



**STRATEGIC PLANNING COMMITTEE  
OF THE BOARD OF DIRECTORS**

March 30, 2016  
10:00 A.M.  
Boardroom  
125 Worth Street, Room 532

**AGENDA**

- I. Call to Order Gordon J. Campbell
- II. Adoption of December 1, 2015  
Strategic Planning Committee Meeting Minutes Gordon J. Campbell
- III. Information Item
- a. NYC Health + Hospitals' Vision 2020 Plan & System Scorecard
- Raven Carter, MBA/FACHE  
Director, Patient & Family Experience
- Udai Tambar, Chief Transformation Officer
- IV. Old Business
- V. New Business
- VI. Adjournment Gordon J. Campbell



## **MINUTES**

### **STRATEGIC PLANNING COMMITTEE MEETING OF THE BOARD OF DIRECTORS**

**DECEMBER 1, 2015**

The meeting of the Strategic Planning Committee of the Board of Directors was held on December 1, 2015 in NYC Health + Hospitals' Boardroom, which is located at 125 Worth Street with Ms. Josephine Bolus, NP-BC, presiding as Chairperson.

#### **ATTENDEES**

##### **COMMITTEE MEMBERS**

Josephine Bolus, NP-BC, Chairperson of the Committee  
Ram Raju  
Anna Kril  
Robert F. Nolan  
Mark Page  
Bernard Rosen

##### **OTHER MEMBER**

Udai Tambar, representing First Deputy Mayor Anthony Shorris

##### **OTHER ATTENDEES**

J. Agrawal, Office of Management and Budget  
J. Cassidy, Analyst, Office of Management and Budget  
J. DeGeorge, Analyst, New York State Comptroller  
M. Dolan, Senior Assistant Director, DC 37  
E. Kelly, Analyst, New York City Independent Budget Office  
J. Wessler, Guest  
S. Wheeler, Budget Analyst, Office of Management and Budget

##### **NYC HEALTH + HOSPITALS' STAFF**

M. Belizaire, Assistant Director of Community Affairs, Office of Intergovernmental Relations

C. Barrow, Associate Director, Lincoln Medical and Mental Health Center  
J. Bender, Assistant Director, Media, Communications and Marketing  
C. Borden, Senior Assistant Vice President, Medical and Professional Affairs  
L. Brown, Senior Vice President, Corporate Planning, Community Health and Intergovernmental Relations  
T. Carlisle, Associate Executive Director, Corporate Planning Services  
E. Casey, Director, Corporate Planning, HIV Services  
D. Cates, Chief of Staff, Office of the Chairman of the Board of Directors  
E. Davis, Data Center Director, World Trade Center Environmental Health Center  
R. Dixon, Associate Director, Harlem Hospital Center  
C. Dunn, Senior Director, Communications and Marketing  
L. Glover, Senior Director/Strategic Analyst, Medical and Professional Affairs  
L. Guttman, Assistant Vice President, Office of Intergovernmental Relations  
C. Jacobs, Senior Vice President, Safety and Human Development  
J. Jurenko, Senior Assistant Vice President, Office of Intergovernmental Relations  
Z. Liu, Senior Management Consultant, Corporate Planning Services  
L. Lombardi, Chief Strategy Officer, Bellevue Hospital Center  
P. Lockhart, Secretary to the Corporation, Office of the Chairman of the Board of Directors  
A. Marengo, Senior Vice President, Communications and Marketing  
R. Mark, Chief of Staff, Office of the President  
A. Martin, Executive Vice President and Chief Operating Officer, Office of the President  
T. Miles, Executive Director, World Trade Center Environmental Health Center  
S. Penn, Deputy Director, World Trade Center Environmental Health Center  
N. Peterson, DSRIP Facility Manager, Woodhull Medical and Mental Health Center  
C. Philippou, Assistant Director, Corporate Planning Services  
S. Russo, Senior Vice President, Office of Legal Affairs  
P. Slesarchik, Assistant Vice President, Labor Relations  
K. Whyte, Senior Director, Corporate Planning, Community Health and Intergovernmental Relations  
M. Winiarski, Assistant Director, Corporate Planning Services

**CALL TO ORDER**

Ms. Josephine Bolus, NP-BC, Strategic Planning Committee Chairperson, called the December 1<sup>st</sup> meeting of the Strategic Planning Committee (SPC) to order at 10:33 A.M. The minutes of the November 10, 2015 SPC meeting were adopted.

**SENIOR VICE PRESIDENT'S REMARKS****Announcements**

In lieu of the Senior Vice President's remarks, Ms. Brown announced that she would be leaving NYC Health + Hospitals in mid-January to assume the role of President and Chief Executive Officer (CEO) of Interfaith Medical Center.

Ms. Brown reminded the Committee that today, December 1, 2015, was World AIDS Day and that NYC Health + Hospitals has been playing a significant role both at the state and the national levels in efforts to eradicate the AIDS epidemic. She announced that the Governor was honoring Ms. Terry Hamilton, Assistant Vice President for HIV services for her contribution towards ending AIDS in the State of New York. Ms. Brown applauded Ms. Hamilton, as well as the work of NYC Health + Hospitals' clinicians and staff who have toiled for many years to improve patients' lives and strengthen the system's services in affected communities. Ms. Brown invited Ms. Eunice Casey, Director of HIV Services, to share with the Committee the latest "hot off the press" news concerning AIDS transmission to newborns.

Ms. Casey reported that, on November 30th, the NYC Department of Health and Mental Hygiene (DOHMH) had announced that, for the first time since the start of the HIV epidemic in New York State, there were no infants who were born HIV positive this year. This means that HIV positive pregnant women in the state received high quality care, which helped them maintain good health and keep their babies healthy. As a result, there were no transmissions of the HIV virus to their infants. Ms. Casey added that NYC DOHMH had released data that also showed that all of the system's acute care facilities and Gouverneur were below the transmission threshold. Six of the twelve facilities are above the goal for viral load suppression (85%), and six facilities are between 80% and 84%. Ms. Casey explained that both points demonstrate that the facilities are significantly contributing to the goal of ending the HIV epidemic in the state. Ms. Brown added that AIDS was miraculously identified in the 1980's; and in 2015, one could see the end of this disease on the horizon. It is a major milestone to have babies born without having contracted the HIV virus.

**INFORMATION ITEM #1:**

**NYC Health + Hospitals' Journey towards "Leader in Healthcare Equality for LGBT Patients"**  
Mark G. Winiarski, Ph.D., Assistant Director, Corporate Planning Services

Ms. Brown explained that considerable progress had been made concerning NYC Health + Hospitals' path towards being deemed a leader in healthcare equality for LGBT patients. Not only is NYC Health + Hospitals considered a leader from the perspective of the larger national advocacy organization, but it is also considered a leader in the communities where the system's services are being provided. Ms. Brown emphasized that this work is very much supported by Dr. Raju. Dr. Winiarski, Assistant Director of Corporate Planning, has been the Division's stalwart leader. He has provided support by working closely with all the facilities including long term care and diagnostic and treatment centers to assist them with their journey.

Dr. Winiarski began his presentation by stating that the goal to achieve LGBT Health Equality designation embodied the mission of NYC Health + Hospitals, which is “to extend equally to all New Yorkers, regardless of their ability to pay, comprehensive health services of the highest quality in an atmosphere of human care, dignity and respect.” Dr. Winiarski stated that he had been an advocate for LGBT health care equity since 2008. He reminded the Committee that, in 2014, Dr. Raju had made a three-part commitment to the Committee, which included achieving the benchmarks of LGBT care from the national organization, creating foundational policies, and to provide training. Dr. Winiarski quoted recent statements that were made by Dr. Raju, which states that, “*We need to own every patient’s experience. We need to put ourselves in their shoes every day, every time, and make sure we do no less than what we would expect for ourselves, for our families, for our mothers and our own children.*”

Dr. Winiarski explained that the Human Rights Campaign (HRC) is the largest LGBT advocacy group in the country. HRC provides “Leader in LGBT Healthcare Equality” designation to health care facilities. To achieve this designation, a survey comprised of 150-200 questions is completed by facilities across the country. Performance is measured against the national benchmarks, which allows NYC Health and Hospitals’ facilities to compare their results with those of 1,500+ health care systems. Dr. Winiarski added that, in 2014, 1 out of 3 or 427 health care facilities in the United States had met HRC’s “Leader” criteria.

Dr. Winiarski described NYC Health + Hospitals’ journey. He reported that, in 2008, the Public Advocate had issued a report on LGBT health access. Key findings of that report include that:

- The healthcare environment was heterocentric, gender-normative
- Providers lack knowledge about health disparities affecting LGBT people
- LGBT individuals experienced hostility and discrimination in care
- Concerns about homophobia and transphobia keep LGBT individuals from using healthcare services
- Voluntary training does not reach all staff

Dr. Winiarski described NYC Health and Hospitals’ achievements for the period 2008-2013 as the following:

- Internal working group was convened and makes recommendations
- Curricula developed, training launched and made mandatory in 2012
- Gouverneur opened LGBT clinic
- Metropolitan became the first NYC Health and Hospitals facility to obtain HRC Leader designation

Ms. Brown clarified that, when the curricula and the training were launched, it was a major milestone because NYC Health + Hospitals was the first health care system in the nation to require this training for new and incumbent employees. At that time, the Centers for Medicaid and Medicare Services (CMS) and the Joint Commission released their educational information around health care for the LGBT community. NYC Health + Hospitals was recognized for taking that step as a healthcare organization. Dr. Winiarski added that, by 2014, NYC Health + Hospitals’ initiatives focusing on LGBT care had expanded in the following ways:

- Seven acute care facilities, one network, and one diagnostic and treatment center earned Leader designation
- Metropolitan’s LGBT Clinic opened
- LGBT Advisory Group established by LGBT colleagues and allies
  - Enlisted board members, executives and managers to acknowledge the special challenges of serving LGBT patients and to commit to a policy of informed and respectful treatment

- Advocated for the creation of a safe space in the healthcare system for the LGBT community
- Fostered a respectful environment for LGBT employees

Dr. Winiarski informed the Committee that, in 2015, more facilities worked to meet HRC's criteria, which are outlined below:

- **Criterion One:** Patient non-discrimination statement includes “sexual orientation” and “gender identity”
- **Criterion Two:** Statement of equal visitation rights for LGBT patients and their visitors
- **Criterion Three:** Employment non-discrimination policy includes “sexual orientation” and “gender identity” and must be publicly promulgated
  - Shared with patients and public
  - Employees educated
  - Policies posted on facility websites
- **Criterion Four:** Training on LGBT patient-centered care
  - Nearly 1,000 employees trained

Dr. Winiarski reported that to be designated, each facility worked with the Office of Legal Affairs to add the City's anti-discrimination paragraph (presented below) to the Patient Bill of Rights, which was translated into 13 different languages by the Office of Culturally and Linguistically Appropriate Services. The anti-discrimination paragraph reads:

*“In addition, HHC is committed to compliance with the New York City Human Rights Law that states it is unlawful to discriminate on the basis of actual or perceived sex, including a person's "gender identity, self-image, appearance, behavior or expression," whether or not different from "that traditionally associated with the legal sex assigned to that person at birth." **Administrative Code of the City of New York Title 8***

Dr. Winiarski described NYC Health + Hospitals' journey to achieve HRC Leader designation, which included:

- Working with the Equal Employment Opportunity (EEO) Office and Human Resources (HR) to inform job seekers about NYC Health + Hospitals' EEO policy
- Working with the Communications Office to create links to Patient Bill of Rights on all facility websites and posters
- Working with facilities to ensure that all criteria are met
- Working with HRC to explain our complicated system

Dr. Winiarski reported that, for 2015 and 2016, a total of 21 facilities were named “Leader in LGBT Healthcare Equality”:

- **First time:** Belvis, Carter, Coler, East New York, Gouverneur, McKinney, Kings, Morrisania, Queens, Renaissance, Sea View
- **Second year:** Bellevue, Coney Island, Cumberland, Elmhurst, Harlem, Jacobi, North Central Bronx, Lincoln, Woodhull
- **Third year:** Metropolitan

Dr. Winiarski announced that, for 2017, HRC planned to raise the bar. New benchmarks will include:

- Organization's plan to reduce health disparities must include LGBT patients

- Updated on-line training for employees
- LGBT information added to corporate website
- Clinical services are reviewed and gaps addressed
- LGBT-responsive facilities are publicized
- Practice changes are disseminated
- Brochures are published for patients
- For employees, insurers add clear statements regarding transition services to insurance summary plan documents

Dr. Winiarski distributed the “I am an ally” postcard shown below, which already had been distributed across the system. The message to staff is that this alliance is not distinct from the mission of the system, but embodied the same spirit of the mission.



Dr. Winiarski concluded his presentation by acknowledging the following NYC Health + Hospitals’ facility representatives who worked on the 2015-16 survey:

- **Evelyn Borges:** Bellevue
- **Shelay Alava & Dennise Alvarado:** Belvis
- **Jeannette Rosario & Nelson Cabrera:** Coler
- **Young Lee:** Coney Island
- **Glenn Zuraw:** Elmhurst
- **Steve Hemraj:** East New York
- **Mark Baehser:** Gouverneur
- **Mary Caram:** Harlem
- **Jeannette Rosario & Nelson Cabrera:** Henry J. Carter
- **Vivian Nolan:** Jacobi
- **Natasha Burke:** Kings
- **Hyacinth Johnson:** Lincoln
- **Sarah Bender:** Metropolitan
- **Olayemi Abioye:** Dr. Susan Smith McKinney
- **Deborah Mabry:** Morrisania
- **Vivian Nolan:** North Central Bronx
- **Gertie Brown & Carolyn Adderley:** Queens



- **Gregory Atwater & Sandra Sanson:** Renaissance
- **George Taylor:** Sea View
- **Anthony Divittis:** Woodhull

Ms. Brown reassured Mrs. Bolus that contact information for the above listed representatives would be provided. Ms. Brown explained that the focus is to ensure that there is information on NYC Health + Hospitals' website that NYC Health and Hospitals' facilities have been designated as LGBT Healthcare Equality leaders; to ensure that the public and the community, especially patients, know which facilities have LGBT clinics; and to provide the contact information. The idea is not to rely on a specialized clinic in a single facility, but to ensure that there is a foundation of informed staff, respectful policies and practices and an environment in which no matter where an individual who is LGBT goes in the system, that individual would get the care that they need. Ms. Brown stated that health care equality for LGBT patients aligned with Dr. Raju's 2020 Vision by focusing on increasing patients' engagement, and growing our patient population. NYC Health + Hospitals will be working with its health plan, MetroPlus, to create opportunities. Together, they will create the message that NYC Health + Hospitals facilities, with MetroPlus as the principal insurer, are responsive to the needs of the LGBT community.

Mr. Nolan asked if provisions have been made for follow-up training for new and current employees to continue to raise awareness of the needs of the LGBT community. Dr. Winiarski responded affirmatively. Ms. Brown emphasized that Dr. Winiarski had been working with the Office of Safety and Human Development's staff to develop an online training module. Ms. Carolyn Jacobs, Senior Vice President, Safety and Human Development, added that, currently, there is an online cultural competency module, which includes information on working with LGBT patients. She informed the Committee that she had been working with Dr. Winiarski to create a specific LGBT awareness module that would be available electronically to all employees on an as needed basis. The goal is to create an annual employee-training program, which would be mandatory for all employees.

Mrs. Bolus asked if a brochure or pamphlet with contact information for NYC Health + Hospitals' LGBT clinics and services that could be distributed at health fairs and community venues had been developed. Dr. Winiarski responded that this project was on next year's agenda. He added that, as part of NYC Health + Hospitals' integration with the LGBT community, the system's LGBT programs have been promoted at health fairs and, for the first time, in public libraries.

Mr. Nolan asked if the system's facilities have gone beyond educating their employees about LGBT patients by also reaching out to the community through tenant associations and local community association meetings. Dr. Winiarski responded affirmatively and stated that Metropolitan Hospital had recently sponsored an LGBT community event in Harlem. Dr. Winiarski added that he was also working with Community Advisory Board members. Ms. Brown encouraged the NYC Health + Hospitals' facilities, including the Gotham sites that have met the HRC designation, to engage their local community stakeholders, tenant associations, community planning boards and community-based organizations.

## **INFORMATION ITEM II:**

### **Presentation: Forces Driving the Future of Post-Acute and Long Term Care Services**

Scott Amrhein, President, Continuing Care Leadership Coalition

Gabriel Oberfield, J.D., M.S.J, VP of Policy and Operations, Continuing Care Leadership Coalition

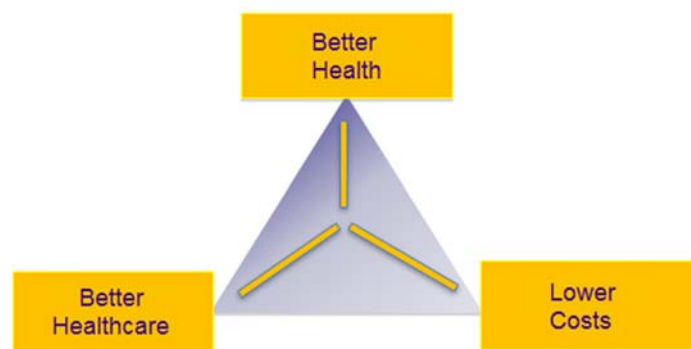
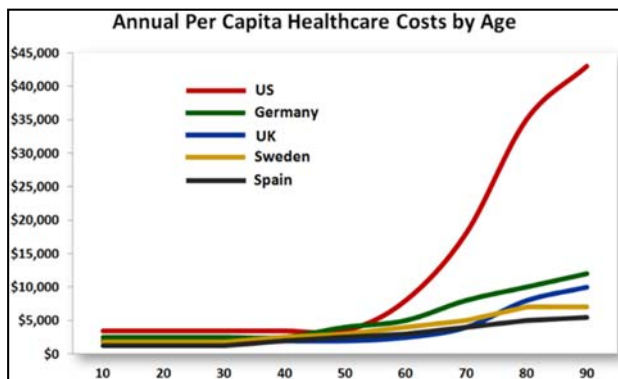
Ms. Brown informed the Committee that the Post-Acute/Long Term Care Services presentation would provide a learning opportunity about the importance of the post-acute care and long term care services that NYC Health + Hospitals provides as a system. Ms. Brown added that, while NYC Health + Hospitals has not leveraged its capacity, these services will become increasingly important in terms of health care reimbursement, health care service delivery and transformation strategies. Ms. Brown introduced Mr. Scott Amrhein, President, and Gabriel Oberfield, J.D., M.S.J, Vice President of Policy and Operations of the Continuing Care Leadership Coalition. She invited them to present the overarching environmental policy and reimbursement framework from which NYC Health + Hospitals could build its strategy. Ms. Brown reminded the Committee of the new Office for Long Term Care that will be created as part of NYC Health + Hospitals’ restructuring initiative. She assured the Committee that this information combined with the work that was prepared by the Corporate Planning staff, who worked with Mr. George Proctor, Senior Vice President, North/Central Brooklyn Network, would help to inform the new corporate leader.

Mr. Amrhein began his presentation by first stating that the forces of change in terms of long term care are based on the market, policy and regulatory changes. He added that, throughout his presentation, he would discuss how NYC Health + Hospitals’ long term care facilities are very well positioned to take advantage of a lot of the changes that are taking place.

Mr. Amrhein stated that all the forces of change relate back to the Triple Aim (see below). In the face of increasing annual per capita health care costs by age, we are all seeking to achieve better health care, better health and at lower costs. He commented that it is amazing to see what countries spend on health care per capita. For those in the range of 80-85 years old, the U.S. spends 4.5 times as much as any other developed countries. Mr. Amrhein stated that we have a long way to go to achieve good care for less. The Triple Aim focuses on how to deliver better health care experiences at lower cost.

In the face of this:

We all seek to achieve this:

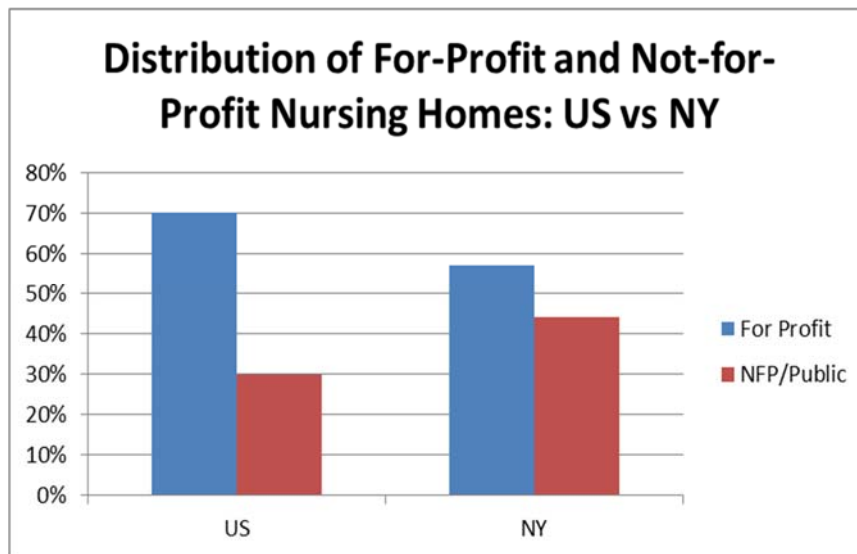


Mr. Rosen asked about the big disparity of health care costs for older individuals living in the United States (US) compared to other countries. Mr. Amrhein explained that in the U.S. a lot of money is spent on heroic measures at the end of life trying to keep people alive an extra two or three months in lieu of adapting a palliative care model. On one hand, there is a tendency to focus on length of life rather than quality of life. On the other hand, the approach to treating individuals who are of advanced age mirrors too often the approach that medicine follows across the board, which is very specialized and very disease-specific, but not dealing with the person holistically. He added that without that holistic view, the research indicates that a lot of money is spent for outcomes that are not in the best interest of the patient. Furthermore, the disparity is also in the amount of dollars spent on institutional care such as skilled nursing facilities for long periods of time in addition to end of life and

heroic methods at all costs. Mr. Oberfield added that it was also important to take into account the patient's needs and wants. He applauded NYC Health + Hospitals for doing a terrific job to that effect and for its robust palliative care programming, which has been recognized nationally.

Mr. Amrhein referred to the forces of change in three buckets: market driven, policy and regulatory forces. Policy and regulatory forces are two different views of the same thing. Policy forces are innovative and disruptive, which changes the way things are happening. On the other hand, regulatory forces are geared towards achieving the same goals but oftentimes by very old school ways. It is very difficult to operate in an environment where all these changes are occurring, which are driven by the state, federal government and at the same time by embedded regulatory structures.

Mr. Amrhein reported that the not-for-profit and public provider communities have been essential to keeping the quality bar high in New York State (NYS). The distribution of for-profit and not-for profit nursing homes in the U.S. compared to NYS and NYS's performance on selected measures are provided below:



#### NY Performance on Selected Measures

- 6% better than the US on CMS Quality Measures
- 11% more facilities achieve 5 star status than in the US overall
- 11% better performance than the US on anti-psychotic medication use

Mr. Amrhein reported that NYS had a much greater proportion of long term care being delivered in the public and not-for-profit sector. Looking back 10 to 15 years earlier, the blue and the red bars would have been equivalent. Notwithstanding, there has been a reduction of not-for-profit and public nursing homes in NYS. Mr. Amrhein informed the Committee that the Continuing Care Leadership Coalition (CCLC) is striving to keep the state's commitment at the highest level around supporting the not-for-profit and public long term care facilities. Mr. Amrhein emphasized that NYS scored 6% better than the U.S. on CMS' quality measures. NYS has 11% more facilities that achieved a 5-star rating than the U.S. overall and 11% better performance on antipsychotic medication use. He explained that there is a lot of attention at CMS focusing on reducing the extent to which nursing homes utilize off label antipsychotic medication, not for a particular severe mental diagnosis, but, in particular, to manage behaviors in patients with dementia. The Continuing Care Leadership Coalition, the long term care affiliate of Greater New York Hospital Association (GNYHA), has been functioning as the leader within NYS on the Dementia Improvement Initiative, which is focused on reducing the inappropriate use of antipsychotic medications.

Mr. Amrhein discussed the four major market trends as outlined below:

1. Shifting Demographics (driving demand for more services)
  - Continued growth of an aging population

- Changes in disease and disability prevalence
  - Persistent needs of a population in poverty
  - A worsening caregiver ratio
2. Changing Consumer Preferences
    - A more informed population is seeking greater control, more person-centered care models
    - Consumers want to receive care in their homes and communities for as long as possible
  3. Demand for Efficiency in an Ever More Costly Care Environment
    - Labor costs – facing upward pressure – remain the preponderance of LTC service delivery costs
    - Resource needs will rise as patient needs become more acute at every level of care
    - Simultaneously, Medicaid payment levels remain well below actual costs

Mr. Amrhein stated that NYS has the biggest gap in the country between the cost for a day of nursing home care and what the Medicaid program actually pays. The differential on a per day basis per patient is \$40. By multiplying that number with the number of Medicaid patients in NYC Health +Hospitals’ system, the result is a dramatic challenge for a system that is so Medicaid involved. Ms. Brown added that the gap and this challenge noted by Mr. Amrhein did not include the additional challenge of a significant number of uninsured individuals being served by NYC Health + Hospitals’ long term care facilities.

Mr. Rosen asked if the Medicaid payments were global across all long-term care institutions. Ms. Brown responded that it was across the board notwithstanding ownership. The \$40 a day differential is inclusive of not-for-profit/public and for-profit long term care facilities. Mr. Amrhein noted that because labor and negotiation contracts for the for-profit institutions are leaner than other providers, the cost structure is less (i.e., they may be losing less than \$40). The for-profit facilities make it up by boarding as many patients with Medicare Part A as possible to ensure payments (profits).

4. A Shifting Mix of Provider Types in NYS

**Table 1.  
Number of Nursing Facilities by Year and Sponsorship, New York State**

	1996	2000	2005	2010
For-Profit	312	313	310	310
Not-for-Profit	295	298	290	258
Public	48	51	49	44
Total	655	662	649	612

Source: RCF4 nursing facility cost reports filed with the New York State Department of Health, 1996-2010, obtained through HANYS/FACETS.

Mr. Amrhein commented that the equilibrium between for-profit and not-for-profit is changing in New York State. He added that there is a greater decline trend in the not-for-profit and the public side. Over the last five to six years, the pattern has been one not-for-profit or public closure every two months. Those closures have resulted in conversions to for-profit organizations. Ms. Brown clarified that all NYC Health + Hospitals nursing homes were included in the public number.

Mr. Amrhein invited his colleague, Mr. Gabriel Oberfield to present the policy and regulatory forces that are impacting long term care services. Mr. Oberfield began his presentation by first clarifying the

differences between policy and regulatory changes. He explained that, while the regulatory changes are less responsible for some of the dynamic changes that are occurring in the market place, the policy changes are affecting NYC Health + Hospitals' long term care facilities and other similar institutions. Mr. Oberfield stated that the following three dominant policy themes were important to emphasize:

- Moving financial risk downstream
- Managing health at the population level
- Shifting care delivery to the lowest cost, least restrictive sites

Mr. Oberfield stated that some of the specific policy trends that are affecting the long term care continuum in New York State included:

- Migration of the long term care population and benefit to managed care
  - Mandatory Managed Long Term Care (MLTC)

Effective as of February 2016 in New York City with expansion to the other surrounding counties during the summer. The Medicaid benefit that had been carved out and was fee-for-service is now carved in and is included with a broader capitated rate. A myriad of operational issues derived from that shift. According to the State, by bringing care into closer coordination and alignment, it can be delivered efficiently.

- Transitional issues include:
  - Payer mix has moved more into Managed care than the fee-for-service side
  - Paying on time is a big issue
  - Denials have increased because the nomenclature is not necessary uniform across plans
- Expansion of the Medicare Advantage programs
  - They are increasingly prevalent in the market place
  - There is a lesser prevalence of fee-for-service in the Medicare program
- Implementation of the Fully-Integrated Dual Advantage Program (FIDA) in NYS
  - Due to operational challenges and other issues, this demonstration project, which was projected to include as many as 50,000 to 60,000 members at a minimum, currently has 6,000 enrollees
  - Both CMS and the State have invested in seeing this demonstration through
  - CMS and the State have convened some active working sessions earlier this fall at which they solicited community feedback concerning needed adjustments to the demonstration
- Organization of care for the Medicaid population through DSRIP Performing Provider Systems (PPSs)
  - Through OneCity Health, NYC Health + Hospitals is well positioned to move forward in this new paradigm with the largest PPS in the City.
  - Across the State, there is a move to integrate and coordinate care through the expenditure of \$8 billion that would infuse itself through the broader system over the next five years.

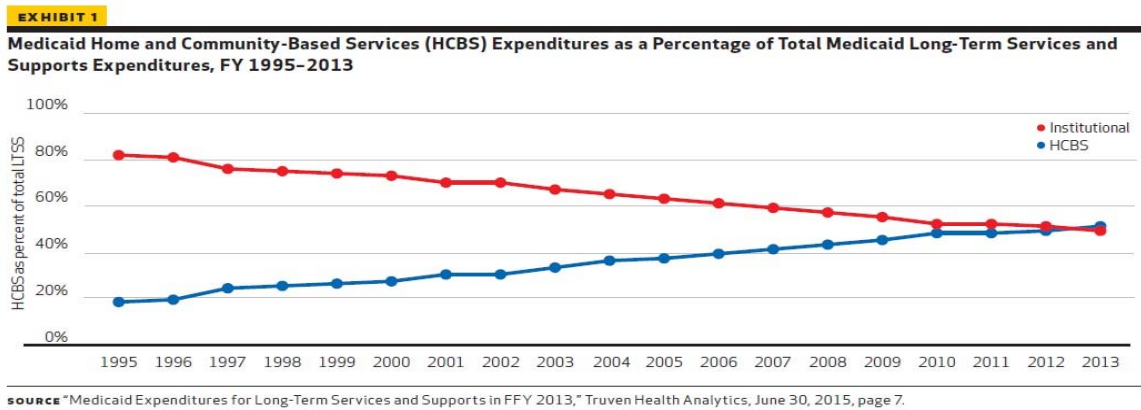
- Implications for payment
  - PPSs will play a much more coordinated role among those who are seeking to provide care to individuals who are attributed to those PPS's
- Implications for care delivery models and approaches
  - PPS will serve as a locus of care
  - Within that locus, there is a continuum play for long term care suite of services
- Emergence of aggressive value-based purchasing agendas at the state and federal levels
  - The State has taken an invested approach in developing sub-committees. These sub-committees concluded their activities this month and made formal conclusions and recommendation for programming that would guide the State as it moves toward the implementation of value-based payment. That approach has been tied to expectations that were aligned in the agreement that the State executed with CMS at the time of its agreement to receive DSRIP funds. There is also analogous activity at the federal level. Medicare is moving to the value-based payment space as well. It is a trend that would be worth watching closely over the next two to four years.
  - Value-based purchasing is an approach at looking at care delivery at the nexus of cost and highest quality. To do that in a long term care setting is a conversation that is evolving. In order for PPSs and others that would be involved in the arrangements of delivering value-based payments to otherwise ensure the quality of care of the individual under their watch, there will be a need to identify targeted partners who have emphasized quality as a key component of the care that they already are delivering.

Mr. Amrhein added that the Nursing Quality Improvement (NQI) Program has redistributed \$50 million to providers based on their achievement of top performance outcomes. You earn that money back if you are one of the better providers. Through CMS' vision of value-based purchasing, the payment to the nursing facility would be based on the role that the nursing facility plays in a capitated environment and its ability to keep the overall cost of care for patients down.

Ms. Brown clarified that NYC Health + Hospitals' long term care facilities (i.e., Sea View, McKinney, Henry J. Carter and Coler) will become increasingly important not just for the services they have been providing historically, but important to the PPSs and the managed care plans in how they contribute to service delivery and the cost of services provided to a patient throughout his/her entire health care experience. It is increasingly important to ensure that there are strong connections between NYC Health + Hospitals' acute care, long term care facilities and home care services because the entirety of a patient's health care services will be counted as part of value-based purchasing. The length of stay in an acute care facility can be significantly lowered if there is a very close link to that patient getting post-acute care services within the NYC Health + Hospitals' system.

Ms. Brown added that NYC Health + Hospitals has been very lucky in having a number of post-acute care facilities and services. It is apparent that the patient that comes in for an operation would be in need of post-acute care. Therefore, the patient should be offered a package of services including the post-acute care services versus just getting paid for the acute care.

- Shifting care to the community results in a cumulative effect of an array of factors which include
  - ADA-Olmstead decision - money follows the person
  - Balancing Incentive Program - community first choice option



Mr. Oberfield stated that, over the last 20 years, the prevalence of institutional care had diminished. By contrast, home and community-based services have expanded in its overall percentage of prevalence in terms of delivery of services and support. He added that we have now reached a point where these two lines have crossed. The integration of different service paradigms, representing some of the changes in patient preference as well as ways of delivering services in a cost effective way, is increasingly critical.

Mr. Oberfield described the regulatory forces and actions as the following:

- Array of new regulatory actions will impose new expectations on providers, in tension with policy emphasis on transitioning greater risk and accountability to providers
  - CMS' "Conditions of Participation Rule:" Sweeping changes for nursing facilities
  - CMS' Rule on "Changes to discharge planning regulations for hospitals, LTCHs and home health"
  - New overtime pay expectations for home care
  - Minimum wage changes, also with implication for home health sector
- Other regulatory actions will reinforce the direction of current policy thinking
  - CMS' Final Rule on Bundled Payment for Joint Replacement
  - In-process changes to NYS' nursing home bed need methodology
- Further observations
  - Environmental regulations continue to challenge providers (e.g., sprinkler regulation, smoking and e-cigarettes)
  - Providers are challenged by overlapping and duplicative regulations for providers and managed care plans

Mr. Amrhein concluded his presentation by sharing a path to success, which included:

- Leveraging NYC Health + Hospitals' resources
  - Unique alignment between NYC Health + Hospitals' experience and assets and the demands of the emerging health environment
    - Experience operating as a "true system"
    - Expertise in dealing with prevalent chronic diseases of the population
    - Leadership in the patient-centered medical home model



- Engagement with the community, through communication, collaboration
  - Leadership position in delivery of behavioral health services
  - Deep experience with home health and telehealth services
  - Award-winning system-wide palliative care program
  - Documented track record of attaining superior quality outcomes
- Risks and Challenges
    - Sustaining effective communications across system elements
    - Measuring what works; tweaking practices based on experience
    - Ensuring a strong voice for the system's long term care components in planning, decision-making, in the PPS context and beyond
    - Remaining both "entrepreneurial" and attentive to the regulatory/compliance environment simultaneously

Ms. Brown stressed that the administrators of the long term care facilities have to manage within this hugely and increasingly complicated regulatory and reimbursement environment with the expectations of quality care. There is a need for someone to look at opportunities and innovative changes to help the facilities make those changes. She emphasized that no single Chief Operating Officer (COO) can do all of that at the same time. To ensure a strong voice within the policy and state regulatory system, we need someone at those tables, along with our partners at CCLC and other trade associations, to make sure that the populations that NYC Health + Hospitals serves and the services that are being rendered by the public post-acute care providers are being taken into serious consideration.

Mrs. Bolus asked if there was anything being done to encourage people at a young age to purchase long term care insurance. Mr. Amrhein responded that New York State has been getting better incentives in place. Senator Jeff Klein is a proponent and one of his initiatives is to encourage people to get a rider that would be included in their life insurance policy that would convert some of the value of a life insurance policy into long term care insurance to pay for long term care expenses. He informed the Committee that part II of that bill has not yet been passed. By doing so, Senator Klein is seeking to bump up the tax benefit. Mr. Oberfield added that more needs to be done to make it happen. Mrs. Bolus recommended a trip to Albany to support this initiative.

Mr. Nolan asked Mr. Oberfield to explain CMS' final rule on bundled payment for joint replacement. Mr. Oberfield responded that CMS, recognizing the fact that these are both commonplace and expensive procedures, is trying to bring into alignment the various care providers to contribute to the overall cost of care. By bundling, the notion is that there will be a locus for payment that will be distributed among the providers who would contribute to the care of individuals needing these specific procedures. That level of coordination is coming through the regular avenue at the federal level by way of mandate. Mr. Oberfield stated that NY and a number of different major jurisdictions across the country are being told, not asked, that this is the payment approach that the federal government is accepting in order to reimburse for these activities.

Mr. Oberfield further clarified that, if one were to have a right hip replacement surgery, it is not the federal government's responsibility to anticipate that the left hip would need to be replaced soon, but to ensure that following the right hip replacement, the various care providers will contribute to the patient's recovery. In this scenario, the hospital and the long term care provider would be working together and the payment for that coordination would also be well coordinated. Mr. Amrhein added that it is about changing the incentives. He explained that, during the old regime, it was in the hospital's best interest under fee-for-service to keep the patient in the hospital for a realistic number of six days. Under the new regime, if medical evidence indicates that the patient could be discharged from the hospital in two or three days and receive post-acute care services in a long term care facility or at home, the hospital, which is in control of the bundle would retain any excess if the patient can be



moved out of the hospital after two days to a post-acute care facility and to home as quickly as possible thereafter, for much less cost than it would have been in the old regime. Ideally, it means better care for the patient and lower cost for the system.

#### **ADJOURNMENT**

There being no further business, the meeting was adjourned at 11:50 AM.



# Vision 20/20 Plan & System Scorecard

Raven C. Carter, MBA, FACHE  
Director, Patient & Family Experience

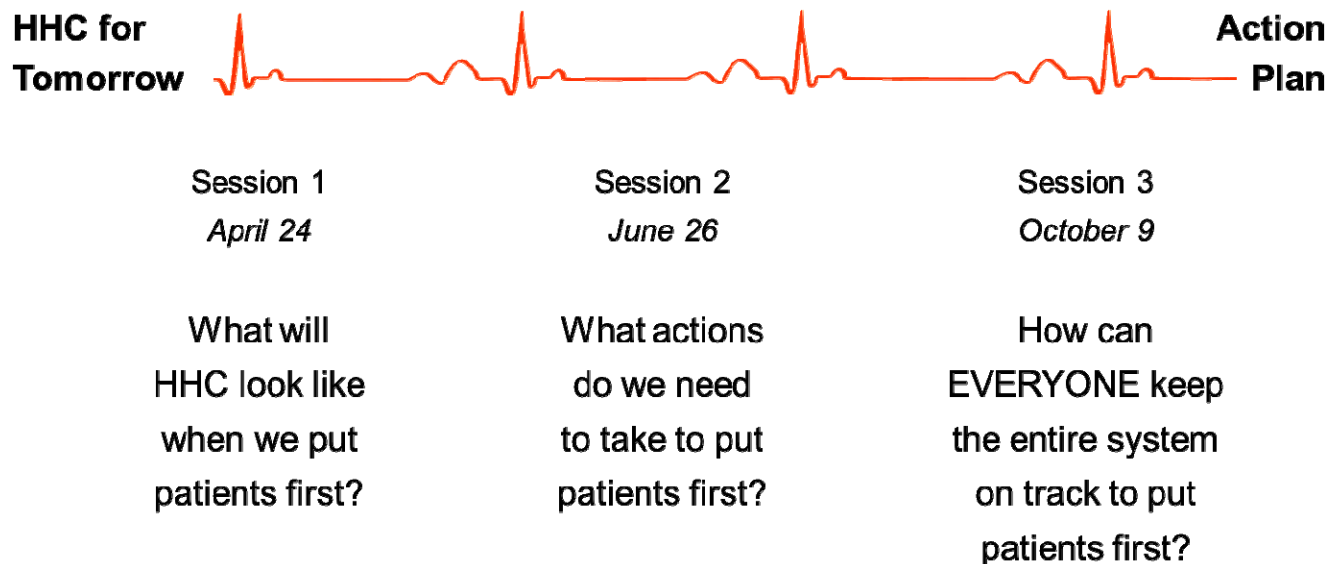
Udai Tambar  
Chief Transformation Officer

Strategic Planning Committee  
Board of Directors  
March 30, 2016



# Strategic and Creative Process

- Created by the 20/20 Visionaries (*a multi-disciplinary team of 400+ formal and informal leaders from across the health system*)
- 3 interactive retreats over a 7 month period in 2015 that resulted in 22 initiatives to be implemented by year 2020
- Includes evidence based best practices from around the country



# Strategic Framework

**VISION:** By 2020, every patient and family will experience coordinated safe care that exceeds their expectations.

**MISSION:** Quality care for all, without exception.

## STRATEGIES FOR 20/20

1

ANTICIPATE AND MEET  
OUR PATIENT NEEDS

2

ENGAGE OUR WORKFORCE  
WHERE EACH OF US IS  
SUPPORTED AND ACCOUNTABLE

3

PROVIDE HIGH QUALITY SAFE  
CARE IN A CULTURALLY  
SENSITIVE, COORDINATED WAY

4

EXPAND ACCESS  
TO SERVE MORE PATIENTS

5

INCREASE EFFICIENCY  
THROUGH TECHNOLOGY AND  
CAPITAL INVESTMENT

**NYC**  
**HEALTH+**  
**HOSPITALS**



# Anticipate & meet patient needs

METRIC	DEFINITION	INITIATIVE
1 <b>Out-patient overall mean satisfaction</b>	roll-up average of all outpatient scores from each section of the survey; by discharge date	<ul style="list-style-type: none"><li>• <b>Universal behavior standards</b></li><li>• Team huddles</li><li>• Ambulatory care expansion</li><li>• Primary care transformation</li><li>• Population health management</li><li>• Tech-enabled rounding</li><li>• Centralized call center</li></ul>
2 <b>In-patient rate-the-hospital top box score</b>	% in-patients surveyed who rank hospital 9 or 10 out of 10; by discharge date	<ul style="list-style-type: none"><li>• <b>Universal behavior standards</b></li><li>• Team huddles</li><li>• Rounding on patients and staff</li><li>• Nurse direct call</li><li>• Training led by own experts</li><li>• After-visit communication</li><li>• Tech-enabled rounding</li></ul>

# Engage our workforce

where each of us is supported & personally accountable

METRIC	DEFINITION	INITIATIVE
3 <b>Staff completing leadership development</b>	cumulative YTD managers completing executive fellowships or middle-management training ~5,000 employees eligible	<ul style="list-style-type: none"><li>• Training led by our own experts</li><li>• Personal improvement plans</li></ul>
4 <b>Employee engagement</b>	survey of employees "I would recommend this organization as a good place to work"; baseline: Q3 2015; actual: Q1 2016; target: national safety net average	<ul style="list-style-type: none"><li>• Universal behavior standards</li><li>• Team huddles</li><li>• <b>Rounding on staff</b></li><li>• Talent acquisition</li><li>• Training led by own experts</li><li>• Employee recognition</li><li>• Personal improvement plans</li></ul>

# Provide high quality safe care in a culturally sensitive coordinated way

METRIC	DEFINITION	INITIATIVE
5 <b>Hospital-acquired infections – CLABSI SIR</b>	observed / expected Central Line Associated Blood Stream Infection - Standardized Infection Rate; data not finalized for 5 months after the reporting period	<ul style="list-style-type: none"> <li>• <b>Purposeful rounding on patients</b></li> </ul>
6 <b>DSRIP on track</b> funding vs. max available	total PPS \$ awarded / total potential (up to \$1.2 B over five years); cumulative since April 2015; reported Jan & Jul	<ul style="list-style-type: none"> <li>• Ambulatory care transformation</li> </ul>



# Expand access to serve more patients (market share)

METRIC	DEFINITION	INITIATIVE
7 <b>Access to appts</b> new adult patient TNAA days	average days to third next available appointment for new adult patients (primary care only)	<ul style="list-style-type: none"> <li>• Ambulatory care expansion</li> <li>• Primary care transformation</li> <li>• MetroPlus membership growth</li> <li>• Centralized call center</li> <li>• Urgent care pilot</li> </ul>
8 <b>Unique patients</b> thousand	12-month cumulative unique patients across entire system, not double counting those visiting many sites; high estimate	<ul style="list-style-type: none"> <li>• Ambulatory care expansion</li> <li>• Primary care transformation</li> <li>• MetroPlus membership growth</li> </ul>
9 <b>MetroPlus</b> <b>members</b> thousand	active MetroPlus members across all categories at the end of the quarter	<ul style="list-style-type: none"> <li>• Ambulatory care expansion</li> <li>• <b>MetroPlus membership growth</b></li> </ul>
10 <b>Patient revenue</b> (proportion of expenditure)	patient-generated revenue / operating expense (cash receipts & disbursements YTD)	<ul style="list-style-type: none"> <li>• Primary care transformation</li> </ul>

# Increase efficiency through investment in technology & capital (organizational reform)

METRIC	DEFINITION	INITIATIVE
11 <b>EMR budget variance</b>	EMR implementation over or under budget	<ul style="list-style-type: none"> <li>• <b>EPIC / GO EMR implementation</b></li> </ul>
12 <b>EMR implementation on track</b>	estimate of milestones completed on time: Green = 100%; Yellow = missed milestones have no impact on go-live dates; Red = delays expected for go-live	<ul style="list-style-type: none"> <li>• <b>EPIC / GO EMR implementation</b></li> </ul>
13 <b>Contractor performance at service level</b>	% vendors compliant with Key Performance Indicators (for 11 biggest spend contracts); KPIs vary by contract	<ul style="list-style-type: none"> <li>• Rounding on staff</li> </ul>
14 <b>FEMA projects on track</b>	% milestones on track (green or yellow)	<ul style="list-style-type: none"> <li>• --</li> </ul>

# System Scorecard – 2015 Q4

METRIC	LEAD	TARGET Q4	ACTUAL Q4		PRIOR Q	PRIOR YR Q4	TARGET 2020	
<b>PATIENT EXPERIENCE</b>								
1	<b>Out-patient overall mean satisfaction</b>	COO	80%	78%	Y	78%	77%	93%
2	<b>In-patient rate-the-hospital top box score</b>	COO	62%	59%	R	62%	61%	80%
<b>EMPLOYEE ENGAGEMENT</b>								
3	<b>Staff completing leadership development</b>	COO	536	536	G	462	246	370
4	<b>Employee engagement (5 point scale)</b>	COO	4.1	3.5	R	3.6	NA	4.1
<b>QUALITY</b>								
5	<b>Hospital-acquired infections – CLABSI SIR</b>	CMO	1.00	0.86	G	0.85	0.82	0.50
6	<b>DSRIP on track (funding vs. max available)</b>	OneCity	90%	100%	G	100%	NA	90%
<b>ACCESS (MARKET SHARE)</b>								
7	<b>Access to appts (new adult patient TNAA days)</b>	CMO	14	22	Y	21	32	14
8	<b>Unique patients (thousand)</b>	COO	1,200	1,238	G	NA	1,242	2,000
9	<b>MetroPlus members (thousand)</b>	M+ CEO	480	482	G	472	473	1,000
10	<b>Patient revenue (proportion of expenditure)</b>	COO	60%	58%	Y	56%	62%	70%
<b>EFFICIENT SUPPORT (ORGANIZATIONAL REFORM)</b>								
11	<b>EMR budget variance</b>	CIO	0%	0%	G	0%	NA	0%
12	<b>EMR implementation on track</b>	CIO	100%	90%	Y	90%	NA	100%
13	<b>Contractor performance at service level</b>	COO	100%	91%	Y	91%	NA	TBD
14	<b>FEMA projects on track</b>	COO	100%	92%	Y	100%	NA	100%

G = on target. Y = trending toward target. R = off target. 2015 Q4 is October – December 2015.