $119,292,988 million for the initial two year period.

The resolution was approved by the committee to be considered by the board.

INFORMATION ITEM:

Charles Barron, MD, Interim Medical Director of Behavioral Health, Medical and Professional Affairs presented to the committee the Behavioral Health Updates.

Behavioral Health Transformation - Current state

NY State is transitioning to Medicaid managed care with fully integrated behavioral/physical health and specialized Health and Recovery Plans (HARPs) for the seriously ill, between 2015-17 – ending fee-for-service (FFS) reimbursement for carved-out services. Impending changes to BH Medicaid funding could significantly impact HHC. DSRIP has major implications for BH. Given its large BH service, high proportion of Medicaid patients, significant value at risk and strong mission for serving the neediest, our efforts here need strong support. The Largest BH service in NYC (e.g., >40% of total IP discharges). Medicaid FFS accounts for ~52% IP/~40% OP by volume with $250M revenue at risk. HHC has taken significant strides recently to improve its BH service. It's improved outpatient wait times by 15% as part of ambulatory care access project. It has reduced length of stay (LOS) for inpatient psych by >20% since 2012.

The managed care transformation overall project phases & timeline:
Phase 1 Rapid baselining 9/15/14 to 11/1/14
Phase 2 Solution design Planning 11/1/14 to 1/1/15
Phase 3 Program launch Demonstrate in 4 sites (3 adult, 1 child/adolescent) 1/1/15 to 7/1/15
Phase 4 Standardized pilot roll-out 7/1/15

Phases 2 & 3: Solution Design & Program Launch
"Pillars" of Transformation
Increase use of peers: Strengthen care management; Make care co-occurring capable; Primary care integration; Complete OP and crisis continuum; and Develop community partnerships.

There are **4 Early Adopter Sites** - Adult population: Elmhurst; Kings County; Gouverneur Health and Child/Adolescent population: Bellevue.

Standardized Transformation Activities: Wave 1 - ACCESS: HIGH UTILIZER REPORTS – kick off July, 2015 and Wave 2 - IP-TO-OP BRIDGING; OUTPATIENT ENGAGEMENT and BH/PC INTEGRATION – Kick off /September, 2015

Pilots and Lessons Learned: Early Adopter Pilots – Kings, Elmhurst, Gouverneur (Adults) and Bellevue (Child)

Lessons Learned -The importance of facility steering committee, Inclusion of Finance, Managed Care, DSRIP, Importance of a site transformation coordinator, Importance of regular weekly team performance meetings, importance of regular monthly steering committee meetings, need for Behavioral Health coach for teams and the need to standardize future pilots across all facilities simultaneously.

Next Steps

To develop new, efficient ambulatory and crisis services including rehabilitation and recovery services as part of the 1915(i) waiver (HCBS – Home and Community Based Services); Accelerate efforts for prepare for Managed behavioral health and HARP; Coordinate above efforts with the DSRIP initiatives - especially integration of primary and BH. These require: changes to both clinical practice and operations strengthened relations with finance, centrally and at facility levels; a stronger culture of continuous quality improvement along with standardization of increased data collection and analysis

There being no further business the meeting was adjourned at 9:56AM.

Sal Guido, Acting Senior Vice President/Corporate CIO
Enterprise Information Technology Services
Report to the M&PA/IT Committee to the Board

Thursday, September 10, 2015@ 9:00 AM

Thank you and good morning. I'd like to provide the Committee members with several updates:

1. **Soarian Stress Testing:**

I am pleased to report that Information Technology's Business Applications is on target for completing the Soarian Stress testing on September 10, 2015. This testing is in preparation for the Soarian Financials go-live.

Stress testing simulates peak system use using a pre-determined number of users in order to judge the overall performance of the system as well as identifying areas within the system that are performing like bottlenecks. This type of testing ensures that the system has been sized correctly. Through this testing, HHC can remain confident that the Soarian Financials and Scheduling application will perform as expected, especially at peak usage.

Cerner originally estimated delivery of the Soarian test environment to be between August 25th and August 31st. The test environment was delivered on Tuesday, September 1st. Unfortunately, the environment was delivered without any production data which resulted in delays in the development of the necessary automated scripts for the Load test. Both Business Applications and Infrastructure teams created the test scripts after review from Finance and based on input and structure from Cerner which used results from their own internal stress tests. Once completed, these test scripts will run automatically and often repeating their scripted tasks while the tests are performed.

Test scripts will mimic normal user activity on the Soarian system, including admitting, transferring and discharging a patient along with assigning charges for anything related to the patient's visit. Simultaneously, we will have scripts perform look-ups of patients, doctors, as well as run reports similar to normal activity as experienced today.

If successful, this stress testing will prove that the system can handle the extra load that will be placed on it as HHC facilities are placed on the system as well as the added transactional load that will be expected with the Epic integration. With this testing we will also be able to identify any areas that would need to be improved either on the HHC side or Cerner's.

I will report back to the Committee on our progress.

2. Update on HHC's Exchange Email System Migration:

In my June Report to the Committee, I announced that HHC's Enterprise Infrastructure team was initiating the migration of the HHC workforce from the current Novell Groupwise email system to Microsoft Exchange, establishing one single email system for the entire Corporation. This migration to a more advanced and feature rich email system would provide users with functionality such as instant messaging, mobile applications and integrated and video archiving which was not previously available on the Groupwise email system.

I am pleased to report that at this time over 50% of HHC facilities have either completed or have active migrations underway. Two (2) main factors have caused our slowdown to completing the migration: the need to replace older BlackBerry devices which are no longer supported and the additional time required to plan and prepare for the migration of Correctional Health users to this new platform.

We anticipate that all of HHC will be on the new Exchange platform by November 2015. I will keep the Committee updated on our progress.

3. ePrescribing (eRX) Go-Live Update:

ePrescribing (eRX) software officially went live at HHC on Tuesday, August 18, 2015. This software allows for HHC providers to electronically send an accurate, error-free and understandable prescription directly to a pharmacy from the point of care (Provider). This process is an important element in improving the HHC patient experience by making it easier for our patients to get their medications and reduce medication errors. eRx is also critical to the implementation of our new electronic medical record.

On September 28, 2015, Quadramed will begin to apply an upgrade patch within the ePrescribing module which will address enhancements to renewals of prescriptions and will turn off the ability to add a duplicate pharmacy.

This completes my report today. Thank you.

Resolution

Authorizing the New York City Health and Hospitals Corporation (HHC), through its President, to delegate to each acute care hospital's Grievance Committee responsibility for the prompt resolution of grievances and complaints from patients and/or their families. The activities of the Grievance Committees will be reviewed and reported through each hospital's Quality Assurance process to the Board of Directors.

WHEREAS, HHC and its facilities are committed to the delivery of high quality health services in an atmosphere of dignity and respect; and

WHEREAS, the Board of Directors has continuing responsibility for the effective operation of HHC's facilities; and

WHEREAS, the Board of Directors serves as the Governing Body of HHC's facilities;

NOW, THEREFORE, be it

RESOLVED that HHC, through its President, will delegate to each acute care hospital's Grievance Committee responsibility for the prompt resolution of grievances and complaints from patients and/or their families. The activities of the Grievance Committees will be reviewed and reported through the Quality Assurance Committee process to the HHC Board of Directors.

EXECUTIVE SUMMARY

Resolution to delegate the review and resolution of patient and family grievances and complaints to patient grievance committees at HHC hospitals

HHC acute care hospital has a well-developed process for responding to concerns raised by patients and their families. HHC's operating procedure 90-1 sets out the responsibility and authority of the Office of Patient Relations at each HHC facility, and a 1992 resolution sets out additional HHC policies on patients' rights. These procedures apply to all of the Corporation's facilities. In addition, the Corporation's hospitals must adhere to the conditions of participation for hospitals established by the Centers for Medicare and Medicaid (CMS) in 42 CFR § 482.13. (2) (a). The regulation requires that

"The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. The hospital's Governing Body must approve and be responsible for the effective operation of the grievance process and must review and resolve grievances, unless it delegates the responsibility in writing to a Grievance Committee. The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization."

Each HHC acute care hospital has established a committee that reviews and resolves complaints and grievances as defined by CMS. The activities of those committees will be reviewed by the facility hospital-wide quality assurance committee, and data collected regarding patient complaints and grievances must be incorporated in the hospital's Quality Assessment and Performance Improvement Program. These data are currently reported to the Quality Assurance Committee of the Board of Directors.

This process conforms to every aspect of the regulation except the requirement that the Governing Body delegate responsibility in writing to a Grievance Committee. CMS has cited some HHC hospitals because of the lack of a written delegation from the Governing Body.

This resolution is the written delegation of responsibility required by the CMS regulation. Hereafter complaints and grievances will be reported to the Quality Assurance Committee of the Board of Directors and the hospital's Governing Body.

Resolution

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to enter into a sole source agreement with SURESCRIPTS, LLC for e-prescribing software and related services for an amount not to exceed $4,769,555 (which includes a contingency reserve of $229,817 for additional services that may be required) over a three-year term with up to two one-year renewal terms.

WHEREAS, New York State Public Health Law and Education Law mandate the implementation of e-prescribing for all medications including controlled substances by March 2016; and

WHEREAS, the Corporation is adopting the Surescripts LLC e-prescribing technology to work in conjunction with the Epic Electronic Medical Record system; and

WHEREAS, Surescripts LLC operates the nation's only health information network with the capability to electronically transmit prescriptions and refill requests, which network will allow the Corporation to connect the Corporation's prescribers with community pharmacies in order to enable the secure, reliable transmission and delivery of electronic prescription orders and refill authorization requests; and

WHEREAS, the contract with Surescripts LLC will provide all software and services necessary for the Corporation to implement e-prescribing in compliance with NYS mandate requirements; and

WHEREAS, the funding for this contract will be provided through the Epic EMR budget previously presented to the Board of Directors; and

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

NOW, THEREFORE, be it:

RESOLVED, THAT the President of New York City Health and Hospitals Corporation be and hereby is authorized to enter into a sole source agreement with SURESCRIPTS, LLC for e-prescribing software and related services for an amount not to exceed $4,769,555 (which includes a contingency reserve of $229,817 for additional services that may be required) over a three-year term with up to two one-year renewal terms.

EXECUTIVE SUMMARY

The accompanying Resolution requests approval to enter into a sole source contract with Surescripts LLC ("Surescripts") for enterprise-wide e-prescribing system in an amount not to exceed $4,769,555 (which includes a contingency reserve of $229,817) for the contract term of 3 years with up to 2 one-year renewals upon mutual consent of the parties. The funding for this contract will be provided through the Epic EMR budget previously presented to the Board of Directors.

New York State Public Health Law and Education Law mandate the implementation of e-prescribing for all medications including controlled substances by March 2016. The contract with Surescripts will provide all software and services necessary for HHC to implement e-prescribing in compliance with NYS mandate requirements. HHC is adopting the Surescripts e-prescribing technology to work in conjunction with the Epic Electronic Medical Record system.

Enterprise Information Technology Services ("EITS") received approval from the CRC to initiate negotiations for a sole source contract with Surescripts which operates the nation's only health information network with the capability to electronically transmit prescriptions and refill requests. E-Prescribing is the secure transmission, using electronic media, of prescription or prescription related information between a prescriber, dispenser, pharmacy, pharmacy benefit manager, or health plan. E-Prescribing includes two way transmissions between the point of care and the dispenser.

Surescripts will provide the foundation infrastructure including interface specifications, transaction routing infrastructure, software licenses, participant management services, and error management services. In addition to the prescription routing services to a large network of community pharmacies, Surescripts also connects to a Benefits Manager and Medication History of the patient that further strengthen HHC's patient safety and patient satisfaction measures.

HHC is adopting the Surescripts e-prescribing technology to work in conjunction with the Epic Electronic Medical Record system to enable the Corporation's prescribers to electronically access:

- the secure, reliable transmission and delivery of electronic prescription orders and refill authorization requests to patient designated pharmacies. These pharmacies can be within the HHC facility or neighborhood pharmacies that are not part of the facility.
- patient prescription benefit plan information, both formulary and eligibility, allowing the prescriber to choose medications that are covered by the patient drug benefits at the lowest cost, as a result pharmacies receive fewer prescriptions that require changes;
- with a patient's consent, electronically access a patient's medication history to obtain critically important information of the patient's current and past prescriptions to allow the prescriber to better assess potential medication issues (i.e. potential harmful drug interactions, allergies, adherence) and improve patient safety.

CONTRACT FACT SHEET

New York City Health and Hospitals Corporation

Contract Title: Surescripts E-Prescribing

Project Title & Number: Epic/E-Prescribing

Project Location: EITS

Requesting Dept.: Central Office - EITS

Successful Respondent: SURESCRIPTS LLC

Total Not to Exceed: $4,769,555.41 (includes $229,817.38 contingency)

Contract Term: 3 years with up to 2 one year renewal terms

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

Range of Proposals: N/A

Minority Business Enterprise Invited: Yes If no, please explain: N/A

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

Method of Payment: Lump Sum ☐ Per Diem ☐ Time and Rate
☑ Other: Monthly Fees based on number of Certified Beds as well as additional transaction fees

EEO Analysis: Approved

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

Vendex Clearance ☐ Yes ☐ No ☑ 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):*

This contract is required for the Epic EMR project. New York State Public Health Law and Education Law mandate the implementation of e-prescribing for all medications including controlled substances by March 2016. The contract with Surescripts will provide all software and services necessary for HHC to implement e-prescribing in compliance with NYS mandate requirements.

Enterprise Information Technology Services ("EITS") received approval from the CRC to initiate negotiations for a sole source contract with Surescripts which operates the nation's only health information network with the capability to electronically transmit prescriptions and refill requests. E-Prescribing is the secure transmission, using electronic media, of prescription or prescription related information between a prescriber, dispenser, pharmacy, pharmacy benefit manager, or health plan. E-Prescribing includes two way transmissions between the point of care and the dispenser.

Contract Review Committee

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

CRC approval was received to initiate negotiations for a sole source contract with Surescripts LLC in November 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):*

This is a sole source contract.

Enterprise Information Technology Services ("EITS") received approval from the CRC to initiate negotiations for a sole source contract with Surescripts which operates the nation's only health information network with the capability to electronically transmit prescriptions and refill requests.

Scope of work and timetable:

Surescripts will provide the software and services necessary for the foundation infrastructure including interface specifications, transaction routing infrastructure; participant management services, and error management services. In addition to the prescription routing services to a large network of community pharmacies, Surescripts also connects to a Benefits Manager and Medication History of the patient that further strengthen HHC's patent safety and patient satisfaction measures.

HHC is adopting the Surescripts e-prescribing technology to work in conjunction with the Epic Electronic Medical Record system to enable the Corporation's prescribers to electronically access:

- the secure, reliable transmission and delivery of electronic prescription orders and refill authorization requests to patient designated pharmacies. These pharmacies can be within the HHC facility or neighborhood pharmacies that are not part of the facility;
- patient prescription benefit plan information, both formulary and eligibility, allowing the prescriber to choose medications that are covered by the patient drug benefits at the lowest cost, as a result pharmacies receive fewer prescriptions that require changes;
- with a patient's consent, electronically access a patient's medication history to obtain critically important information of the patient's current and past prescriptions to allow the prescriber to better assess potential medication issues (i.e. potential harmful drug interactions, allergies, adherence) and improve patient safety.

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

E-Prescribing is a regulatory requirement.

The costs of the contract for the five year period is $4,769,555.41 which includes a contingency of $229,817.38. The annual cost is based on 3,181 Certified beds, billable monthly at the rate of $ 136.00 per bed for the approximately 3,181 Certified beds (HHC Corporate Planning Services, prepared 2/13/2015) within the Corporation's facilities. Other components and transaction fees include:

- One Time Fees – Staging fee $1,500 and $25,000 to establish connectivity to the Surescripts system to meet Clinical Network Services requirements.
- Faxing fees, Prior Authorizations for registered providers and Clinical Network services fees – all fees have been incorporated into the total 5 year budget.

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

Not applicable.

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

E-Prescribing is a regulatory requirement.

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 Sal Guido, Senior AVP / Interim 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):*

Received By E.E.O. ____5/19/14___________
Date

Analysis Completed By E.E.O._____ 9/2/14__________
Date

_________________Manasses Williams, Senior AVP__________________
Name

Surescripts Sole Source Contract

Medical & Professional Affairs/

IT Committee

9/10/2015

Overview

- e-Prescribing – Background 3
- Purpose of the Contract 4
- Surescripts sole source provider 5
- Estimated Cost by Fiscal Year 6
- 6 Year Epic Implementation Budget 7
- Questions

e-Prescribing – Background

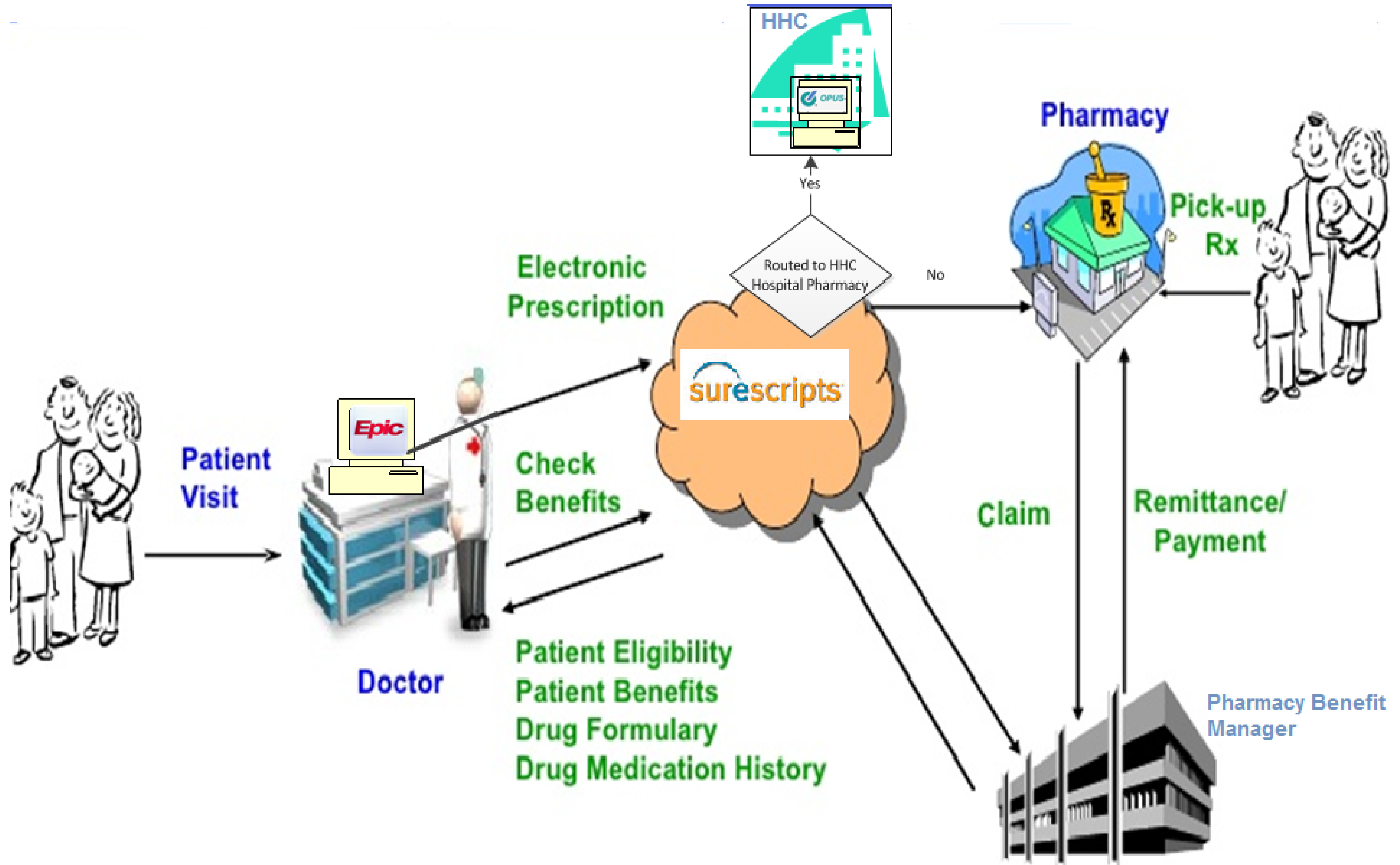
- The CMS definition of e-prescribing …"the transmission, using electronic media, of prescription or prescription related information between a prescriber, dispenser, pharmacy, pharmacy benefit manager, or health plan, either directly or through an intermediary, including an e-prescribing network. E-prescribing includes, but is not limited to, two way transmissions between the point of care and the dispenser."
- The New York State Public Health Law and the Education Law mandate the implementation of electronic prescribing by March 27, 2016.
- The contract with Surescripts will provide all software and services necessary for HHC to implement e-prescribing in compliance with NYS mandate requirements. HHC is adopting the Surescripts e-prescribing technology to work in conjunction with the Epic Electronic Medical Record system.
- Surescripts operates the nation's largest health information network with the capability to electronically transmit prescriptions and refill requests.

Purpose of Contract

The purpose of the contract is to procure the essential Surescripts e-prescribing software and services that uniquely provides the following benefits:

- **Electronically Access That Patient's Prescription Benefit Information:** Prescribers can choose medications that are covered by the patient's drug benefit as well as those of lower-cost. Pharmacies receive fewer prescriptions that require changes.
- **With a Patient's Consent, Electronically Access that Patient's Medication History:** Prescribers receive critically important information on their patients' current and past prescriptions which assists with patient safety. Prescribers can also can gain insight into a patient's medication compliance.
- **Electronically Route the Prescription to the Patient's Choice of Pharmacy:** Exchanging prescription information electronically between prescribers and pharmacies improves the accuracy of the prescribing process reducing the need for pharmacy staff to key in prescription data reducing errors.

Surescripts Sole Source Provider



Estimated Costs By Fiscal Year

Contract Year	$ Amount
Year 1 *	$876,616
Year 2	$875,619
Year 3	$901,842
Year 4 (Renewal)	$928,897
Year 5 (Renewal)	$956,764
Contingency	$229,817
Five Year Estimated Total	**$4,769,555**
** Assumes 10/1/15 start date. Year One includes initial one time fees.*	

6 Year Epic EMR Implementation Budget

E-Prescribing was included in in Third Party and Other Software Costs

	Item		Total Implementation Dollars (in millions)		
			Total Budget	Expenditures [Paid or in Process] as of 07/31/2015	Balance
1	**Epic Contract**	Includes Software and Implementation and Training Services.	$144	$66	$78
2	**Third Party & Other Software**	Includes Endoscopy, Fetal Monitoring Systems, ePrescribing, Patient Education.	$30	$4	$26
3	**Hardware**	Includes Servers, Storage, Server Licensing, Network Switches.	$84	$26	$58
4	**Interfaces**	Includes Interface Software/Biomed Middleware.	$39	$4	$35
5	**Implementation Support**	Third party vendor staff augmentation, go-live support and training (includes costs associated with backfilling non-IT staff and temps).	$355	$37	$318
6	**Application Support Team**	New HHC FTE staff to be used through the implementation period including fringe benefits. These costs will become on-going after implementation period.	$113	$29	$84
	Clinicals-Only Total	[Without QuadraMed Transition/Existing Application/Existing Staff Costs]	**$764**	**$165**	**$599**

Table title: **EMR Project - Six Year Implementation Budget** — **[Expenditures include Invoices Paid or In-Process]**

Note: :
1. 5 year current cost projection for Revenue Cycle was an additional $125 million. Budget is under review. Further evaluation required.
2. $154 million has been paid through 7/31/15. An additional $11 million is in process to be paid for a total of $165 million.

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 10, 2015

Contents

- Membership
- Growth Initiatives
- Exchange (QHP) Pricing and Membership
- Provider Network
- HHC Financial Arrangement
- Consumer Guide Results
- 2015 Changes: FIDA, HARP, EP
- Challenges
- Summary

MetroPlus Membership

- Membership at 473,340 as of August 1, 2015.

LOB	January 1, 2015	August 1, 2015		% Change
Medicaid	409,118	418,016	↑	2.17%
CHP	12,124	12,432	↑	2.54%
HHC	3,629	3,560	↓	-1.90%
SNP	4,891	4,676	↓	-4.40%
Medicare	8,559	8,469	↓	-1.05%
MLTC	806	875	↑	8.56%
QHP	22,442	24,754	↑	10.30%
SHOP	685	483	↓	-29.49%
FIDA	4	177	↑	4325.00%
Total	**462,258**	**473,442**	↑	**2.42%**

Primary Care Assignment	
HHC	52.91%
Community	47.09%

Growth Initiatives

- Expansion to Staten Island
- Office of Labor Relations – make MetroPlus available to all NYC employees
- Aggressive Exchange pricing for 2016
- DSRIP Project 11

Exchange Product Pricing - 2016
Silver

Premium Rates		2015	2016	Change
Metal/Tier	Company			
Silver	Metro Plus	382.57	369.04	-4%
Silver	Affinity	371.75	394.73	6%
Silver	North Shore LIJ	394.00	406.04	3%
Silver	Fidelis(NYS Cath)	383.54	408.04	6%
Silver	HealthFirst	387.46	422.41	9%
Silver	Wellcare	476.31	448.54	-6%
Silver	Emblem HIP	407.28	452.79	11%
Silver	Oscar	434.96	466.68	7%
Silver	Health Republic	428.64	486.96	14%
Silver	MVP HP	432.46	487.66	13%
Silver	Empire HMO	471.19	553.45	17%
Silver	UHNY	544.76	555.37	2%
Silver	Oxford OHP	627.50	555.97	-11%

Exchange Product Pricing - 2016 Platinum

Premium Rates		2015	2016	Change
Metal/Tier	Company			
Platinum	Metro Plus	515.08	505.65	-2%
Platinum	Affinity	517.42	549.08	6%
Platinum	North Shore LIJ	513.00	556.32	8%
Platinum	HealthFirst	537.48	592.00	10%
Platinum	Fidelis(NYS Cath)	580.06	607.42	5%
Platinum	Wellcare	619.34	615.43	-1%
Platinum	Oscar	591.32	637.67	8%
Platinum	Emblem HIP	600.98	649.27	8%
Platinum	MVP HP	610.55	667.12	9%
Platinum	Health Republic	588.92	668.88	14%
Platinum	Empire Assur.		746.60	
Platinum	Empire HMO	665.90	750.82	13%
Platinum	UHNY	759.87	773.64	2%
Platinum	Oxford OHP	875.58	774.48	-12%

Current Exchange Membership

Metal Level	Benefit Type	0 to 19	20 to 35	36 to 49	50 to 59	60+	Total
Bronze	Non-Standard	5	356	271	220	103	955
Bronze	Standard	8	80	87	73	38	286
Gold	Non-Standard	30	410	445	296	155	1,336
Gold	Standard	13	99	117	116	63	408
Platinum	Non-Standard	40	531	701	582	336	2,190
Platinum	Standard	41	111	149	124	78	503
Silver	Non-Standard	69	5,545	4,314	3,601	1,814	15,343
Silver	Standard	89	1,144	1,011	986	539	3,717
Total		243	8,282	7,095	5,998	3,126	24,744

Age		% of Membership
0-19	243	0.98%
20-35	8,282	33.47%
36-49	7,095	28.67%
50-59	5,998	24.24%
60+	3,126	12.63%
Total	24,744	**100%**

Benefit Type		% of Membership
Standard	4,914	19.89%
Non-Standard	19,824	80.11%
Total	24,744	**100%**

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

MetroPlus Health Plan

Provider Network

MetroPlus Network Sites	12/3/2013	8/1/2014	% Change	8/1/2015	% Change
Primary Care Providers (PCPs)	3,357	3,649	8.70	3,944	8.08%
Specialty Providers	13,260	16,259	22.62	**17,638**	8.48%
OB / GYN	757	728	(3.83)	**779**	7.01%
TOTAL	17,374	20,636	18.78	22,361	8.36%

	2Q 2011	2Q 2012	2Q 2013	2Q 2014	2Q 2015
HHC PCPs	526	517	554	540	546

*HHC PCPs" represents unique HHC PCPs. If a PCP is at multiple locations, for the purpose of this report, he/she is only counted once.

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 10 years*. For the first time ever, in 2011 MetroPlus was ranked #1 in New York State **and** New York City.

Year	Rank
2014	2nd
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.

2015 Changes

- FIDA – January 1, 2015
- HARP – October 1, 2015
- Essential Plan (formerly known as Basic Health Plan) – 2015 Open Enrollment Period – effective January 1, 2016
  - Four products – based on FPL (up to 200% FPL)
  - Aliessa population

FIDA

- FIDA is a partnership between the State of NY and CMS to test a new model for providing Medicare-Medicaid enrollees with a more coordinated, person centered care experience.

- Poor enrollment state-wide and high rate of opt outs
  - Approximately 47,702 eligible individuals opted out of FIDA
  - Approximately 43,000 eligible individuals have not opted out; therefore they can potentially be passively enrolled.
  - There are 4,407 enrollments across the 21 plans state-wide.

- Challenge: long and burdensome training prevents providers from being engaged in all the required sections.

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).
- Going live October 1, 2015.
- MetroPlus received Conditional Approval following on-site audit

Essential Plan (EP)

- EP will utilize MAGI rules and provide people with temporary eligibility pending verification of information.
- Effective Date of Enrollment -EP will follow the 15th of the month rule for enrollment.
- Individuals must report changes that could effect eligibility throughout the year.
- Enrollment will be open all year.
- Applications for EP coverage in 2016 will be processed starting on October 1, 2015.

Challenges

- Securing access for our new Exchange membership
  - 52.64% of Exchange members are assigned to HHC for Primary Care
  - 52.91% of all members are assigned to HHC for Primary Care
- Temporary Exchange membership auto-assignment adjustment based on access availability
- Significant Exchange members' discontent with clinic environment
- Maximizing and enhancing member retention through focused evaluation of current retention tactics
- Highly competitive and rapidly changing healthcare landscape and market.

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
  - HARP Referrals
  - **DSRIP Project 11**

MetroPlus Health Plan

Patient Safety Update 2015

Mei Kong, RN, MSN
Assistant Vice President,
Office of Patient Safety and Employee Safety

M&PA IT Committee
Thursday, September 10, 2015

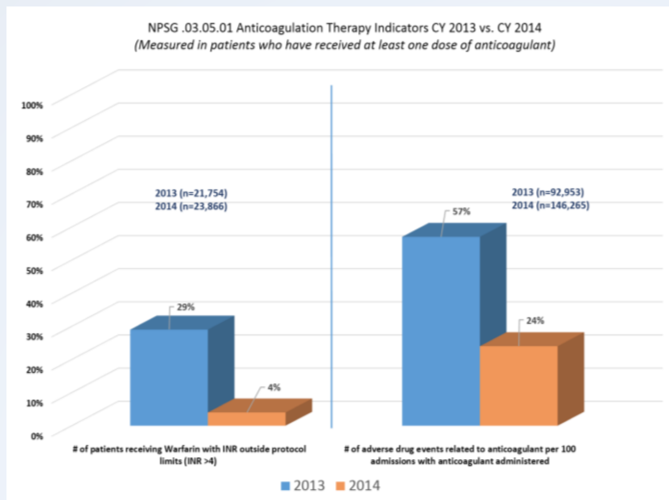
Patient Safety Update

Overarching Goal: Foster a high reliability culture of safe practices across HHC to reduce harm or potential harm to our patients and staff

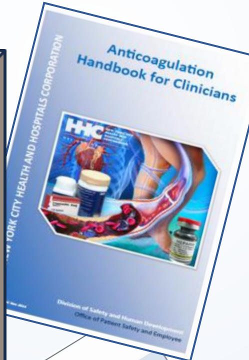
HHC's 2020 Strategic Goals

- *Improve Patient Experience*
- *Improve Access*
- *Increase Market Share*
- *Ensure Financial Strength*

Process Design



- Educate staff on strategies for working effectively with aggressive patients safely:
  - *Utilizing TeamSTEPPS Strategies and Tools to Deescalate Violence (non-violent crisis intervention) and Prevent Harm*
  - *Bellevue Forensic Psychiatry Unit baseline 1st Q 2014 violence rate - =0.78%. Post intervention 2nd=0.62%, 3rd =0.41%, and 4th=0.43%*
  - *Patient assault against staff 1st Q 2014 benchmark of 3.1 per 1,000 bed days. Post intervention decreased to 2ndQ= 1.4 , 3rdQ=1.9 , and 4thQ=0.8 per 1,000 bed days*
  - *TeamSTEPPS and Escalation*
- Joint Labor-Management Forum – HHC and CIR/SEIU
  - *Working with Disruptive Patient Behaviors While Keeping Safe*



- Anticoagulant Handbook for Clinicians – Version 2.0
- Managing Hyperglycemia in the Hospitalized Adult Patient Handbook
- Medication Safety Council Newsletter – *"Bar Code Medication Administration (BCMA): Challenges and Successes to Avoid Patient Harm"*
- Electronic Medication Intervention:
  - Total interventions 74,438 (2014) vs. 58,687 (2013)
    - Clinical Recommendations – 13,656
    - Order clarification – 7,666
    - Duplication of Therapy/Order – 7,557
- Adverse Drug Reaction (ADR) – New Electronic Database

- Coler - Reduction in Falls and Injury Prevention Rates: NYS Average 3.2% (EQUIP for Quality- MDS Data)
  CY12 = 2.1%; CY13 = 2%; CY14 = 1.1%; CY15 Q1 & Q2 = 0.6%
- Queens Hospital – Blood Bank Safety – reduced discarded mismatched specimens by eliminating type and screen requisition form. All type and screen orders placed in QuadraMed will generate bar code specimen labels only.
- Coney Island – Close Call Identification Program (CCIP) – CCI Safety Pyramid, executive walkrounds, and developed an electronic anonymous reporting system

Adverse Drug Reaction (ADR) Electronic Database

Adverse Drug Reaction | Home | Search | New ADR | My Saved ADRs | Administrator Reports | Hello Rhea Datta | Log off

New ADR

Adverse Drug Reaction Reporting Tool

Facility * --Select One--

Patient Information

Patient MRN * | Patient Gender * --Select One-- | Patient Age *

Adverse Drug Reaction Data

Date of Occurrence * | Time of Occurrence (use military time) *

Where did ADR occur * --Select One--

Service where patient is being treated --Select One--
- --Select One--
- Other
- Amb Care
- Cardiology
- CCU
- Critical Care
- Dentistry
- ED
- Medicine
- MICU
- Neonatal ICU
- Neuro ICU
- Nursing Unit (for LTC)
- OB/GYN
- OHS/EHS
- Oncology
- OR
- PACU
- Pediatrics
- PICU
- Psychiatry
- Radiology
- Rehab
- SICU
- Sub-acute Unit (for LTC)
- Surgery

Patient's Current Location * --Select One--
- --Select One--
- Other
- Ambulatory Care
- Clinic
- ER
- Home (Home Health)
- Inpatient
- LTC
- Sub-acute Rehab

Known Allergies (Check all that apply) * | No Known Allergies

Patient Diagnosis / Medical History *

Suspected Medication *

Route * --Select One-- | Frequency * --Select One--

Type of Reaction *

Relevant Lab Values *

ADR Level * --Select One--
- --Select One--
- Level 1 - ADR occurred without harm to the patient, no monitoring required
- Level 2 - ADR resulted without harm to the patient but with an increased need to monitor the patient
- Level 3 - ADR resulted in the need for alternative treatment, medication or an increased length of stay
- Level 4 - ADR resulted in a patient transfer to a higher level of care or required intervention to prevent permanent impairment or damage
- Level 5 - ADR resulted in permanent patient harm
- Level 6 - ADR resulted in Patient Death

Probability

Prescriber Name (Last, First)

Description of the Event (Summarize what happened, incl symptoms and lab results) *

ADR Reported by * --Select One-- | Outcome * --Select One--

ADR Reviewed By --Select One-- | Source * --Select One--

Reported to * --Select One-- | Action Taken * --Select One--

Save ADR to complete later | Submit ADR Data

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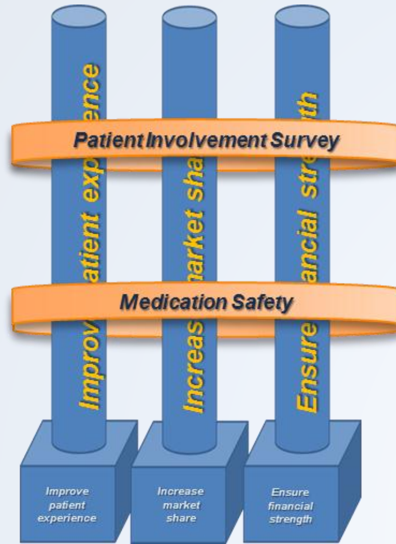
Patient and Family Partnerships



Patient Involvement Survey

HHC NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

nyc.gov/hhc

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.

- "Just-in-time" tool to objectively assess patients' perception of involvement in their care
- Translated into 12 languages
- 6,908 surveys completed in CY 2014

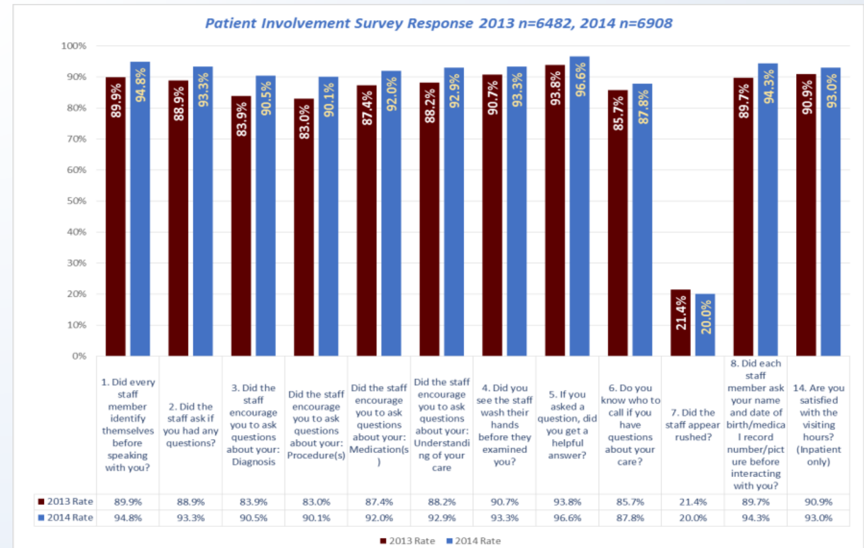
- Reduction of Antipsychotic Medication in LTC Dementia Population Utilizing Novel Non-Pharmacological Approaches

  NYS Average 19.3% (EQUIP for Quality- MDS Data)

  - Coler – CY11 = 15.6%; CY12 = 11.4%; CY13 = 10.3%; CY14 = 9.8%; CY15 Q1 & Q2 = 2.4%

- Patient Engagement Through Health Literacy - Take the Pledge. Take Your Meds (Woodhull Medical Center)

- Patient Experience - Communication About Medications (Bellevue Hospital)



	1. Did every staff member identify themselves 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	Did the staff encourage you to ask questions about your: Procedure(s)	Did the staff encourage you to ask questions about your: Medication(s)	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 and date of birth/medical record number/picture before interacting with you?	14. Are you satisfied with the visiting hours? (Inpatient only)
2013 Rate	89.9%	88.9%	83.9%	83.0%	87.4%	88.2%	90.7%	93.8%	85.7%	21.4%	89.7%	90.9%
2014 Rate	94.8%	93.3%	90.5%	90.1%	92.0%	92.9%	93.3%	96.6%	87.8%	20.0%	94.3%	93.0%

Medication Safety

Woodhull Patient Engagement Through Health Literacy

TAKE THE PLEDGE. TAKE YOUR MEDS.

POCKET JOURNAL.

MY MEDICINES

Including prescriptions, over-the-counter medicines, vitamins and supplements

Medicine	Why I take it	Start date	Refill date	How much do I take?	When do I take it?
Example: Naproxen	Arthritis	6/1/14	7/1/14	1 tablet, 250mg	Twice a day

QUESTIONS TO ASK MY DOCTOR/PHARMACIST

1. What is the name of the medicine?
2. Why do I need this medicine? (What does it do and why I should take it?)
3. How much
4. When and h

What shoul

5. Can I stop taking it if I feel better?
6. Are there any side effects?
7. Is it safe to take it with other medicines or vitamins?

> MY DOCTOR IS...

Name

Phone number

Call your Primary Care Practice if you have problems filling your presciption.

> MY WOODHULL PHARMACIST IS...

Pharmacist's name

Phone number

> MY NEIGHBORHOOD PHARMACY IS...

Business name

Address

Phone number

> EMERGENCY

Call 911 in the case of a medical emergency.

> NURSE TRIAGE CALL CENTER

Call anytime for health advice: 800.654.0022

> WOODHULL APPOINTMENT CENTER

Schedule an appointment: 718.388.5889

TAKE THE PLEDGE. TAKE YOUR MEDS.

Keep your medication list with you.

Keep it up-to-date. Your doctor or pharmacist can help.

Bring your medicines and your medication list to each visit.

Always take your medicine as directed.

I, ____________ (Sign name), will take my meds.

Date

- **One page flyer** translated into Spanish and Polish, includes important contact numbers and questions to prompt the patient to ask their provider about their medicine.
- **Pocket Journal** available in English/Spanish and English/Polish designed to aid patients in keeping track of important contacts and medication list.

Medication Communication "Script"

Key Changes

New Medication Communication Script for RN's

- Let's talk about the ***new medication*** that your doctor prescribed for you.
- It's called: (*Med Name - - -*).
- Its purpose is to (*Med Purpose - - -*).
- Just like any medication, (*Med Name- -)* can have possible side effects.
- What I mean by side effects is that even though (*Med Name- - -*) is to help you with (*Med Purpose - - -*), you might also feel:
  - Side effect #1 - - - - - - or
  - Side effect #2 - - - - - - or
  - Side effect #3 - - - - - -
- Do you have any questions or concerns about the purpose of your new medication or its side effects?"

WE CARE ABOUT YOU

New Medication? Side Effects?

Please, ask us!

Key Changes

Medical House Staff and Nursing Staff - New Standard Worksheets

Standard Work Sheet

Operation: House Staff — Process: Communication About Discharge Medications

Step	Description	Key Point / Image / Reason	Who	Time
1	Ensure that insurance status and plan is known.	To clarify if patient needs to fill their prescriptions at BHC or outside pharmacy (reduce motion waste)	Resident/ Social work	During interdisc. Rounds
2	If patient has insurance: Discuss formulary and start prior authorization.	Fewer patients unable to fill Rx and lower co-pays will improve patient satisfaction. Prior authorization may take time.	Attending/ House Staff	During interdisc. Rounds
3	QuadraMed medication reconciliation. Consult formularies if necessary (e.g., via QuadraMed).	To promote an early discharge on the next day (ideally by 2pm).	House Staff	ideally on the day before discharge
4	Print out discharge medication list and check (if necessary, repeat step 4), then bring list to the patients bedside.	To avoid duplicate or missing medications. (will reduce motion waste)	House Staff	On /before Discharge date
5	Talk to patient about meds to stop/start. Use discharge medication list but do not leave at patient's bedside.	This interaction will help improving patient experience and medication error rate. Medication list not to be left as changes may occur later.	House Staff/ Patient	On/before Discharge date
6	Ask patient if they need refills for previous meds that are being continued. Note on medication list.	To avoid additional Rx later (reduce motion waste). To provide reference for prescriptions that were not required printing.	House Staff/ Patient	On/before Discharge date
7	Ask patient about insurance status and plan.	To verify if information is correct. Fewer patients unable to fill Rx will improve patient satisfaction.	House Staff/ Patient	On/before Discharge date
8	Print prescriptions or e-prescribe (3/27/15)		House Staff	On/before Discharge date
9	If patient has no insurance: Fax Rx to BHC outpatient pharmacy and call or QuadraMed-mail.	To anticipate when BHC pharmacy is ready and who will deliver meds when (reduce motion waste)	House Staff/ Pharmacy	On/before Discharge date
10	Talk to nurse and give discharge time estimate.	To ensure awareness and to be able to plan ahead.	House Staff/ Nurse	On Discharge date
11	Place all Rx in patient's chart, along with discharge medication list.	To provide a reference so that missing prescriptions can be easily identified.	House Staff	On Discharge date

Standard Work Sheet | Page 1 of 1 | Date: 1/30/2015

Standard Work Sheet

Operation: House Staff — Process: Communication About "New" Medications

Step	Description	Key Point / Image / Reason	Who	Time
1	Inform the patient's nurse of any new medication that you prescribe for your patient.	Patient medication education will be done repeatedly throughout the patient's hospital stay.	House Staff	
2	Talk to the patient about any new med that you prescribe on admission, during hospital stay and upon discharge.	Patient prefers to hear from the doctor first prior to nurse administering the new medication (s).	House Staff	

Standard Work Sheet

Operation: Staff Nurse — Process: Communication About "New" Medications

Step	Description	Key Point / Image / Reason	Who	Time
3	Use the "New Medication Communication" Script every interaction with patient regarding new medication	Process will be done consistently to help patient's understanding of the purpose and possible side effect of new med(s).	Staff Nurse	
4	Show and leave the flyer "We Care About You" to encourage patient to ask question(s) about their new medication	Patient will feel more freely to interact with the provider and nursing staff regarding their medications.	Staff Nurse	
5	Repeat step #3 and #4 as often as possible on patient initial assessment, during hospital stay and upon discharge.	Empower the patient the knowledge of their care related to medication purpose and possible side effects.	Staff Nurse	

MEDICATION GUIDE FOR NURSES

A QUICK REFERENCE TO HIGHLIGHT PATIENT EDUCATION ON MEDICATIONS 1

ACE INHIBITORS (Angiotensin Converting Enzymes)

Generic (Brand) Name	Indication	Possible Side Effects
Benazepril (Lotensin)	High Blood Pressure Heart Failure	Lightheadedness Dizzy Dry Cough
Captopril (Capoten)		
Enalapril (Vasotec)		
Fosinopril (Monopril)		
Lisinopril (Prinivil, Zestril)		
Moexipril (Univasc)		
Perindopril (Aceon)		
Quinapril (Accupril)		
Ramipril (Altace)		
Trandolapril (Mavik)		
Benazepril (Lotensin)		
Captopril (Capoten)		

ANTIARRHYTHMICS

Generic (Brand) Name	Indication	Possible Side Effects
Amiodarone (Cordarone)	Control Irregular heartbeats	Dizziness Headache
Disopyramide phosphate (Norpace)		
Dofetilide (Tikosyn)		
Flecainide (Tambocor)		
Mexiletine HCL (Mexitil)		
Procainamide (Procan, Pronestyl)		
Propafenone HCL (Rythmol)		
Quinadine gluconate (Quinaglute)		
Sotalol (Betapace)		
Tocainide HCL (Tonocard)		

ANTICOAGULANTS/ANTIPLATELET

Generic (Brand) Name	Indication	Possible Side Effects
Dalteparin (Fragmin)	Prevent harmful clots Slow blood clot formation	Bruising Gums bleeding Nose bleeding Blood in urine or stools
Enoxaparin (Lovenox)		
Heparin (Various)		
Warfarin (Coumadin)		
Aspirin (Various)		
Clopidogrel (Plavix)		
Dabigatran (Pradaxa)		
Prasugrel (effient)		
Rivaroxaban (Xarelto)		

ANTICONVULSANTS

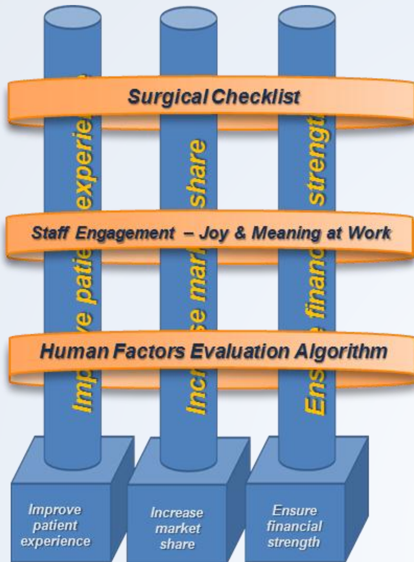
Generic (Brand) Name	Indication	Possible Side Effects
Carbamazepine (Tegretol)		Diziness Lethargy Blurred vision
Pehytoin (Dilantin)		
Valproic Acid (Depakote)		

ARB (ANGIOTENSIN II RECEPTOR BLOCKERS)

Generic (Brand) Name	Indication	Possible Side Effects
Candesartan (Atacand)	High Blood Pressure Heart failure	Low blood pressure Lighttheadedness
Eprosartan (Teveten)		
Irbesartan (Avapro)		
Losartan (Cozaar)		
Telmisartan (Micardis)		
Valisartan (Diovan)		

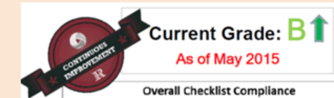
UNIT	Baseline %	Target %	June 2015
16E Top Box Scores	49	60	58.5
17N Top Box Scores	66	75	67.9
Patient Survey Result:			
Q: Did your nurse talk to you about med side effects? (YES)	22 (n=18)	75	100% (N=53/53)
Q: Did your doctor discuss with you what medications you should take when you go home? (YES)	50 (n=10)	100	98% (N=52/53)
House Staff Survey Results:			
Q: Talk to RN about discharge prescriptions? (YES)	56 (n=16)	100	100% (N=53/53)
Q: Talk to patient about discharge prescriptions? (YES)	69 (n=16)	100	100% (N=53/53)

Human Factors Integration



- HHC Office of Patient Safety and Employee Safety partnered with Kerm Henriksen, Ph.D., Human Factors Advisor for Patient Safety at Agency for Healthcare Research and Quality and developed:
  - Human Factors Evaluation Algorithm
  - Human Factors Evaluation Worksheet

- Surgical Checklist – Elmhurst Hospital
- Compliance with key elements (8)
  1. Cessation of activity during brief
  2. Cessation of activity during time-out
  3. Image verification during brief
  4. Image verification during time-out
  5. Safety statement by the surgeon
  6. Procedure verification
  7. Patient verification
  8. Communication



- Completion Plan
  - Increase OR senior leaders visibility
  - Escalation procedure to address non-compliance
  - Dialogue with directors of service and their staff
  - Establish observation target

1. I am treated with dignity and respect by everyone at work?
2. I have what I need, in order to make a contribution that gives meaning to my work life?
3. I am recognized and thanked for what I do at work?

Human Factors Integration

Staff Engagement - Joy and Meaning at Work

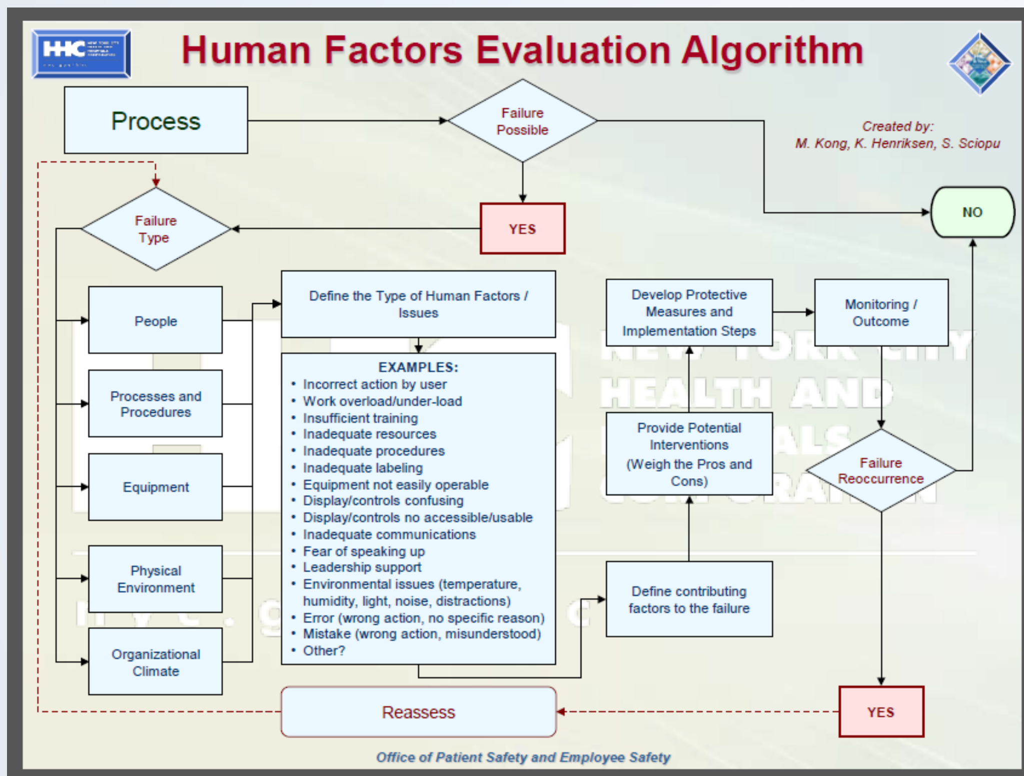
Date	Answer	I am treated with dignity and respect by everyone at work?		I have what I need, in order to make a contribution that gives meaning to my work life?		I am recognized and thanked for what I do at work?	
Medical residents 2013-2014	Yes	466	64%	No Data	No Data	461	64%
	No	264	36%	No Data	No Data	260	36%
Q2-2013	Yes	31	44%	46	73%	45	70%
	No	39	56%	17	27%	19	30%
Q2-2014	Yes	86	49%	102	63%	59	34%
	No	90	51%	59	37%	116	66%
Q3-2014	Yes	34	36%	50	66%	43	46%
	No	61	64%	26	34%	50	54%
Q4 -2014	Yes	91	42%	140	63%	112	51%
	No	125	58%	82	37%	107	49%
Q1-2015	Yes	41	34%	73	64%	64	50%
	No	78	66%	41	36%	64	50%
Q2-2015	Yes	70	58%	77	61%	63	51%
	No	50	42%	50	39%	60	49%
Q3-2015	Yes	67	42%	87	55%	73	47%
	No	93	58%	70	45%	83	53%
Total	Yes	886	53%	575	63%	920	55%
	No	800	47%	345	38%	759	45%
Total responses		1686		920		1679	

All other staff: physicians, nurses, hospital police, human resources, behavioral health associates, etc.

Human Factors Integration

Human Factors Evaluation Algorithm

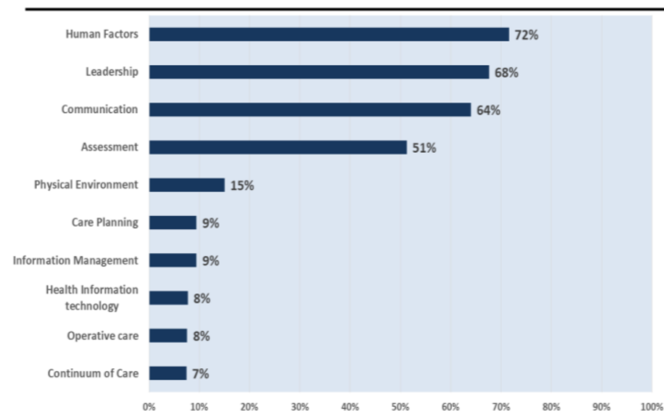
- To provide a systems approach when reviewing causative factors
- To provides additional information when evaluating failure type(s)



Human Factors Evaluation Worksheet

	People	Processes and Procedures	Equipment	Physical Environment	Organizational Climate
Define the Type of Human Factors / Issues					
Define contributing factors to the failure					
Provide Potential Interventions (Weigh the Pros and Cons)					
Develop Protective Measures and Implementation Steps					
Monitoring / Outcome					

Office of Patient Safety and Employee Safety — Created by: M. Kong, K. Henriksen, S. Sciopu



Reliability Culture

- Just Culture Certification Course – 3 Days

  Provides a comprehensive overview of the fundamental elements of 5 skills for producing better outcomes:

  1. Identifying values and setting expectations
  2. Improving system design
  3. Managing behavioral choices
  4. Building and utilizing robust learning system
  5. Ensuring justice and accountability – The Just Culture Algorithm

  90 passed the examination – This cadre of individuals will be the resident experts and provide Just Culture consultation as needed in their facilities

  Participants included: Chief Nurses/Physicians & Designees, Patient Safety Officers/Assoc., Human Resources, Labor Relations, Risk Management, Administrators, Hospital Police

- High Reliability Organization – Self Assessment
  - Leadership
  - Safety Culture
  - Performance Improvement

  Participants included:

  SVP/ED, CMO, CNO, COO, CFO, Director of Quality/Risk Manag./Pharm/Social Work, PSO, Chief of Services (med,ED, Surg, Psych, OBGYN, HNs, ADNs, Supv.

High-Reliability Health Care: Getting There from Here

MARK R. CHASSIN and JEROD M. LOEB

The Joint Commission

Context: Despite serious and widespread efforts to improve the quality of health care, many patients still suffer preventable harm every day. Hospitals find improvement difficult to sustain, and they suffer "project fatigue" because so many problems need attention. No hospitals or health systems have achieved consistent excellence throughout their institutions. High-reliability science is the study of organizations in industries like commercial aviation and nuclear power that operate under hazardous conditions while maintaining safety levels that are far better than those of health care. Adapting and applying the lessons of this science to health care offer the promise of enabling hospitals to reach levels of quality and safety that are comparable to those of the best high-reliability organizations.

Methods: We combined the Joint Commission's knowledge of health care organizations with knowledge from the published literature and from experts in high-reliability industries and leading safety scholars outside health care. We developed a conceptual and practical framework for assessing hospitals' readiness for and progress toward high reliability. By iterative testing with hospital leaders, we refined the framework and, for each of its fourteen components, defined stages of maturity through which we believe hospitals must pass to reach high reliability.

Findings: We discovered that the ways that high-reliability organizations generate and maintain high levels of safety cannot be directly applied to today's hospitals. We defined a series of incremental changes that hospitals should undertake to progress toward high reliability. These changes involve the leader-

Three Day
Just Culture
CERTIFICATION COURSE
Be Fair. Be Open. Be Just.
HHC NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
nyc.gov/hhc

January 12, 13 & 14, 2015
HHC Conference Center
Jacobi Medical Center, Building #4

The Just Culture COMMUNITY

High Reliability Organization Survey Tool

Safety Culture	Trust Check one below: Beginning Developing Advancing Approaching	Trust or intimidating behavior is not assessed.	First codes of behavior are adopted in some clinical departments.	CEO and clinical leaders establish a trusting environment for all staff by modeling appropriate behaviors and championing efforts to eradicate intimidating behaviors.	High levels of (measured) trust exist in all clinical areas; self-policing of codes of behavior is in place.
	Accountability Check one below: Beginning Developing Advancing Approaching	Emphasis is on blame; discipline is not applied equitably or with transparent standards; no process exists for distinguishing "blameless" from "blameworthy" acts.	The importance of equitable disciplinary procedures is recognized, and some clinical departments adopt these procedures.	Managers at all levels accord high priority to establishing all elements of safety culture; adoption of uniform equitable and transparent disciplinary procedures begins across the organization.	All staff recognize and act on their personal accountability for maintaining a culture of safety; equitable and transparent disciplinary procedures are fully adopted across the organization.
	Identifying Unsafe Conditions Check one below: Beginning Developing Advancing Approaching	Root cause analysis is limited to adverse events; close calls ("early warnings") are not recognized or evaluated.	Pilot "close call" reporting programs begin in few areas; some examples of early intervention to prevent harm can be found.	Staff in many areas begin to recognize and report unsafe conditions and practices before they harm patients.	Close calls and unsafe conditions are routinely reported, leading to early problem resolution before patients are harmed; results are routinely communicated.
	Strengthening Systems Check one below: Beginning Developing Advancing Approaching	Limited or no efforts exist to assess system defenses against quality failures and to remedy weaknesses.	RCAs begin to identify the same weaknesses in system defenses in many clinical areas, but systematic efforts to strengthen them are lacking.	System weaknesses are catalogued and prioritized for improvement.	System defenses are proactively assessed, and weaknesses are proactively repaired.
	Assessment Check one below: Beginning Developing Advancing Approaching	No measures of safety culture exist.	Some measures of safety culture are undertaken but are not widespread; little if any attempt is made to strengthen safety culture.	Measures of safety culture are adopted and deployed across the organization; efforts to improve safety culture are beginning.	Safety culture measures are part of the strategic metrics reported to the board; systematic improvement initiatives are under way to achieve a fully functioning safety culture.

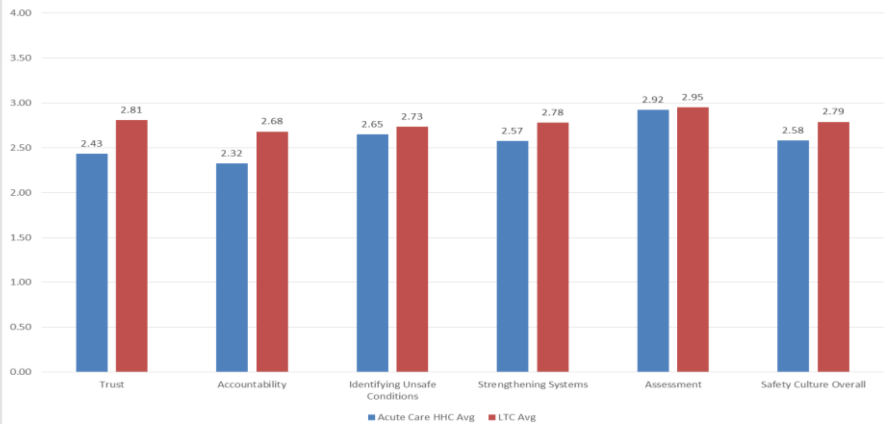
Performance Improvement	Methods Check one below: Beginning Developing Advancing Approaching	Organization has not adopted a formal approach to quality management.	Exploration of modern process improvement tools begin.	Organization commits to adopt the full suite of Robust Process Improvement (RPI) tools.	Adoption of RPI tools is accepted fully throughout the organization.
	Training Check one below: Beginning Developing Advancing Approaching	Training is limited to compliance personnel or to the quality department.	Training in performance improvement tools outside the quality department is recognized as critical to success.	Training of selected staff in RPI is under way, and a plan is in place to broaden training.	Training in RPI is mandatory for all staff, as appropriate to their jobs.
	Spread Check one below: Beginning Developing Advancing Approaching	No commitment to widespread adoption of improvement methods exists.	Pilot projects using some new tools are conducted in a few areas.	RPI is used in many areas to improve business processes as well as clinical quality and safety; a positive ROI is achieved.	RPI tools are used throughout the organization for all improvement work; patients are engaged in redesigning care processes, and RPI proficiency is required for career advancement.

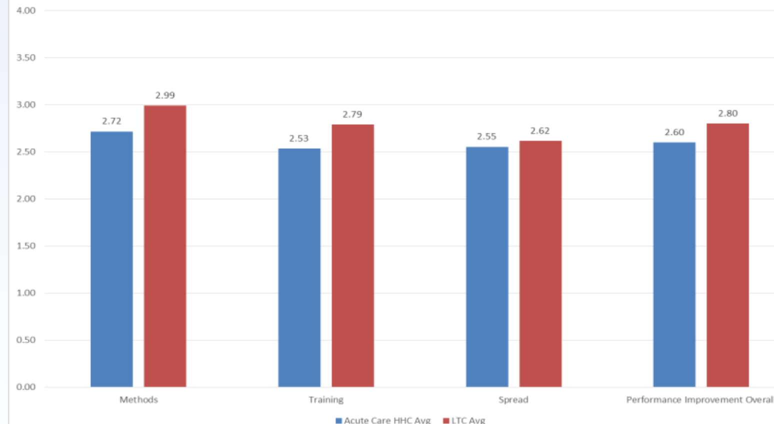
Title:______________________

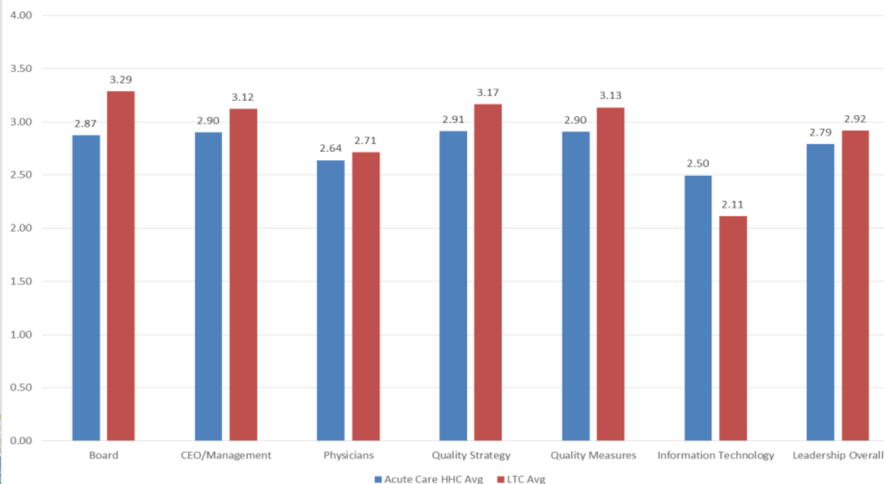
Assessing your Organization's Potential to become a High Reliability Organization

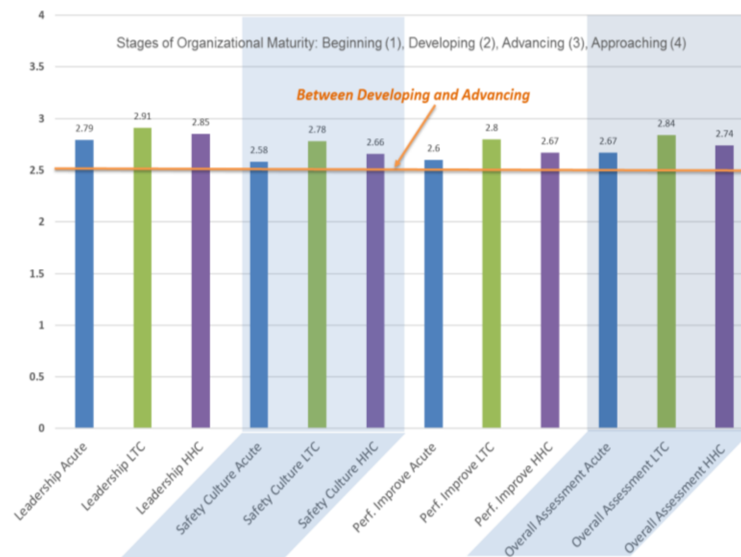
HRO Characteristic	Component	Stages of Maturity			
		Beginning(1)	Developing(2)	Advancing(3)	Approaching(4)
Leadership	Board Check one below: Beginning Developing Advancing Approaching	Board's quality focus is nearly exclusively on regulatory compliance.	Full board's involvement in quality is limited to hearing reports from its quality committee.	Full board is engaged in the development of quality goals and approval of a quality plan and regularly reviews adverse events and progress on quality goals.	Board commits to the goal of high reliability (i.e., zero patient harm) for all clinical services.
	CEO/ Management Check one below: Beginning Developing Advancing Approaching	CEO/management's quality focus is nearly exclusively on regulatory compliance.	CEO acknowledges need for plan to improve quality and delegates the development and implementation of a plan to a subordinate.	CEO leads the development and implementation of a proactive quality agenda.	Management aims for zero patient harm for all vital clinical processes; some demonstrate zero or near-zero rates of harm.
	Physicians Check one below: Beginning Developing Advancing Approaching	Physicians rarely lead quality improvement activities; overall participation by physicians in these activities is low.	Physicians champion some quality improvement activities; physicians participate in these activities in some areas but not widely.	Physicians often lead quality improvement activities; physicians participate in these activities in most areas, but some important gaps remain.	Physicians routinely lead clinical quality improvement activities and accept the leadership of other appropriate clinicians; physicians' participation in these activities is uniform throughout the organization.
	Quality Strategy Check one below: Beginning Developing Advancing Approaching	Quality is not identified as a central strategic imperative.	Quality is one of many competing strategic priorities.	Quality is one of the organization's top three or four strategic priorities.	Quality is the organization's highest-priority strategic goal.
	Quality Measures Check one below: Beginning Developing Advancing Approaching	Quality measures are not prominently displayed or reported internally or publicly; the only measures used are those required by outside entities and are not part of reward systems.	Few quality measures are reported internally; few or none are reported publicly and are not part of reward systems.	Routine internal reporting of quality measures begins, with the first measures reported publicly and the first quality metrics introduced into staff reward systems.	Key quality measures are routinely displayed internally and reported publicly; reward systems for staff prominently reflect the accomplishment of quality goals.
	Information Technology Check one below: Beginning Developing	IT provides little or no support for quality improvement.	IT supports some improvement activities, but principles of safe adoption are not often followed.	IT solutions support many quality initiatives; the organization commits to principles and the practice of safe adoption.	Safely adopted IT solutions are integral to sustaining improved quality.

High Reliability Organization Survey Tool









Going Forward

- **Patient Safety Exposition – September 21st at HHC Conference Center at Jacobi Medical Center**
- **Implement Electronic Adverse Drug Reaction (ADR) Database**
- **Joint Labor-Management Forum – CIR/SEIU**
- **Work with senior leaders to expand visiting hours**
- **Affordable Care Act PSO Mandate**
  - January 1, 2017, qualified health plans in insurance exchanges may not contract with a hospital of 50 beds or more unless that hospital has a patient safety evaluation system and reports data to a PSO.
- **Extend Just Culture education to labor colleagues**
- **Focus on Ambulatory patient safety opportunities**

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

http://patientsafety.nychhc.org/

http://employeesafety.nychhc.org/