STRATEGIC PLANNING COMMITTEE

OF THE BOARD OF DIRECTORS

July 16, 2020

Boardroom

125 Worth Street, Room 532 – VIRTUAL MEETING

10:00am

AGENDA

I.	Call to Order	Feniosky Peña-Mora
II.	Adoption of February 6, 2020 Strategic Planning Committee Meeting Minutes	Feniosky Peña-Mora
III.	Information Items a. Update and System Dashboard	 Matthew Siegler Senior Vice President Managed Care, Patient Growth, CEO One City Health & CEO ACO Dr. Eric Wei Senior Vice President Chief Quality Officer
IV.	Old Business	
V.	New Business	
VI.	Adjournment	Feniosky Peña-Mora

MINUTES
STRATEGIC PLANNING COMMITTEE MEETING
OF THE BOARD OF DIRECTORS
FEBRUARY 6, 2020

The meeting of the Strategic Planning Committee of the Board of Directors was held on February 6, 2020 in HHC's Board Room, which is located at 125 Worth Street with Dr. José Pagán, presiding as Chairman of the Board of Directors.

ATTENDEES

Committee Members
José Pagán, Chairman of the Board of Directors
Mitchell Katz, M.D.
Sally Hernandez-Piñero
Feniosky Peña-Mora
Freda Wang

Other Attendees
J. DeGeorge, Office of the State Comptroller
M. Dolan, Senior Assistant Director, DC 37

HHC Staff
M. Belizaire, Director, Government and Community Relations
D. Brown, Senior Vice President, Government and Regulatory Affairs
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
T. Long, Vice President, Office of the President
A. Marengo, Senior Vice President, Office of Communications
J. Morrison, Coordinating Manager, Office of the Chair, Board Affairs
K. Olson, Assistant Vice President, Revenue Budget
S. Ritzel, Associate Director, NYC Health + Hospitals/Kings
M. Siegler, Senior Vice President, Managed Care and Patient Growth
Y. Villanueva, Vice President, Human Resources
E. Wei, Vice President, Chief Quality Officer

CALL TO ORDER

Dr. José Pagán, Chairman of the Board of Directors, called the February 6th meeting of the Strategic Planning Committee (SPC) to order at 9:13 A.M.

Dr. Pagán turned the meeting over to Matt Siegler, Sr. Vice President, who presented the meeting's agenda as follows:

- Quarterly update through the end of calendar year 2019

- Quick public policy update (including state and federal government)
- Dashboard update (including positive trending measures and measures that are being tracked differently)

Policy Update

Ms. Deborah Brown, Senior Vice President, reported on two major issues:

1. On the federal level, requests are still being made for either a long standing or a permanent delay of the Disproportionate Share Hospital (DSH) fund cuts. Most recently, the delay on these cuts were extended until May 22nd. The two year extension was granted as a result of hard work and a few things happened in the 11th hour as they do. The question will be what vehicle those delays are joined to, whether it is something related to prescription billing, prescription drugs, or surprise billings. Ms. Brown stated that there continues to be strong bipartisan support for delaying the cuts, and again ideally for two years. We will continue to work with the Mayor's Office, the hospital trade associations to delay the cuts.

2. Ms. Brown reported that the state budget is a very fluid and significant situation. $4 billion of the State's $6 billion deficit are being attributed to Medicaid. They have thus far imposed a one percent across the board cut, for H+H this is $30 million. A new Medicaid Redesign Team (MRT), which was effectively used when facing a similar deficit in 2011, was announced, but has not yet convened. Health + Hospitals is closely working with members of the MRT, and its colleagues in the city with similar interests as well as other allies.

Dr. Wei stated that the second quarter of FY 20 October-December 2019 was a very good quarter in terms of movements in the right direction. He turned the presentation over to Matt Siegler, Senior

Vice President to report on the Access to Care metrics.

System Dashboard – February 2020
Reporting Period – *Q2 FY20 (Oct-Dec 2019)*

		EXECUTIVE SPONSOR	REPORTING FREQUENCY	TARGET	ACTUAL FOR PERIOD	VARIANCE TO TARGET	PRIOR PERIOD	PRIOR YEAR SAME PERIOD
Access to Care				FY 2019				
1	Unique primary care patients seen in last 12 months	VP AMB	Annually	418,000	N/A	N/A	N/A	425,000
2	Number of e-consults completed/quarter	VP AMB	Quarterly	46,000	51,379	+1.1%	46,393	15,341
3	NYC Care *(New as of Q1 FY20)*	VP AMB	Quarterly	10,000	11,000	+1,000	5,000	N/A
Financial Sustainability								
4	Patient Care Revenue/Expenses	CFO + SVP MC	Quarterly	60%	N/A	N/A	61.7%	59.2
5	# insurance applications submitted/quarter	CFO + SVP MC	Quarterly	25,250	20,887	-17%	19,814	21,483
6	% of M+ medical spend at H+H	SVP MC	Quarterly	45%	N/A	%	40%	37.4%
7	Total AR days per month (excluding in-house)	CFO	Quarterly	45	52.8	+7.8	54.0	54.2
Information Technology								
8	Epic implementation milestones	CIO	Quarterly	100%	100%	-	100%	-
9	ERP milestones	CIO	Quarterly	100%	75%	-25%	80%	-
Quality and Outcomes								
10	Sepsis 3-hour bundle	CMO + CQO	Quarterly	63.5%	66.8%	+3.3%	71.2%	70.0%
11	Follow-up appointment kept within 30 days after behavioral health discharge	CMO + CQO	Quarterly	66%	58.2% *preliminary	-7.8%	57.42%	53.6%
12	HgbA1c control < 8	CPHO + VP AMB	Quarterly	66.6%	67.2%	+0.6%	65.8	64.7%
13	% Left Without Being Seen in the ED	CMO + CQO	Quarterly	4%	6.56%	-3.83%	7.83%	8.66%
Care Experience								
14	Inpatient care - overall rating (Top Box)	CQO	Quarterly	65.4%	65.2%	-0.2%	62.6	62.0%
15	Ambulatory care (medical practice) Recommend Provider Office (Top Box)	CQO + VP AMB	Quarterly	83.6%	84.8%	+1.2%	82.3%	81.0%
16	Post-acute care - likelihood to recommend (mean) [2016]	CQO + SVP PAC	Semi-Annually	86.3%	86.7%	+0.4%	87.1%	80.7%
Culture of Safety								
17	Acute Care – Overall Safety Grade	CNO + CQO	Annually	76%	63%	-13%	62%	62%
18	Number of Good Catches/Near Misses *(New as of Q1 FY20)*	CNO + CQO	Quarterly	1000	543	-457	478	N/A

N/A = not available

25

Access to Care:

1. Unique primary care patients seen in last 12 months: Data not available. Will report back after transitioning to EPIC.
2. Number of E-consults completed/quarter: positive trending measure. The numbers surpass all of our goals. The goal for E-consult is to have every specialty referral in our system done through E-consult by the end of this calendar year. We are well on a trajectory to get there.

3. NYC Care (New as of Q1 FY20): positive trending measure. We are surpassing our targets. In the first six months of the Bronx launch we hit the goal of enrolling 10,000 patients into the program two months early. Currently, 13,000 patients are enrolled. All new patients have been offered an appointment within two weeks of when they called for an appointment. That's 50% better than the national average for private hospitals and private systems. Availability at our hospitals and clinics in the Bronx are being checked six times a day every day. Twenty-seven thousand visits were completed, and more than 20,000 medications have been filled and only in the expanded hours of the pharmacy. Pharmacies in all hospitals on weekdays are open until 9:00 pm and 24/7 overnight access in Brooklyn and Staten Island for those that really cannot get their medications because of their job schedules. Ms. Sally Hernandez-Piñero, Board Member, commented that it is worth mentioning that the hospitals scores as reported by Press Ganey for time taken for the initial visit have just been going up and up. Ms. Hernandez-Piñero asked if we are keeping track of the initial contact to appointment time. Matt answered that, while it has not been on the board deck, the next available appointment for primary care is tracked across multiple specialties across the system. It is also on

the population health dashboard and on the Mayor's national report. Mr. Siegler reiterated that Ted and his team checks on the NYC care six times a day for all patients, MetroPlus and NYC Care. Health + Hospitals' new patient commitment is two weeks for everybody.

NYC Care went live last week in Brooklyn and Staten Island. The goal is to enroll 15,000 patients in the first six months.

Dr. Wei invited Matt Siegler to report on the next pillar.

Financial Sustainability

4. Patient Care Revenue/Expenses: data not available until next quarter.
5. # Insurance applications submitted/quarter: increased dramatically over the 2018 year and into the middle of 2019. Now that we are all on EPIC, the focus is on what needs to be done to really multiply the number of applications our staff can process in a day using the core workflow technology changes we have. We staffed up dramatically in the number of Health Careers Information System (HCIS), to provide financial counseling to applicants. We have hit the maximum the physical space of our clinics and others can handle with people physically processing in-person applications. Efforts are being made to do much more of the processing in advance on the phone and to help people with MyChart to make it a more seamless process. It is still a big increase over about a year or year and a half ago, but leveled out roughly. Dr. Pagán asked why the target was set so high; and also, given that space was mentioned, was it an issue of not enough space? Mr. Siegler answered that the target was set high in part because MetroPlus did a number of these applications and the percentage of people in MetroPlus thought they were actually eligible for MetroPlus versus redirected to HHC options, now NYC care. Not only it was different but also it was a lower eligibility for insurance than expected. The processing time per application hit about a ceiling of what can be done as people were transitioning to EPIC. Now that we are all on one platform, we have an opportunity to move a lot of this outside of the clinic walls, get things processed ahead of time, and then have people finish an application right before appointment or do everything in advance, which will dramatically speed up the clinic throughput. Retention is also an issue. MetroPlus is having a tough time with retention. The numbers are really declining. The broadest reason everyone gives is because a lot of people are getting off Medicaid because of the $15 minimum hourly wage rate. Besides, the uninsured rate in New York State and New York City is the lowest it has ever been. There may just be a more limited amount of people who are actually eligible to enroll in coverage or have the coverage they need.
6. % of M+ medical spend at H + H: Data is not available until next quarter. MetroPlus' year-end close takes a little longer to pull together for this report.
7. Total AR days per month (excluding in-house): 52.8. This metric is above the target of 45. This is a measure of the speed of our billing operation. Improvement is made year over year. The reason still being on target as these numbers spike a little bit every time they go live and then catch up quite quickly.

Dr. Wei reported on the Information Technology Pillar.

Information Technology

8. EPIC implementation milestones: 100%. On track. One of the biggest successes up to this point. Kudos to Kevin Lynch, Senior Vice President, Kim Mendez, Chief Health Informatics Officer and the entire IT team. After the go-live EPIC at Kings County on December 6, 2019, Henry Carter LTACH long-term acute hospitals will be last to implement EPIC. Subsequently, this metric will be removed from the Dashboard as a successful retired metric. Replacement metrics in this category are being

sought to show how the power of EPIC is being utilized and how that big investment in EPIC is paying off in terms of financial, operational and clinical improvements.

9. ERP milestones: 75%. On track. The metric went down from 80% due to the delay of the electronic time capture program, which will replace the triplicate time cards that are manually filled and sent to HR. The Electronic Time Capture program will kick off late this summer or early fall.

Quality and Outcomes

10. Sepsis 3-hour bundle: slipped from 71.2% to 66.8%, but is still well above the New York State benchmark of 63.5%.
11. Follow-up appointments kept within 30 days after behavioral health discharge: increased from previous quarter of 54.7% to 58.2%. Compared to the prior period, last year same quarter, above 5% increase. Dr. Katz commented that he discussed with Dr. Charles Barron, Deputy Chief, MPA, Behavioral Health Administration, that he does not like having measures where we do not have a new plan because the same plan will give the same results. The one possible plan that generally works would be to give incentives to clients for coming, like a $10 Target card that they could use to buy food or toilet paper. This approach that has been used by MetroPlus all the times is seen as being coercive by the State. The bottom line is unless we start doing something different, the outcome is not going to change. We give people the appointment, we arrange things and they will not show up.

    Dr. Wei explained that these two measures (#10 & #11) which were inherited from the prior dashboard were selected because of their prominence on the BBP program from which Health + Hospitals receives $30 million per quarter incentivized around six metrics. While we still have more checks to collect, that program's measurement period is over and we hit all $600 million that were available in the program. These two measures should retire.

12. HgbA1c control < 8: 67.2% for this quarter, up from 65.8%. It is the highest the A1c control has ever been in our system. One of the different approaches attributed to that success is the introduction of clinical pharmacists in 10 of our clinics. 85% of the diabetic patients who have seen clinical pharmacists have had an improvement in A1c with an improvement of 1.5%. Another different approach, explained Dr. Machelle Allen, Senior Vice President, Medical & Professional Affairs, is the point of care testing. A huge investment with significant operating costs was made in the laboratories for the point of care testing to speed up the results of the hemoglobin A1c from the lab. Dr. Katz added that the point of care testing is as helpful as it eliminates the possibility of having a lag between the appointment and when the patients can come back to change their medicine or their regimen if the A1c is too high. He commented that Matt worries about this because some of the contracts do not pay for point of care testing as it is viewed as part of the clinic visit. Contrary to other systems, Health + Hospitals have always made things convenient for its patients, which is wonderful; however we do not get reimbursed. Ms. Hernandez-Pinero asked if there is openness from the insurers to change the contracts to reflect how we do our billing. Mr. Siegler answered that there is no openness. Generally, if they like the deals they have and can keep them in place, they will. Health + Hospitals had renegotiated the major contracts and have unbundled many of these services, i.e., doctors, tests, imaging or set ourselves on a path. Health plans get nervous about unbundling, which is the biggest single expense. For most of these contracts a phased approach will be used whereas we would get a small increase in the global rate, and then unbundle this and that. Mr. Feniosky Peña-Mora, Board Member, asked if there are at least data that shows how much we are short and do we look at the data and analyze how much it is now costing us if we were to de-bundle? Matt answered that they are in the middle of a contract by contract renegotiation, Emblem being the current one with a lot of bundled rates. Mr. Peña-Mora, also asked if there is a way for other hospitals

to join together not to consolidate, but to get comparatives for negotiating rates, as the farmers have done, and if that is illegal. Matt answered that Health + Hospitals is much bigger than we give ourselves credit for and that major negotiations on some of the contracts were accomplished with threats and by coming very close to bring ourselves out of network.

13. % Left Without Being Seen in the ED: 2.1% down from the same quarter a year prior. While still not at our 4% goal yet, about half of our EDs are currently doing some form of provider triage, which allows a patient to see a doctor upfront right after triage.

Care Experience

14. Inpatient care –overall rating: 65.2%, close to the target of 65.4%. Similar to the hemoglobin A1c, the in-patient care box rating is the highest it has ever been for Health and Hospitals as a system.
15. Ambulatory Care (medical practice) Recommend Provider Office: 84.8%. It exceeds the target of 83.6%. Kudos to Ted Long and his team.
16. Post-acute care – likelihood to recommend (mean) {2016}: metric slipped a little bit from 87.1% to 86.7%, but still above the target of 86.3%.

Culture of Safety

17. Acute Care – Overall Safety Grade: data for the Agency for Healthcare Research and Quality (AHRQ) vision safety culture survey finally available after two years. The last question on that survey is: "please give your work area or unit an overall safety grade," where only A's and B's count as excellent or very good. The good news is that this metric went up even if it is only by one percent: 63%. While we went up on teamwork and communication within units, we fell down, bottom one percent in staffing and non-punitive response to error. The patient safety group is taking that to heart and working on corrective action such as restoring psychological safety and shared learning. Dr. Katz asked Dr. Wei to expand and formulate what is actually being asked on the two questions that we are not doing well. Dr. Wei paraphrased the question as follows: a) Do you have enough staff to safely provide services? b) When an error happens, is the individual blamed?
    a. NYSNA negotiations were just completed; bodies are not in the units yet. Safe minimum staffing is necessary to improve the culture of safety. We are now have nursing staffing models and, thanks to the work of Dr. Allen and Deborah Brown on the affiliate contract negotiations, we are working on the provider ones.
    b. Part of this is that we have just culture and our just culture algorithm is an algorithm people treat after the fact. At the request of Freda Wang, Board Member, Dr. Wei explained that the just culture algorithm is a risk management HR compliance kind of collaboration. The idea is, a punitive culture is on one extreme. Just culture is the idea that you have accountability to your own personal actions based off your training, your role and the decisions you make; but you cannot be blamed for where the system falls. Just culture algorithm is an algorithm to help you think through in a fair way your response based off of the responsibility you are attributing to the person rather than just how this manager or supervisor feels. Dr. Wei hypothetically brought up the example of a nurse working in an unsafe setting and covering too many patients. Medicines that look alike and sound alike are stocked right next to each other, can we really blame that nurse if she accidentally grabs the wrong medication in a hurry if she is covering more patients than we consider safe? As such, the system should be examined first during a root cause analysis. After developing a timeline with all the facts of the events, highlight which of those are system issues and which of those were people. People issues are referred out to peer review for physicians, or nurse peer review to HR; and that is where the just culture piece comes in. For the system issues, find the corrective actions to close those gaps so the system does not allow this error to keep happening. Dr. Wei informed the Committee that the Institute for Healthcare

Improvement (IHI) recently came out with an interesting new approach to the just culture algorithm that is supported by both Natalia Cineas, our Chief Nurse Officer and himself. It first asks a lot of questions about the patient and family, the staff and the system gaps before putting the person through the just culture algorithm.

Dr. Wei shared with the Committee the following valuable resources that are available to restore psychological safety: 1) Helping Healers Heal Program. There currently are 18 helping healers heal teams across our system and over a thousand peer support champions. 2) Joy in Work initiative. The goal is to reconnect our staff back to the "why they went into healthcare." 3) Leverage the Arts in Medicine: to improve staff wellness and engagement as well as our patient experience. Well engaged happy staff are going to take better care of patients, provide higher quality and safer patient care. 4) ICARE values: engrain just culture in all aspects of our work. As a way of holding people accountable to the ICARE values, some form of professional advocacy will be rolled out this year.

Dr. Wei reviewed a grid that shows some of our patient safety counsel and system wide patient safety efforts. He highlighted debriefing as a major initiative as part of the patient safety counsel. Oftentimes, debriefing is given a bad name as it is only used when somebody is in trouble. Yet, even if things in our minds go perfect, there's value to debrief and say why they went so perfectly; can we hard wire those options the team took so we do it the same way next time and what can we do differently if things weren't perfect.

Mr. Peña-Mora asked Dr. Wei the following question: "Considering that other hospitals are also making implementations in different areas, are there local chapters in which the people working in similar areas that meet quarterly or biannually to discuss ideas and see if there are best practices across, even though they may have different environment contexts and you have different constraints?" Dr. Wei answered that he has cell phone numbers and email addresses of all the Chief quality officers of all our sister systems. Intensive retreats with all day long lectures are conducted twice a year locally. Last December, they all attended a national meeting at the Institute for Healthcare Improvement and at that meeting, they talked about standardizing hospital alert codes. Hospital codes are not yet synchronized within Health and Hospitals, but a proposal is on the way.

18. Number of Good Catches (New as of Q1 FY20): 543 across the system. It is the number of catches and near misses. The set goal is 1,000 per quarter. In July 2019, the implementation of electronic incident reporting system was launched and it lowered the barrier for staff to speak up. Mr. Peña-Mora asked how the 1,000 number was picked. Dr. Wei answered that even though it sounded like a very ambitious number, it is accomplishable. The current paper form to report an adverse event is replaced by an electronic incident reporting system linked directly from EPIC, which will lower the barrier for staff to speak up. Dr. Wei announced the creation of an insider, the e-newsletter series of good catches. On a monthly basis, a staff member, who did something amazing above and beyond to protect a patient, will be highlighted in the newsletter. Mr. Peña-Mora raised concerns about putting a number on this measure as it may incentivize behavior that is not necessarily positive. Dr. Wei answered that there are lot and lots of things that are happening well over 1,000 a quarter that could fall in this category. He reiterated that they are harm events and near misses, good catches. The goal is to be doing root cause analysis on near misses or good catches, where the event does not even happen to the patient. This is a measure not so much of you must hit a thousand but more of a measure for our staff feeling more psychological safety to raise their hand and let us know. It is more on the culture of safety, feeling safe enough to say there is a problem here.

ADOPTION OF THE MINUTES

Dr. Pagán noted that a quorum was established. The minutes of the May 16, 2019 and November 7, 2019 were adopted.

ADJOURNMENT

There being no further business, the meeting was adjourned at 10:05 AM.

NYC HEALTH+ HOSPITALS

Strategic Planning Committee Update

Matt Siegler
SVP MANAGED CARE AND PATIENT GROWTH

Dr. Eric Wei
SVP CHIEF QUALITY OFFICER

July 16, 2020

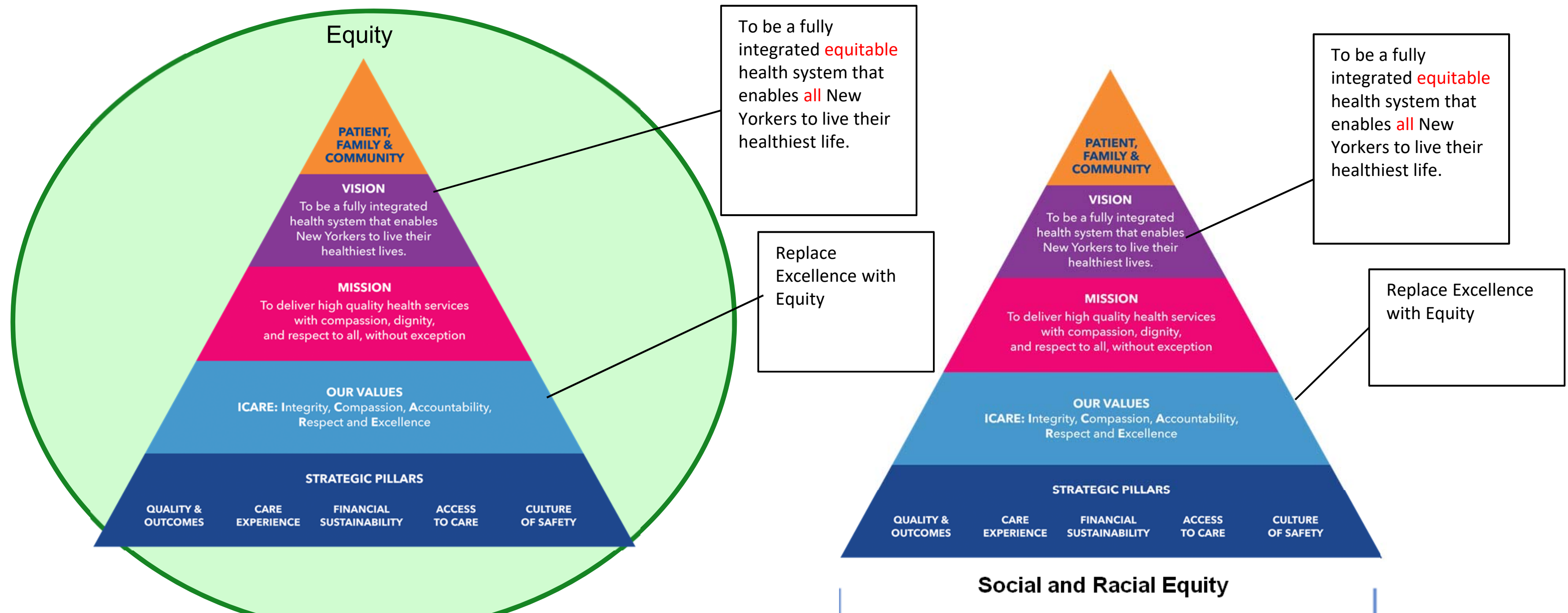
NYC HEALTH+ HOSPITALS

Q3 Performance and FY21 Strategy: COVID-19 Response and Resilience

- Q3 FY 2020 (Jan 1, 2020 – March 31, 2020) includes the pre-COVID surge preparation period and a portion of COVID surge period
- Decline in non-COVID volume, shift to telework, overall disruption of early COVID surge period has significant impact on key strategic measures
- Shifting utilization patterns, city and state budget challenges, and new operational priorities in pre-vaccine period will change FY 21 targets and priority measures
- The system's amazing response to the crisis – speed, ingenuity, and collaboration – help us set new, more ambitious goals in key areas

NYC H+H System-wide Strategy: Ongoing Commitment to Equity

- NYC Health + Hospitals ongoing effort to promote racial and social equity is fundamental to our organizations strategy
- The Board's recent creation of our Equity and Access Council is a key step in advancing this work
- We believe our amended strategic pyramid should also do so. Options for consideration below:



Full mission statement: To extend equally to all New Yorkers, regardless of their ability to pay, comprehensive health services of the highest quality in an atmosphere of humane care, dignity, and respect. To promote and protect as both innovator and advocate, the health, welfare, and safety of the people of the City of New York. To join with other health care workers and with communities in a partnership which will enable each of our institutions to promote and protect health in it is fullest sense – the total physical mental and social well-being of the people .

NYC H+H System-wide Financial Strategy: FY21

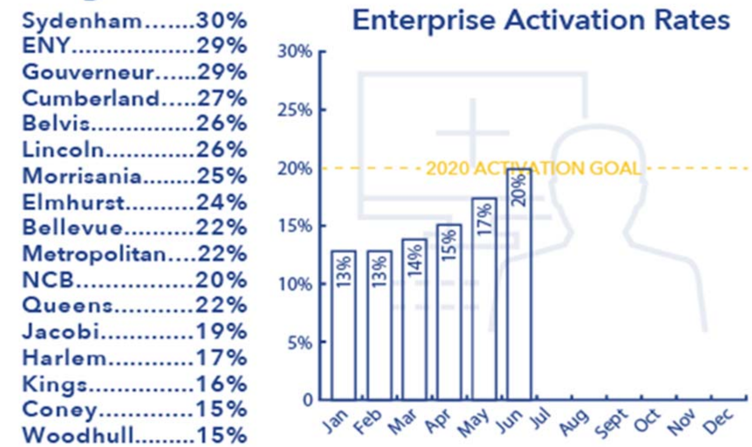
A more narrow, focused financial strategy for FY 21, in line with our broader strategy, will help us be resilient and respond to rapidly changing conditions

- Improve surgical efficiency and margin; grow surgical volume
- Design Ambulatory Care Model to account for telehealth and volume trends
- Create service partnerships across facilities and be great at the basics
- Succeed in Value Based Payment
  - Grow primary care patients (panel management, attribution/membership)
  - Keep specialty business in the system (e.g. cardiac surgery to Bellevue; SNF/LTACH partnership)
  - Hit managed care quality measures (patient experience, access, CRG, care gaps)
- Other Opportunities MRTII and special populations; new contracts and settlements with major payers; use of Test & Trace Corps as an opportunity to expand My Chart,

  reduce self-pay volume, and boost referrals

Q3 Performance: Positive Trends

- # of e-consults: **51,544** from 51,379 [1]
  - Moving to universal e-consult for internal referrals; overall system-wide focus on improving referral review, scheduling and follow up time
- NYC Care: **20,000** from 11,000 [1]
  - Launching city-wide in 2020
- Patient care revenue/expenses: **61.6%** from 60.8% [2]
- ERP milestones: **80%** from 75% [1]
- MyChart Activation
  - New measure on dashboard but already exceeded 2020 goal of 20% activation
  - Critical gateway to telemedicine as well as patient experience, scheduling and financial clearance improvements
  - MetroPlus members have an activation rate of 34% - significantly above H+H average.
  - More partnership with health plans on MyChart is under development.



[1] Change reflected from the prior period of Q2 FY20 (Oct-Dec 19).
[2] Change reflected from the prior year, same period (Q3 FY19—Jan-Mar 19).

NYC HEALTH+ HOSPITALS

Update – eConsult and Specialty Access

- eConsult utilization has grown dramatically:
  - **216** distinct subspecialty departments; 25% increase since Feb 2020
  - During COVID surge, % of referrals managed electronically increased from 12% (Feb) to 18% (April)
- First 6 months of 2020 show improved access, even with Covid disruption
  - Referral volume dropped 85% from 99,228 (Feb) to 14,064 (April); now back to ~58% of normal volume
  - eConsults allow for specialist engagement more rapidly than in person scheduling.
    - Referrals to eConsult clinics were reviewed by specialist within 4.7 days on average.
  - eConsults allow more patients to get specialty appointments - if necessary
    - Of referrals requiring a visit, 71% have been scheduled in eConsult clinics so far compared with 52% of referrals to non-eConsult clinics

Q3 Performance: Negative Trends

- # Insurance applications submitted: 18,146 from 20,887 [1]
- Total AR days per month: 68 from 52.8 [2]
- Sepsis 3-hour bundle: 65% from 66.8% [3]
- Follow-up appointment kept within 30 days after behavioral health discharge: 56.8% from 58.2%
- HgbA1c control <8: 66.1% from 67.2%
- % left without being seen: 7.84% from 6.56%
- Care Experience: Inpatient care – overall rating: 63.6% from 65.2

* Change reflected from the prior period of Q2 FY20 (Oct-Dec 19).
[1] *# of insurance applications submitted:* declined because starting in March, MetroPlus and Healthfirst staff stationed at H+H facilities enrolled patients remotely rather than in-person, resulting in the inability to quantify # of applications from March on.
[2] *Total AR days/month:* increased in Q3 due to decline in revenue beginning in March as a result of the COVID-19 pandemic. There also was a temporary impact on this metric because of the December Epic go-live.
[3] *Sepsis 3-hour bundle:* contains data only up until end of 2019; there have been postponements in State reporting of this metric due to the COVID-19 pandemic.

NYC HEALTH+ HOSPITALS

Q3 Performance: Steady Trends

- Care Experience: Ambulatory care recommend provider office: 84.5% (prior period, 84.8%)
- % MetroPlus medical spend at H+H: (39.2% vs 39.8%)

NYC HEALTH+ HOSPITALS

System Dashboard – July 2020

REPORTING PERIOD – Q3 FY20 (Jan 1st – March 31st | 2020)

		EXECUTIVE SPONSOR	REPORTING FREQUENCY	TARGET	ACTUAL FOR PERIOD	VARIANCE TO TARGET	PRIOR PERIOD	PRIOR YEAR SAME PERIOD
	ACCESS TO CARE							
1	Unique primary care patients seen in last 12 months	SVP AMB	Annually	418,000	N/A	_	_	_
2	Number of e-consults completed/quarter	SVP AMB	Quarterly	46,000	51,544	1.1%	51,379	21,907
3	NYC Care	SVP AMB	Quarterly	10,000	20,000	10,000	11,000	new
	FINANCIAL SUSTAINABILITY							
4	Patient care revenue/expenses	CFO + SVP MC	Quarterly	60%	61.60%	1.60%	_	60.80%
5	#Insurance applications submitted/quarter	CFO + SVP MC	Quarterly	22,242	18,146	-18.4%	20,887	20,666
6	% of M+ medical spend at H+H	SVP MC	Quarterly	45%	39.20%	-5.80%	_	40%
7	Total AR days per month (excluding in-house)	CFO	Quarterly	45	68	23	52.8	_
	INFORMATION TECHNOLOGY							
8	MyChart Activations	CQO + SVP AMB	Quarterly	30%	21%	new	new	new
9	ERP milestones	CIO	Quarterly	100%	80%	-20%	75.00%	80%
	QUALITY AND OUTCOMES							
10	Sepsis 3-hour bundle	CMO + CQO	Quarterly	63.50%	65%	1.50%	66.80%	70.90%
11	Follow-up appointment kept within 30 days after behavioral health discharge	CMO + CQO	Quarterly	66.00%	56.82%	-9.18%	58.20%	58.70%
12	HgbA1c control < 8	SVP AMB + CPHO	Quarterly	66.60%	66.10%	-0.50%	67.20%	63.70%
13	% Left without being seen in the ED	CMO + CQO	Quarterly	4.00%	7.84%	3.84%	6.56%	6.66%
	CARE EXPERIENCE							
14	Inpatient care - overall rating (top box)	CQO + CNO	Quarterly	65.40%	63.60%	-1.80%	65.20%	59.00%
15	Ambulatory care (medical practice) recommended provider office (top box)	CQO + SVP AMB	Quarterly	83.60%	84.50%	0.90%	84.80%	82.10%
16	Post acute care - likelihood to recommend (mean) [2016]	CQO + SVP PAC	Semi-Annually	86.30%	_	0.80%	86.70%	87.10%
	CULTURE OF SAFETY							
17	Acute care - overall safety grade	CQO + CNO	Annually	76%	64%	-12%	63%	N/A
	COVID-19							
18	COVID-19 Tests Administered	SVP AMB	Quarterly	undefined	14,415	new	new	new
19	COVID-19 Positive Tests	SVP AMB	Quarterly	undefined	8,426	new	new	new
20	Patients Tested for COVID -19	SVP AMB	Quarterly	undefined	13,542	new	new	new
21	Patients Positive for COVID -19	SVP AMB	Quarterly	undefined	8,085	new	new	new

NYC HEALTH+ HOSPITALS

System Dashboard Glossary

REPORTING PERIOD – Q3 FY20 (Jan 1st – March 31st | 2020)

	METRIC	DESCRIPTION
	ACCESS TO 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
2	Number of e-consults completed/quarter	Top priority initiative and measure of specialty access
3	NYC Care	Total enrollees in NYC Care program
	FINANCIAL SUSTAINABILITY	
4	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
5	#Insurance applications submitted/quarter	Top priority initiative and measure of efforts to convert self-pay to insured
6	% 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
7	Total AR days per month (excluding in-house)	Unity/Soarian. Total accounts receivable days, excluding days where patient remains admitted (lower is better)
	INFORMATION TECHNOLOGY	
8	MyChart Activations	Number of new patient activations in MyChart
9	ERP milestones	Reflects key milestones in finance/supply chain go live, human capital management upgrade, and payroll project design
	QUALITY AND OUTCOMES	
10	Sepsis 3-hour bundle	NYSDOH Quarterly Facility Sepsis Report-aggregated to reflect a system score; one quarter lag vs other measures
11	Follow-up appointment kept within 30 days after behavioral health discharge	Follow-up appointment kept with-in 30 days after behavioral health discharge.
12	HgbA1c control < 8	Population health measure for diabetes control
13	% Left without being seen in the ED	Measure of ED efficiency and safety
	CARE EXPERIENCE	
14	Inpatient care - overall rating (top box)	Aggregate system-wide Acute Care/Hospital score HCAHPS Rate the Hospital 0-10 (Top Box)
15	Ambulatory care (medical practice) recommended provider office (top box)	Aggregate system-wide Acute Care/Hospital score HCAHPS Rate the Hospital 0-10 (Top Box)
16	Post acute care - likelihood to recommend (mean) [2016]	Press Ganey Survey. Likelihood to recommend (mean)
	CULTURE OF SAFETY	
17	Acute care - overall safety grade	Measure of patient safety, quality of care, and staff psychological safety
	COVID-19	
18	COVID-19 Tests Administered	Total number of COVID-19 tests (swab and rapid) administered
19	COVID-19 Positive Tests	Total number of tests yielding and positive results (some positive results were recorded after March 31st)
20	Patients Tested for COVID -19	Total number of unique patients tested
21	Patients Positive for COVID -19	Total number of unique patients tested yielding and positive result (some positive results were recorded after March 31st)