NYC HEALTH+ HOSPITALS

STRATEGIC PLANNING COMMITTEE

OF THE BOARD OF DIRECTORS

March 19, 2019
Boardroom
125 Worth Street, Room 532
11:00am

AGENDA

I.	Call to Order	Gordon J. Campbell
II.	Adoption of December 13, 2018 Strategic Planning Committee Meeting Minutes	Gordon J. Campbell
	a . Legislative Agenda	Matthew Siegler Senior Vice President Managed Care & Patient Growth
III.	Information Items	
	a. Update and system Dashboard	Matthew Siegler Senior Vice President Managed Care & Patient Growth Dr. Eric Wei Vice President Chief Quality Officer
IV.	Old Business	
V.	New Business	
VI.	Adjournment	Gordon J. Campbell

MINUTES

STRATEGIC PLANNING COMMITTEE MEETING OF THE BOARD OF DIRECTORS

DECEMBER 13, 2018

The meeting of the Strategic Planning Committee of the Board of Directors was held on December 13, 2018 in HHC's Board Room, which is located at 125 Worth Street with Mr. Gordon J. Campbell, presiding as Chairperson.

ATTENDEES

COMMITTEE MEMBERS

Gordon Campbell, Chairperson of the Strategic Planning Committee
Mitchell Katz, M.D.
Helen Arteaga Landaverde
Robert F. Nolan

OTHER ATTENDEES

M. Elias, Analyst, Office of Independent Budget Office
J. DeGeorge, Office of the State Comptroller
C. Chen, Analyst, Office of Management and Budget
F. Leonard, Analyst, Office of Management and Budget

HHC STAFF

M. Belizaire, Assistant Director, Government and Community Relations
K. Eskenazi, Deputy Press Secretary, Office of Communications
C. Hercules, Corporate Secretary and Chief of Staff, Office of the Chair, Board Affairs
B. Ingraham-Roberts, Assistant Vice President, Government and Community Relations
J. Liburd, Assistant Vice President, Accreditation
A. Marengo, Senior Vice President, Office of Communications
K. Olson, Assistant Vice President, Revenue Budget
S. Ritzel, Associate Director, NYC Health + Hospitals/Kings County
I. Rocha, Vice President, One City Health
L. Saravia, Senior Executive Secretary, Office of the Chair, Board Affairs

J. Segall, Senior Director, Office of Quality & Safety
M. Siegler, Senior Vice President, Managed Care and Patient Growth
M. Smith, Director of Marketing, Office of Communications
E. Wei, Vice President, Chief Quality Officer

CALL TO ORDER

Mr. Gordon Campbell, Chairman of the Strategic Planning Committee, called the December 13th meeting of the Strategic Planning Committee (SPC) to order at 1:10 P.M. The minutes of the July19, 2018 and October 15, 2018 of the Strategic Planning Committee meetings were adopted.

LEGISLATIVE UPDATE

Mr. Siegler greeted and informed the Committee that he would provide a quick public policy update followed by the System Dashboard Reporting: Q1 FY 2019 (July September 2018).

Public Policy Update

Mr. Siegler reported on two items on the Public Policy Update as they are of big strategic importance to NYC Health + Hospitals:

1. Indigent Care Workgroup:
   Mr. Siegler reported that, the Indigent Care Workgroup which was convened by the State, has concluded its meetings and is currently drafting a final report. Mr. Siegler reminded the Committee that the Workgroup agenda was to discuss how Disproportionate Share Hospital (DSH) payments and the indigent care pool (ICP) are distributed across hospital systems in the State. NYC Health + Hospitals' Finance Team including John Ulberg, and Linda Dehart, Senior Vice President, Assistant Vice President respectively and Michelle DiBacco, Assistant Vice President, Government and Community Relations, in partnership with community groups and labor organizations around the State put together the consensus proposal that was discussed in the Workgroup on how to eliminate the transition collar of the indigent care pool and how to distribute funds in a more equitable way to systems across the State. The majority of the members of the Workgroup were supportive of the proposal. Mr. Siegler stated that there were no votes or final recommendations made by the Workgroup. While ultimately any changes has to be done through changes in State law, we feel good and proud about the work done to bring together many disparate groups and memberships of that committee to support one consensus proposal. Mr. Siegler noted that the NYC's Health + Hospitals – Community Coalition's ICP collar elimination/Medicaid rate financing proposal is a great success for our System as we received positive feedback from community groups. Mr. Siegler added that this proposal was not exclusively about our own finances, but took into account the interest of other hospitals around the State and community and labor organizations as well. The final report is being drafted by the chairs of the committee. Mr. Siegler informed the Committee that he will report back to the Committee when the result of the report is made available.

   Mr. Gordon Campbell, asked when the report will be issued. Mr. Siegler answered that it will be early next year and reassured the Committee that the Workgroup's recommendations will be discussed and factored into ongoing budget discussions.

2. Public Charge:
   Mr. Siegler reported that the deadline for public comments to the proposed changes to the "public charge" rules from the Department of Homeland Security has passed. He stated that

NYC Health + Hospitals was proud to be included in a very impressive comment the City submitted. Health + Hospitals submitted its own data analysis and understanding of what the new rules would mean for our System to elected representatives from the federal, state and local level. In addition, we held a press conference with labor partners, community groups with the Commissioner of the Mayor's Office of Immigrant Affairs, among others, at Gouverneur last week. Health + Hospitals estimates that, at a high level, as patients are dis-enrolling from coverage or otherwise changing their behavior, the System's impact could be up to a loss of $362 million in the first year alone. This would warrant changes in our strategy and potential changes in state and local policy to help address that issue.

Mr. Campbell commended the Mayor and his staff, Dr. Katz and Health + Hospitals' at the Press Conference held at Gouverneur. He asked if there is any hope for a modification of the "public charge" rules. Mr. Siegler answered that there has been pushed back across the spectrum of the healthcare industry, social service groups and a variety of different interests. He emphasized that it is a rule and it does not require legislative approval. It falls to us and others who care about this proposal to exert maximum public pressure as the rule is under discussion. Mr. Siegler informed the Committee that many days before the deadline, there were over 120,000 comments submitted to the Department of Homeland Security; a number that could have been doubled by the deadline date. They are required to read and respond to all issues raised, which will lead to a long drawn out comment and review period. The rule will then go back to the Office of Management and Budget at the federal level which will be an indication that a final decision is forthcoming. There is no prescribed deadline on a final decision. They could either sit on it or withdraw, which has been the recommendation that many are hoping for.

Mr. Nolan asked if these proposed changes to the "public charge" rules affect one state more than another. For example, would they affect New York State more than Kansas? Mr. Siegler answered that it affects states with large populations of foreign born individuals, of immigrants and mixed status households. However, the biggest effect is not even the number of people who are directly affected by the proposed changes because of the process of their immigration application, but rather the ones affected because of broader fear about the issue and what those changes could mean for them and their family in the future. In other words, the misinformation around the policy is as damaging as the policy itself.

Dr. Katz recalled a comment made by a staff member from the WIC Department at Gouverneur at the Press Conference. It was reported that a mother, who is not even at risk for her immigration status, asked to dis-enroll from the WIC program for fear that she could be penalized. Her comment was "I don't want to get infant formula because I don't want a public charge." Because the 'public charge' policy is so complicated, it could have a huge impact on services as fear spreads in the community. Dr. Katz noted that, by the time the information reached the people, there is only one ingredient of truth in the information. As a result, this woman does not want to take infant formula for her baby even though there is no issue.

Mr. Nolan would like to know specifically who would be dealing with this issue since the rule does not need to be approved by Congress and that the House can have hearings through the appropriate Committee to continue to keep the issue alive. Would it be Senator Schumer and his position on the Senate side or on the House side? Mr. Siegler answered that both Senator

Schumer and Representative Nadler, as Chair of the Judiciary Committee, and the House which has jurisdiction over it, would be involved and hold direct hearings on the issue. Mr. Siegler cautioned that the impact is so broad that any committee in the House could have a hearing and have a legitimate discussion on what this means for its jurisdiction. He informed the Committee that Commissioner Pallone from the Energy and Commerce Committee where he last worked, has jurisdiction over Medicaid and Public Health Service Act and would expect them to have hearings as well. It would be appropriate to talk to the entire delegation and then to the key health care committees and jurisdictions.

Mr. Nolan commented that California would be as disproportionately impacted as New York by the 'public charge' issue, which would add Speaker Pelosi to Nadler and Pallone from New Jersey in forming a Democratic Alliance that will keep this issue on the front line. Mr. Siegler stated that the "public charge" issue is on the radar as he had raised it with the staff of Leader Speaker Pelosi as well as the Health Committees and it will continue to be in front of their minds.

Mr. Siegler concluded his brief update by informing the Committee that his report at the next meeting will include an update on disproportionate share hospital payments with large federal policy, the State Budget and other relevant issues.

INFORMATION ITEM

Strategic Planning Committee Update and System Dashboard

Matt Siegler
SVP Managed Care and Patient Growth
Dr. Eric Wei
Chief Quality Officer

Mr. Siegler reminded the Committee that we have moved to a fiscal year measure with quarterly reporting. He informed the Committee that the score card measures reflect the first quarter of fiscal year 2019 (see score card on the next page).

Mr. Siegler reported on improving measures that are trending positively. E-consult, which is our mean of expanding access to specialty care and speeding up referrals from primary care doctors into specialties, continues to be an impressive and important area of progress. E-consult is expected to be live, at least in one clinic, at all of our facilities by the end of this year. As mentioned in the Finance Committee meeting earlier today, the Patient Care Revenue over Expenses measure, which focuses on how we are executing on our revenue capture effort and controlling our expenses, continued to improve. The number of insurance applications submitted per quarter measure is still below our target of 23,700, but the number trended up significantly from the prior month and prior quarter. Mr. Siegler noted that the month of October was the first month that we have ever exceeded our target; it was the highest month ever for insurance applications. Lastly, the Sepsis 3-hour bundle measure has seen positive trending.

Mr. Siegler reported on the negative trending measures. Unique primary care patients seen in the last 12 months measure went down from 417,000 the prior period to 414,503. Efforts are being made to push hard on driving and increasing the number of primary care patients. The goal this year was to stabilize the decrease, flatten out where we are on a full 12-month basis and then build from

there. The engagement of more primary care providers and the improvements made in scheduling, and the overall process have rolled out first at Bellevue in the adult medicine clinic and then will move across the entire System.

Mr. Campbell asked if the doctors have only come on board within the last two months. Mr. Siegler answered positively. Dr. Katz interjected that it takes a while as these doctors would have to learn our computer system, the Quadrimed system and complete all the compliance trainings.

Mr. Siegler reported on the AR days per month. Even though 43.5 is below our target of 45, it is still green on the chart because our target is still being met. Mr. Siegler informed the Committee that a new payment vendor was brought on and we had a delay as we were getting bills out the door to certain health plans. Another negative trending measure is the percent of patients who left the emergency department without being seen, which will be addressed later in Dr. Wei's presentation.

Mr. Siegler reported on the individual measures of the System Dashboard – December 2018:

NYC HEALTH+ HOSPITALS

System Dashboard – December 2018
Reporting Period: Q1 FY2019 (July-Sept 2018)

		EXECUTIVE SPONSOR	REPORTING FREQUENCY	TARGET	ACTUAL FOR PERIOD	VARIANCE TO TARGET	PRIOR PERIOD	PRIOR YEAR SAME PERIOD
Increase Primary Care				FY 2019				
1	Unique primary care patients seen in last 12 months	VP PC	Annually	418,000	414,503	N/A	417,000	425,000
Access to Care								
2	Number of e-consults completed/quarter	CPHO	Quarterly	10,000	12,535	+8.98%	10,535	5,090
Financial Sustainability								
3	Patient Care Revenue/Expenses	CFO + SVP MC	Quarterly	60%	61.5%	+1.5%	59%	61.4%
4	# insurance applications submitted/quarter	CFO + SVP MC	Quarterly	23,710	18,923	-20%	17,421	14,852
5	% of M+ medical spend at H+H	SVP MC	Quarterly	45%	39.9%	-5.1%	39.34	39.1%
6	Total AR days per month (excluding in-house)	CFO	Quarterly	45	43.8	-1.2	42.3	47.0
Information Technology								
7	Epic implementation milestones	CIO	Quarterly	100%	100%	-	100	-
8	ERP milestones	CIO	Quarterly	100%	85%	-15%	85	-
Quality and Outcomes								
9	Sepsis 3-hour bundle (2Q18)	CMO + CQO	Quarterly	63.5%	72.6%	+9.1%	66.0%	66.2%
10	Follow-up appointment kept within 30 days after behavioral health discharge	CMO + CQO	Quarterly	66%	59.6%	-6.4%	57.8%	60.0%
11	HgbA1c control < 8	CPHO + VP PC	Quarterly	66.6%	64.1%	-2.5%	63.5	63.8%
12	% Left Without Being Seen in the ED	CMO + CQO	Quarterly	4%	8.67%	-4.67%	7.94	7.37%
Care Experience								
13	Inpatient care - overall rating (Top Box)	CNO + SVP AC	Quarterly	65.4%	62.0%	-3.4%	62%	60%
14	Ambulatory care (medical practice) Recommend Provider Office (Top Box)	CNO + SVP AC + VP PC	Quarterly	83.6%	81.2%	-2.4%	82.1%	80.5%
15	Post-acute care - likelihood to recommend (mean) [2016]	CNO + SVP PAC	Semi-Annually	84.3%	87.1%	+2.8%	85.3%	N/A
Culture of Safety								
16	Acute Care – Overall Safety Grade	CNO + CQO + SVP AC	Annually	76%	-	-14%	-	-
17	Post-Acute Care – Overall Safety Grade	CNO + CQO + SVP PAC	Annually	74%	-	-2%	-	-
18	Ambulatory (D&TC) – Overall Safety Grade	CNO + CQO + VP PC	Annually	50%	-	-11%	-	-

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1. Unique primary care patients seen in last 12 months: Even though the measure is trending down from the prior period, we are still in a positon to meet our target, which is why this measure is still yellow.
2. Number of E-consults completed/quarter: E-consults are already above the target for the quarter and trending up significantly. We were at 5,000 E-consults for the prior year and over 12,000 last quarter. E-consult is a great access to care measure, especially for specialty care.
3. Patient Care Revenue/Expenses: Moving in the right direction. Insurance applications submitted per quarter as discussed is red, but will be green at the next report.
4. # Insurance applications submitted/quarter: We are still a little below our target of 23,710, but the number trended up significantly from the prior month and prior quarter. October was the first month that we ever exceeded our target.
5. % of MetroPlus medical spend at Health + Hospitals: Is ticking up slightly, but is still well below target and is red. Our investments in new clinical services, partnership with Dr. Long's team on how we assign MetroPlus members into our primary care practices will continue to have a good impact.

   Mr. Campbell expressed concern not only looking at the prior period, but a year ago, essentially exactly at where we are. Mr. Siegler clarified for Dr. Katz that the one difference is that .8 percent is about a $50 million difference. It is a large delta. The overall growth in MetroPlus membership is business, which means that .8 is $50 million.

   Dr. Katz asked what determines the width of the MetroPlus network. Are there steps that MetroPlus could take to say that these providers are not actually as good as Health + Hospitals (and so we are going to narrow our network because we have not gotten great service from these individuals, and we have Health + Hospitals prepared to do it)? How would a narrowing happen? Mr. Siegler answered that a narrowing would happen through their regular provider contracting. It is to be noted that MetroPlus have multiple lines of business, the largest of which is Medicaid, and they get to decide who is in and out-of-network. Mr. Siegler explained that, depending on the benefit of the Medicaid program, from an insurance network design perspective, a challenge is you have zero copays and coinsurance largely at most places a person goes. The ability to keep a provider in network or keep someone exclusively out-of-network and keep them from going to them is a little limited, because no matter where they go, there is no copay. He commented that a key way to do it that aligns with both state policy, our mission and MetroPlus' goals is to look at ways to use value-based payment and shared savings. The broader question is that their ability to limit the network is controlled only by state insurance law and people's ability to access the care they need. With a system the size of Health + Hospitals in their network, those general measures are usually met and others are just added depending on the market and product and attract more people into it all.

6. Total AR days per month (excluding in-house): See above
7. Epic Implementation milestones: It is the most important item on the Information technology agenda. A number of hospitals will be rolling out in March including the partnership of Woodhull, Elmhurst, Queens and Coney Island. We have already gone live with the new facilities that are going to be coming on.
8. ERP milestones: Payroll and other internal processing IT project are making progress.

Mr. Siegler turned his presentation over to Dr. Eric Wei, Chief Quality Officer, to talk about the Quality and Outcomes, Care Experience and Culture of Safety measures.

Dr. Wei reported on:

9. Sepsis 3-hour bundle (2Q18): This is the highest we have ever been, 72.6% for the second quarter. This is above the New York State average and a jump of 6.6% from prior period. It is green.
10. Follow-up appointment kept within 30 days after behavioral health discharge: 59.6% for this quarter. It remains red because it is outside of the 5% variance, but is trending up from 57.8 to 59.6%.
11. HgbA1c control < 8: Increased from 63.5 to 64.1%. It is yellow because it is 2.5% below our goal. Dr. Theodore Long, and Dr. Dave Chokshi, Vice Presidents, are working hard making diabetes care one of our key priorities. Dr. Wei highlighted that Clinical Pharmacists in ambulatory care will be able to provide the teaching and the reinforcement of why it's important to take your medications.
12. % Left Without Being Seen in the ED: This metric is red and is at 8.67%. It needs some work as noted above.
13. Inpatient care – overall rating (Top Box): 62% remains the same as prior period. However, our initial results for quarter four are seeing a nice jump due to its correlation to I-CARE training. Some of our facilities that have not traditionally done so well have been improved and are now ranked in the top three after training 70% of their staff on I-CARE values.
14. Ambulatory care (medical practice) Recommend Provider Office (Top Box): Scores 9 and 10. 81.2%, .9 percent decrease due to common cause variation is still on the yellow range and is still within 5% of our goal.
15. Post-acute care – likelihood to recommend (mean) [2016]: 85.3% last period, now 87.1%, which is well above our goal of 84.3%.

Dr. Katz shared with the Committee an interesting comment from an endocrinologist at Coney Island who has been receiving E-consults from general practitioners for diabetes from the system stating, "Please see patient hemoglobin A1C10, patient noncompliant with medicines." Dr. Katz explained that if you are noncompliant, you don't need to see the endocrinologist because the only people who need to see the endocrinologist are the ones who are taking their medicines and are still not controllable. If the doctor already knows that the patient is not compliant, something needs to be done, other than a referral to the endocrinologist. Perhaps what these patients need are health coaches, not necessarily at the RN level, to help them figure out how to live their lives. So maybe that's something in the next discussion of how we address this issue. Even though it is green, we still want it to be much higher than even our goal. Something more needs to be done around diabetic coaches to prevent people from sending the noncompliant patients to the endocrinologist, which is a terrible use of our resources. The endocrinologist should see the difficult-to-treat patients, not the noncompliant patients. These patients need the right resources, not necessarily more doctors because if you are not compliant with your medicines, more doctors is not a very sensible answer.

16-18.:

These Culture of Safety measures are once a year metrics. The full HRQ survey is planned for later next year in 2019. That includes the question, "give your unit and workplace an

overall safety grade." It will be put out as one question in early 2019, so we know how we are doing in that area. The percentage we are looking for is the percentage of people who rate us A's and B's.

Mr. Campbell asked if the one question will be some sort of sampling. Dr. Wei answered that it will be a one question survey and the answers will be sorted by categories such as nurses, PAs, etc.

At the request of Mr. Campbell, Dr. Wei invited Jeremy Segall, Senior Director, System Performance Improvement, to give a brief overview of what our new facility driven performance model will be. That is not the universal performance improvement process across our System, but what's going to replace our QAC for quarterly PI projects.

Mr. Segall greeted Committee members and invited guests. He stated that performance improvement cannot be conducted from Central Office, but at the facility level working with staff and allowing the facilities to realize that they have a voice. To empower facilities to join in on our strategic initiatives of moving the System towards improvement in all of the five pillars, this seven-step model listed below is adopted:

1. Enterprise-Wide meaningful measure selection
2. Choose high-priority facility-based quality initiatives of value
3. Director of PI from Central Office assigned to collaborate with each facility
4. Choose Pilot Units and teams; determine current & target states
5. Gap analyses, action plans, experiment & dashboards
6. Realize success: sustain & spread
7. Align in common direction; share best practices & learning lessons across System

Mr. Segall gave an overview of the new performance improvement model and shared with the Committee how it is going to roll out. He reported that there were over 162 global measures from regulatory and accreditation to DSRIP dashboard to population health metrics as well as facility input on what they wanted to track to meet Joint Commission regulatory requirements. With the support of the facilities as well as senior leadership here at Central Office, the 162 measures were cut down to 62. Those measures were later truncated down to an even lower number of 20; i.e., 10 inpatient care and 10 ambulatory care measures. With the help of Directors of Improvement assigned to all 11 acute care hospitals, facilities are now able to partner with Central Office and work with those clinics as well to select one project per quarter that aligns with the System's five strategic pillars (Quality & Outcomes, Care Experience, Financial Sustainability, Access to Care and Culture of Safety). From each quarter they have an option of selecting one out of four projects they will spearhead, and the Directors of Performance Improvement will work at the bedside with the direct patient care staff, local leaders as well as managers to start to do true tests of change per quarter, which will be reported to the governing body at the Quality Assurance Performance Improvement Board Report meeting. The idea is to learn from each other, help the low performers increase and improve over time and support sustainment for the top performers.

Mr. Campbell commented that, John Ulberg and his team reported that there were about 65 ongoing efforts to support the financial sustainability pillar. He is concerned about how can we be aligned with different approaches. In other words, is there some symmetry that can be created since

everyone is working on achieving the same objective? Mr. Campbell recommended that there should be some sort of discussion in terms of the approach.

Dr. Wei commented that he and Mr. Ulberg had a great meeting last week about how to join the financial work plan process with this overall strategic planning of performance improvement. There are synergistic ways of speaking to each other as they are interrelated and towards achieving the same goals.

Mr. Campbell recommended to have a team or two from the facilities to come and present to the Board not only to showcase what they are doing, but also to give the Board an opportunity to thank them for their good work.

Mr. Segall reported on the three hour sepsis bundle for the second quarter of 2018. He stated that Sepsis 3-Hour Bundle compliance is one of the main improvements for our System. He added that it is a constant moving target and noted that the care we deliver to our patients surrounding sepsis is incredible. He shared with the Committee that sometimes really ensuring that the measure is allowing the transparency to meet where we are actually improving on care can be a challenge.

Mr. Segall informed the Committee that the Sepsis 3-Hour Bundle has been selected as one of the value based purchasing quality improvement program metrics. He reported that the System has earned $180 million due to value based purchase quality improvement program. He explained that the way Sepsis works is that you have to increase or improve every quarter four measures out of six to attain 100 percent incentivized repayment opportunities. He added that the metric definitions changed in the first quarter of 2017; and since those changes, this is the highest compliance rate we have had to date at 72.6 percent. He noted that, the System continues to perform better than the New York State average every quarter and has done so since 2016.

Mr. Segall reported that three facilities, Lincoln, Queens and Bellevue showed dramatic improvement from last quarter ranging from 8.2 to 12.6 percent with overall three hour bundle compliance due to:

- Modified screening processes (i.e. – SIRS, qSOFA)
- Point of Care Lactate
- Enhanced role definition of identifying Sepsis champions from both physician and nursing departments
- EMR enhancements (i.e. – ordering of labs, general order sets, reminders of the sepsis protocol BCx prior to Abx, clinical decision making IT logic to nudge providers to think sepsis and answer specific questions, streamlining to support clinical flow that manages documentation better to meet the measure marks, etc.)
- Education programs that now target residents more robustly
- Provider drill-downs after cases are abstracted to target individualized education surrounding performance
- Improved transparency of facility-specific sepsis compliance in Quality forums

Mr. Segall reported that we currently have four facilities on Epic, the rest on Quadrimed which has been a challenge to roll out new improvements both with the support of Dr. Wei as well as Kevin Lynch. The Sepsis 3-Hour Bundle work that was piloted in the Bellevue environment was deployed; and, as of this Monday, it will be going live to the rest of the Quadrimed sites. Improvements are

also being made on Epic on the in-patient side and it is hopeful that Bellevue and Harlem will be enrolled in Epic shortly.

Mr. Segall reported on individual sepsis interventions within the 3-Hour Bundle:

1. Timely Lactate: +0.4% (93.9% to 94.3%)
   Mr. Segall reported that there were improvements on timing lactate and continue to do so steadily. He noted that we have increased every quarter since the first quarter of 2017 and are at the highest compliance rate at 94.3 percent. Mr. Segall applauded those facilities that have improved in this bundle component ranging from 6 to 10.6%: Woodhull, Harlem and Coney Island.

2. Timely Blood Cultures Prior to Antibiotics: -1.3% (84.8% to 83.5%)
   The timely Blood Cultures Prior to Antibiotics have been a challenge. Although there was a slight decrease for the current quarter, the rate has improved by 8.5 percent since the first quarter of 2017. Two facilities were able to increase their rates: Lincoln by double digits, by 13.4 percent and Metropolitan by 9.5 percent.

3. Timely broad spectrum antibiotics,< 3 hours: +1.9% (89% to 90.9%)
   This bundle component has been a challenge in the past. However, improvements are continuously being made. For the current quarter, the rate has seen an increase of two percent, and this is also its all-time high reaching above 90 percent. Two facilities have made drastic improvements: Kings County, by double digits, by 11.8 percent increases, and Elmhurst 8.2 percent. Other facility improvements are worth noting and are included in the slide. Some of them are due to enhanced communication amongst provider and the care team.

4. Other facility improvements that have helped bundle compliance include:
   - Sepsis Screening Tools to be used by bedside staff and at triage to monitor vitals, etc. to escalate to the appropriate providers
   - Lactic Acid and ED White Board alerts, larger Suspected Sepsis visualization on the cue
   - Sepsis Review Committees and as close to real-time/concurrent feedback

Mr. Segall concluded his presentation stating that future steps include: looking at the Coding Academy to ensure that we are capturing sepsis to the best of our abilities; conducting EMR teach back in-person meeting with multiple stakeholders, so that people understand the new modifications to the System; and starting looking at standardized QA tools and data and collection reporting streamlining because at times identification monitoring and reporting does vary from site to site.

Mr. Campbell asked if we have any sense of how Health + Hospitals fare among city hospitals in the City. Mr. Segall answered as a System we are performing at or about the same as some of the other systems in New York State. He informed the Committee that Bellevue is often invited to speak at Greater New York Hospital Association panels because compared to some of the other systems, public and private, we continue to perform well on some of the 3-hour bundle component elements. He noted, however, that New York City is one of the lower performers across the nation.

Dr. Wei explained that we are at about 66. It is hopeful that we would hold our gains and move to 70. Mr. Campbell commented that this work is in progress but definitely directionally heading in the right direction.

Mr. Campbell thanked Mr. Segall for his presentation.

Dr. Wei reported on the % Left Without Being Seen in EDs metric. He stated that this is a metric with lots of opportunity for improvement. He clarified that this metric means that people who are choosing to come to our hospital, checking into our emergency departments, wanting to receive care were unable to be seen by a provider for a number of reasons. Dr. Wei reported that the slight increase is due to common cause variation. Please note that the "Left without being seen" metric is affected by multiple factors that are being addressed as noted below:

1. ED nurse staffing: working towards getting to a safe minimum staffing model in the Emergency departments.
2. ED provider staffing: doing analysis on matching provider staffing to patient arrivals.
3. Dwell time: patient is admitted but there's no room for them in the hospital so they take up precious space, beds in the emergency department so there's no room to see new patients.
4. Turnaround time: data needed to make a decision about whether a patient stays, goes home or gets transferred. Working on improving those turnaround times in order to make quicker decisions on dispositions.

Dr. Wei pointed out that currently this metric is set up by IT as a "catch all" bucket including:

1. Patients that do not meet that criteria of checking in before they see a provider and walk out.
2. Psychiatric ED patients. Almost all of the EDs have these patients looked at in our medical area first, to make sure there's no medical complaints or issues that need to be addressed in the adult ED before they go to psychiatric ED. But there is no disposition in Quadrimed that says transfer to the Psychiatric ED.
3. Patients transferred to Express Care.
4. Patients who for some reason were not checked out.

Dr. Wei informed the Committee that he is working with the IT team to more accurately reflect the "Left without being seen in EDs" population, which should favorably take off a few percentage points. Dr. Wei informed the Committee that he is doing a rotation working shifts one at a time at each of the eleven EDs. So far, he has done four and is currently at NYC Health + Hospitals/Metropolitan. His observation is that this is something that cannot be solved with one size fits all for our EDs. He recognized that silos within our EDs, and silos within our facilities are making it almost impossible to have meaningful improvement. Dr. Wei explained that because there was no true captain of the ship who is ultimately accountable or responsible for operations and for clinical outcomes in some of our EDs, the only way to get anything done was to go up the chain of command (to the CMO, CNO or COO). After a meeting with William Foley, Sr. Vice President, and his staff, a standard Table of Organization (TOO) was created naming the ED Medical Director or Service Chief that captain of the ship. A true Process Owner is created to help build the performance improvement team in each of the emergency departments to address their issues facing checking people in, and out, and any other relevant issues.

Dr. Wei acknowledged that there are lots of work to be done with this metric. The metric definition, as well as how the data is collected, needs to be fixed. Dr. Wei is gaining invaluable insights by actually working in these shifts and sharing the frustrations that the providers are feeling.

Besides the sample of suppositions collected, Mr. Campbell asked if we know the different hypotheses on why people are leaving. Dr. Wei answered that he will bring that issue to the ED Clinical Council to look for answers. He added that some facilities call back patients that they consider to be high risk. By adding a couple of questions to give them a script, they will be able to gather some information.

Mr. Robert Nolan, Board Member asked if we continue to lose nurses at an alarming rate. His concern is that it is a constant struggle since Health + Hospitals nurses' salaries are not comparable with some of the voluntary hospitals. He commented that Health + Hospitals brings on new nurses, trains them and later on lose them. Dr. Katz answered that it is an interesting challenge. He explained that contrary to Health + Hospitals, most systems pay differentials for nurses who work in specialized areas such as the ICU, ED and NICU. All Health + Hospitals nurses earn the same amount based on certification, and seniority but they do not earn pay differentials for those areas. Therefore, we fall very far behind in the market. Historically in our collaborative relationship with the Nurses' Union, they have not wanted to create differences between nurses. This is a challenge for Health + Hospitals because if we cannot afford to raise all of our nurses salaries (which include the skilled nursing facilities, where we have no issue at all recruiting nurses) to the pay rate of a nurse who is going to give oncologic agents (which is probably the single hardest thing a nurse has to do). Because of this challenge, nurses come to Health + Hospitals especially in the ED, ICU and NICU, only because we will train new grads, and then they leave because there's a huge differential between what we pay and what they could get elsewhere. While Health + Hospitals values all its nurses and appreciates the idea, there needs to be some way to retain our nurses with the understanding that we cannot pay them all at the highest rate. Until that issue is resolved, it will be very hard for Health + Hospitals to maintain all of its nurses.

Dr. Wei interjected that, because of the challenges outlined by Dr. Katz, there was a spiraling negative effect on nurses that were leaving at a faster rate. As the nurses in the Union or departments were leaving, the ones left were covering more and more of the workload and were also going out. According to the latest data, we lost 4% of them as consistent retirements and another 10% through attrition across the System. Dr. Wei reported that a year ago today, 330 new nurses were recruited. It is hopeful that, as we are getting closer to safe minimum staffing, less nurses are choosing to leave because of the work conditions, and the negative culture of the environment. Dr. Wei stated that we are heading in the right direction. He told the Board that he would invite Ms. Mary Ann Marra, Chief Nursing Officer, to bring an update with exact data on that issue.

Mr. Campbell commented that this issue always comes up at every single Annual Public Meeting. He then thanked the dashboard team for not only the Board's but also upper and middle management's edification on the System dashboard and urged them to keep up with the good work.

ADJOURNMENT

There being no further business, the meeting was adjourned at 2:07 PM.

Strategic Planning Committee Update and System Dashboard

Matt Siegler
SVP Managed Care and Patient Growth

Dr. Eric Wei
Chief Quality Officer

Strategic Planning Committee
March 19, 2018

NYC HEALTH+ HOSPITALS

Agenda

- Public Policy Update
- Discussion of Q2 FY 2019 Performance
- Glossary + Dashboard
- Discussion of Selected Measures
  - % of Metroplus spend at H+H
  - # insurance applications submitted/quarter

NYC HEALTH+ HOSPITALS

Public Policy Update

- State Budget including Governor's 30 day amendments:
  - Eliminates the planned increase in Medicaid rates for hospitals (2.0%) and nursing homes (1.5%)
  - Reduces Medicaid rates across the board to achieve $190.2M in state share savings for SFY19-20 and SFY20-21.
  - Does not address pending federal DSH cuts
    - Without a change to the current law, H+H will bear the initial brunt of any federal DSH cuts – at least the first $700 million and up to $870 million in the first year. Illustrative cuts to H+H facilities are below:

H+H impact in Brooklyn = $270 million (M)	H+H impact in Manhattan = $278 M	H+H impact in the Bronx = $192 M	H+H impact in Queens = $131 M
Kings County = $139 M	Bellevue = $139 M	Jacobi = $96 M	Queens = $70 M
Woodhull = $87 M	Harlem = $87 M	Lincoln = $61 M	Elmhurst = $61 M
Coney Island = $44 M	Metropolitan = $35 M	North Central Bronx = $35 M	
	Carter = $17 M		

  - Includes a cut to "Big 7" downstate hospitals Indigent Care Pool DSH funding
    - Does not eliminate "transition collar," address underlying challenge of low Medicaid rates, or address broader unfairness of well resourced hospitals state-wide receiving ICP funds
    - H+H continues to advocate for the community coalition ICP proposal
  - Changes Nursing Home Case Mix, adjusting Medicaid rates based on acuity
    - Gross provider impact of $246 million in all funds
    - Estimate the H+H impact of this proposal to be between $5-10 million
  - Safety Net Funding
    - Proposes $50 million for safety net providers; prior year funding has still not been released
  - Community Health Centers
    - Funds the FQHC safety net rate

NYC HEALTH+ HOSPITALS

State Advocacy

- H+H executive leadership, CEOs, Community Advisory Board Members, Labor Partners and Community Advocates are focused on several key messages to legislators:
  - Reject Medicaid cuts.
  - Add language to the budget protecting H+H from federal DSH cuts by making H+H the same as other major public hospitals.
  - Add language to the budget that ensures that ICP funding goes to hospitals providing care to those who are uninsured or Medicaid enrollees.
  - Reject the proposed Nursing Home cut.
  - Increase safety net funding and release prior year funding.
  - Increase funding for community health centers.

- UPDATE as of March 14th
  - Both the Assembly and Senate have rejected the Governor's key health proposals
  - The Governor has indicated he will not pursue these health cuts and policy changes and will seek savings elsewhere in the budget
  - Health + Hospitals continues to advocate for our proposals to fairly distribute DSH funding and protect safety net institutions should the federal DSH cuts occur

Q2 Fiscal Year 2019 Performance

- Select positive trending measures:
  - Econsult: live in over 100 clinics at all acute facilities; accelerating roll out in the Bronx pre NYC Care
  - Insurance Applications per Quarter: (see slide 8)
  - Post acute care patient experience: started a patient experience council, launched happy or not meters, focused on meals and their PFAC
  - HgbA1c control < 8: large improvement due to system wide performance improvement project on key measure of diabetes care. Improved performance was a major contributor to $30m VBP QIP revenue

- Select negative trending measures:
  - AR days per month and Patient Care Revenues/Expenses: EPIC go-live at Elmhurst, Queens, Woodhull and Coney resulted in backlog of claims and bills. Now nearly caught up and expect smoother process with future EPIC go lives
  - ERP milestones: Large scale payroll, finance and purchasing system redesign. Payroll launch postponed to allow new system to coincide with the new fiscal year.
  - % of Metroplus spend at H+H: (see slide 9)

- Other updates:
  - Primary care patients: aligning primary care data definitions across EPIC and legacy systems is posing challenges. Teams will work to address and include an updated number next quarter.

NYC HEALTH+ HOSPITALS

System Dashboard Glossary – March 2019
Reporting Period: Q2 FY2019 (Oct-Dec 2018)

Increase Primary Care		
1	Unique primary care patients seen in last 12 months	Measure of primary care growth and access; measures active patients only, N/A due to Epic data definition issue
Access to Care		
2	Number of e-consults completed/quarter	Top priority initiative and measure of specialty access
Financial Sustainability		
3	Patient Care Revenue/Expenses	Measures patient care revenue growth and expense reduction adjusting for changes in city/state/federal policy or other issues outside H+H management's control
4	# insurance applications submitted/month	Top priority initiative and measure of efforts to convert self-pay to insured
5	% of M+ medical spend at H+H	Global measure of M+ efforts to steer patient volume to H+H, removes pharmacy and non medical spend
6	Total AR days/month (excluding in-house)	Unity/Soarian. Total accounts receivable days, excluding days where patient remains admitted
Information Technology		
7	Epic implementation milestones	Reflects updated deployment schedule: Enterprise validation and build + four acute care + one ambulatory facility live; testing and training at two other acute care and two ambulatory facilities on track.
8	ERP on track	Reflects key milestones in finance/supply chain go live, human capital management upgrade, and payroll project design
Quality and Outcomes		
9	Sepsis 3-hour bundle	NYSDOH Quarterly Facility Sepsis Report-aggregated to reflect a system score
10	Follow-up appointment kept within 30 days after behavioral health discharge	Follow-up appointment kept with-in 30 days after behavioral health discharge.
11	HgbA1c control < 8	Population health measure for diabetes control
12	% Left Without Being Seen in EDs	Measure of ED efficiency and safety
Care Experience		
13	Inpatient care - overall rating (Top Box)	Aggregate system-wide Acute Care/Hospital score HCAHPS Rate the Hospital 0-10 (Top Box)
14	Ambulatory care (medical practice) - Recommend Provider Office (Top Box)	Aggregate system-wide Acute Care/Hospital score HCAHPS Rate the Hospital 0-10 (Top Box)
15	Post-acute care - likelihood to recommend (mean)	Press Ganey Survey. Likelihood to recommend (mean)
Culture of Safety		
16	Acute Care – Overall Safety Grade	Measure of patient safety, quality of care, and staff psychological safety
17	Post-Acute Care – Overall Safety Grade	Measure of patient safety, quality of care, and staff psychological safety
18	Ambulatory (D & TC) – Overall Safety Grade	Measure of patient safety, quality of care, and staff psychological safety

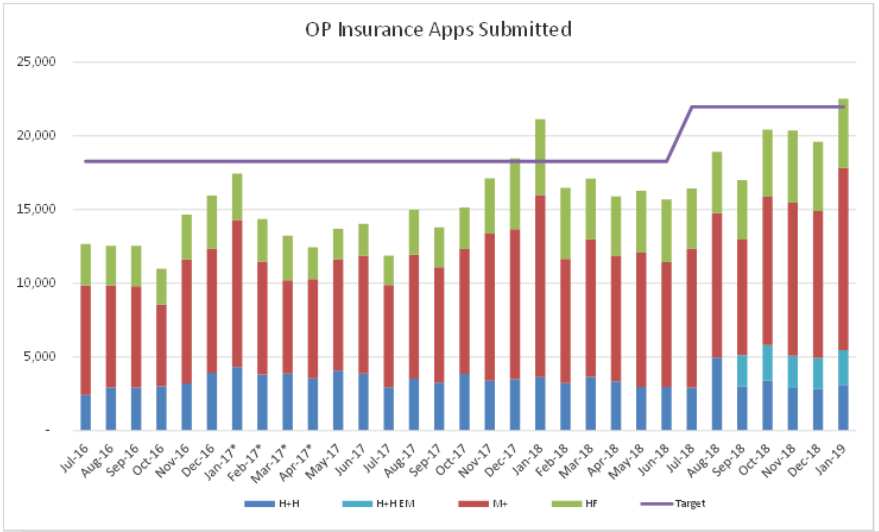
NYC HEALTH+ HOSPITALS

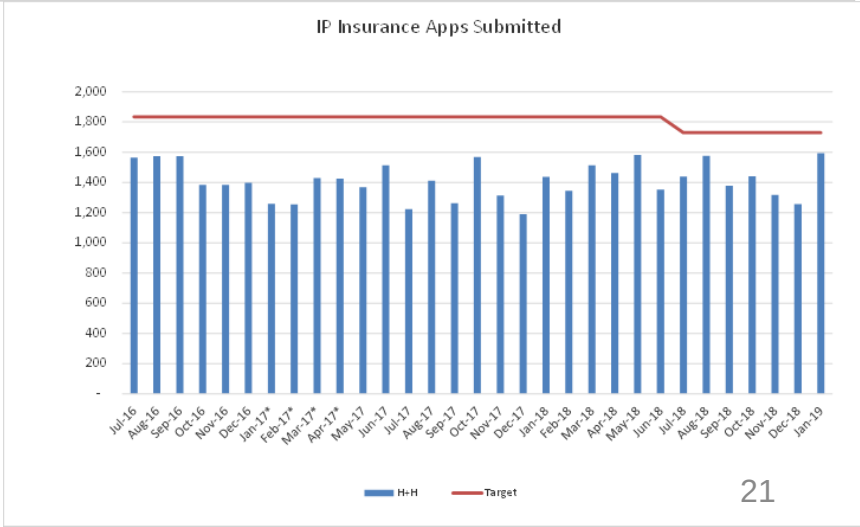
System Dashboard – March 2019
Reporting Period: Q2 FY2019 (Oct-Dec 2018)

		EXECUTIVE SPONSOR	REPORTING FREQUENCY	TARGET	ACTUAL FOR PERIOD	VARIANCE TO TARGET	PRIOR PERIOD	PRIOR YEAR SAME PERIOD
Increase Primary Care				FY 2019				
1	Unique primary care patients seen in last 12 months	VP PC	Annually	418,000	N/A	N/A	414,503	425,000
Access to Care								
2	Number of e-consults completed/quarter	CPHO	Quarterly	14,000	15,341	+9.58%	12,535	6,107
Financial Sustainability								
3	Patient Care Revenue/Expenses	CFO + SVP MC	Quarterly	60%	60.4%	+0.4%	61.5%	56.5%
4	# insurance applications submitted/quarter	CFO + SVP MC	Quarterly	23,710	20,871	-9%	18,923	19,664
5	% of M+ medical spend at H+H	SVP MC	Quarterly	45%	39.5%	-5.5%	39.9	37.7%
6	Total AR days per month (excluding in-house)	CFO	Quarterly	45	54.6	+9.6	43.8	47.0
Information Technology								
7	Epic implementation milestones	CIO	Quarterly	100%	100%	-	100	-
8	ERP milestones	CIO	Quarterly	100%	70%	-30%	85	-
Quality and Outcomes								
9	Sepsis 3-hour bundle (2Q18)	CMO + CQO	Quarterly	63.5%	69.7%	+6.2%	72.6%	65.4%
10	Follow-up appointment kept within 30 days after behavioral health discharge	CMO + CQO	Quarterly	66%	57.4	-8.6%	59.6%	58.6%
11	HgbA1c control < 8	CPHO + VP PC	Quarterly	66.6%	64.7%	1.9%	64.1	64.5%
12	% Left Without Being Seen in the ED	CMO + CQO	Quarterly	4%	7.5%	-3.5%	8.67	6.93%
Care Experience								
13	Inpatient care - overall rating (Top Box)	CNO + SVP AC	Quarterly	65.4%	62.0%	-3.4%	62.0%	61.0%
14	Ambulatory care (medical practice) Recommend Provider Office (Top Box)	CNO + SVP AC + VP PC	Quarterly	83.6%	81.3%	-2.3%	81.2%	82.1%
15	Post-acute care - likelihood to recommend (mean) [2016]	CNO + SVP PAC	Semi-Annually	84.3%	87.1%	+2.8%	87.1%	N/A
Culture of Safety								
16	Acute Care – Overall Safety Grade	CNO + CQO + SVP AC	Annually	76%	-	-14%	-	-
17	Post-Acute Care – Overall Safety Grade	CNO + CQO + SVP PAC	Annually	74%	-	-2%	-	-
18	Ambulatory (D&TC) – Overall Safety Grade	CNO + CQO + VP PC	Annually	50%	-	-11%	-	-

Insurance Applications per Quarter

- System performance continues to improve following new enrollment and Options policies launched in August 2018
- January performance (not reflected in dashboard) – represents first time we have exceeded our system-wide target of 22,000 outpatient applications per month
- Impatient performance remains good – earlier area of focus in revenue cycle effort
- Key areas for improvement: Outpatient financial counseling screening and documentation rates
  - Of the 18,200 patients with an uninsured outpatient visit in the past 30 days, 2,700 were referred to a Financial Counselor through a scheduled Financial Counseling appointment **(15%).** Our goal is 95%.
  - Of scheduled Financial Counseling appointments that were attended during the previous week, **27%** had a documented outcome/status recorded in our Financial systems. Our goal is 100%.
- Key initiatives:
  - Promoting enrollment/insurance verification prior to clinic visit (call center, EPIC my chart, state exchange)
  - Enhancing front end registration training and capability (insurance look up tools, insurance/managed care 101 training, EPIC roll out)





% of Metroplus Spend at H+H

- While measure remains below target, we have seen ~2% point improvement vs 2017, representing approximately $100m of new revenue
  - Previous quarterly updates included artificially inflated year end 2017 number. One time transfer of Metroplus reserves to H+H did not reflect true patient care revenue but was included.
- Key initiatives
  - PCP auto assignment changes (90% of unassigned new members now assigned to H+H; assignments to Gotham sites now included);
  - Rewards for new members keeping PCP visits
  - Changes to utilization management process
  - Completed and exploring new investments in high leakage services – eg: HIV, GI, Cardiology, Ophthalmology
  - Coming soon: new dashboard for facilities on Metroplus risk/revenue, improvements to referral processes/technology, new partnerships with community providers