AGENDA

MEDICAL AND PROFESSIONAL AFFAIRS COMMITTEE

Date: April 11th, 2022
Time: 9:00 AM
Location: VIRTUAL MEETING

BOARD OF DIRECTORS

CALL TO ORDER — **DR. CALAMIA**

ADOPTION OF MINUTES – November 1, 2021

ACTION ITEMS:

Authorizing the New York City Health and Hospitals Corporation (the "**System**") to execute a three-year contract with EAC Network ("**EAC**") for services to operate the Community Reentry Assistance Network ("**CRAN**") program to assist persons detained by the New York City Department of Correction as they leave detention and reenter the community with the System holding two 1-year options to renew for an amount not to exceed $25,000,000 over the entire potential five-year term. — **DR. YANG** **MS. EPSTEIN**

Vendex: Approved
EEO: Approved

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

CHIEF NURSE EXECUTIVE REPORT — **DR. CINEAS**

METROPLUS HEALTH PLAN — **DR. SCHWARTZ**

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

Virtual – Medical and Professional Affairs Committee – November 1, 2021
As Reported by Dr. Vincent Calamia
Committee Members Present- José Pagán, Dr. Vincent Calamia, Sally Hernandez-Piñero, Dr. Michael McCrae representing Dr. Chinazo Cunningham on a voting capacity, Dr. Mitchell Katz - joined at 9:49, Barbara Lowe – joined at 9:13.

Dr. Vincent Calamia, Chair of the Committee, called the meeting to order at 9:03AM. On motion made and seconded, the Committee adopted the minutes of the September 13th, 2021 Medical and Professional Affairs committee.

ACTION ITEM:
Charles Barron, MD, Deputy Chief Medical officer, Behavioral Health presented the resolution to the committee:

Authorizing New York City Health and Hospitals Corporation (the "System") to enter into a best interest five-year renewal agreement with Coordinated Behavioral Care IPA, Inc. ("CBC") for case management of System patients with persistent behavioral health issues at a cost not to exceed $17,977,600.

Dr. Charles Barron – System Deputy Chief Medical Officer, the background on the CBC program and Pathway Home, a history of the partnership between CBC and NYC Health + Hospitals, a rational for a best interest renewal agreement, current accomplishments of the program, the distinguished features and program goals.

The Committee requested clarification on:

- Within the partnership who are the payors, the healthcare providers and the care management agencies, meaning which entities? Dr. Barron response: they are proposing that Health + Hospitals become the payor to CBC, which is a collection of community-based organizations, they will provide the services to the patients for Health + Hospitals. The interventions that they provide are the care management.

- The entity has three entities within it, an IPA, innovation hub, and a Medicaid health home? Dr. Barron response: The CBC is the umbrella organization that has those 3 components. All 3 components are made up of fifty community-based organizations that make up the IPA as well as an innovation hub to try out new evidence base practices. Evidence base practice is the pathway home CTI model.

- Requested, clarify the cost break down of the $18 million. Each team will treat about 100 patients, 400 patients each year for 5 years.

- Is there difficulty with placing troubled mental health patients in homes and facilities that are longer term, how long does the arrangement last? Dr. Barron responded, the formal Pathway critical time intervention program generally last for six to nine months. From the time of discharge, from one of Health + Hospital inpatient services, they will be working intensively with the patient to engage them into treatment, housing needs, and whatever their psychosocial and medical needs are. If by the end of the nine months they feel the patient is still unstable they will continue to work with the patient. The idea is by the end of nine months they are stable enough to be transitioned to a lower level of care management.

- How are the patients selected? Dr. Barron response, there is a criteria established by the state. Anyone that has had 4 psychiatric admissions or Emergency Department visits weather Psych or medical, within a year time period is eligible. The committee had concerns about the cost. Dr. Barron described the study that was done and how they arrived at the cost which was a projection.
- The committee asked for a follow up to the Board on the calculation.

- Have we looked at the individual participants to have a success rate as good as other programs? Dr. Barron response: At present there are 4 different community base organizations of the IPA that are teams, each of the teams are a different CBO. Each one has been looked at and the success rate has been good. Each of the different teams and organizations are being monitored to assure that they are performing up to our expectation. They have been doing an exceptional job so far.

- What are the specific qualifications for case managers? Dr. Barron response, they have experience in case management, they all go through a standard training program that is done by the state. The critical time intervention has its own training combined with the CBC which is given to everyone that participates in the team.

The Committee complemented the work and commented that it was good to see results with such a short term. This program is worthy to look at long term.

The resolutions were duly seconded, discussed and unanimously adopted by the Committee with conditions for consideration by the full board.

CHIEF MEDICAL OFFICER REPORT
Charles Barron MD, Deputy Chief Medical Officer of Behavioral Health reported to the committee full report is included in the materials, he highlighted the following.

BEHAVIORAL HEALTH
Follow up – Esketamine Protocol

We (H+H) have not started use of Esketamine yet, but are in the process of developing appropriate protocols for use and will be adding it to the formulary. Esketamine is approved for use in treatment resistant, severe depression. It is administered in a clinical setting, under supervision and monitoring. It has been shown to be highly effective in treatment of these severe, treatment resistant depressions. The FDNY does use Esketamine in the field for sedation of agitated delirium. They have a protocol for this.

Access in BH Ambulatory Care	Behavioral Health has begun to standardize and optimize ambulatory behavioral health services in order to increase access in our services. Initiatives include optimizing EPIC and electronic modalities to streamline and make appointments, utilization and tracking, data availability more efficient and available. This will allow clinics to use information to better provide services needed by the community.
Child and Adolescent – Post COVID SERVICES: DOE Collaboration	To bring additional support to students in the neighborhoods most impacted by the COVID-19 pandemic, we are collaborating with the Mayor's Office of Community Mental Health and the Department of Education to structure a new partnership between the City's public hospitals and over 25 public schools. This partnership, called Pathways to Care, expedites referrals from schools to connect students to care at our outpatient mental health clinics, where students can receive ongoing therapy, psychiatric evaluation, medication management, and other clinical services. This program rolled out in November 2020. Currently we have four clinics participating: - Kings County - Woodhull - Gouverneur (Gotham) - Elmhurst We are in the process of onboarding 5 MHSC members to 5 Clinics (Harlem, Woodhull, Morrisania, Lincoln, and East NY). We are working with these clinics to begin participating in the program this fall. We also recently found out that H+H will be receiving $5million dollars to work with DOE in strengthening the Continuum of Care. DOE has selected Central Brooklyn and South Bronx as pilot areas. Discussions on this have just started.
B-HEARD	The Behavioral Health Emergency Assistance Response Division, or B-HEARD, is a new health-centered response

	to 911 mental health calls. This began June 6th, 2021 covering East Harlem and parts of Central and North Harlem. In areas where B-HEARD operates, 911 call operators dispatch new B-HEARD Teams —FDNY Emergency Medical Technicians (EMTs)/paramedics teamed with a Social Worker from NYC Health + Hospitals — as first responders to people experiencing a mental health emergency in instances that do not involve a weapon or imminent risk of violence. The B-HEARD teams use their physical and mental health expertise, and experience in crisis response to de-escalate emergencies and provide immediate care. These teams have the expertise to respond to a range of behavioral health problems, such as suicide ideation, substance misuse, and mental illness, including serious mental illness, as well as physical health problems, which can be exacerbated by or mask mental health problems. *How many encounters to date:* The Social workers have provided engagement and assessment for **269** individuals (between 6/6 and 10/2). *Outcomes of the encounters:* If the 269 individuals the Social Worker engaged: - 41% were transported to the hospital for further evaluation - 57% were treated in place and accepted referrals - 2% were treated in place and refused a referral

OBH maintains the **House Staff Wellness** webpage which is dedicated to the mental health and wellbeing all house staff across NYC Health + Hospitals regardless of their academic affiliation or pay line.
It has been in operation since July 1st, 2021.
Website:
http://hhcinsider.nychhc.org/corpoffices/erc/hssw/Pages/default.aspx

It contains:

- Referral information with a concierge service managed by OBH that connects house staff with mental health services
- Information on 24/7 crisis line (1-800-NYC-WELL)
- Selected online resources
- Local and national hotlines
- Information on peer to peer support programs

A board member raised a couple of questions: how many students have been referred since it started? Do we have a program for young people to go for mental health services that is not a referral? Dr. Barron response: We do have walk-in services for young people, minors have to have parent involvement. Ms. Lowe thanked Dr. Barron on the follow up to the

Esketamine topic. Ms. Lowe would hope that in the training they utilize the one legal case ongoing for the adolescent who was given esketamine and died subsequently, that's is one of her concerns clinically.

SYSTEM CHIEF NURSE EXECUTIVE REPORT
Dr. Natalia Cineas, System Chief Nurse Executive reported to the committee full report is included in the materials, she highlighted the following.

In observance of the National Hispanic American Heritage Month (September 15 – October 15), the Office of Patient Centered Care, held educational and virtual dance event on Wednesday, October 13th from 4-5 PM. The NYC Health and Hospitals' System Chief Nursing Executive, **Natalia Cineas, DNP, RN, NEA-BC, FAAN,** along with the nursing staff from various sites and nursing leadership participated via WebEx. The event was led by instructor, **Marlon Mills,** one of New York's most well-known dance personalities in the Salsa dance community, having traveled to many Salsa events in the states, throughout Europe, Asia, Australia, and the Caribbean. National Hispanic American Heritage celebration started in 1968. It is a period where the United States recognizes the contributions and influence of Hispanic Americans to the history, culture, and achievements for the United States

CUNY Partnership launched 10/25/21

- Ongoing partnership between CUNY and H+H will help place new nursing graduates into diverse specialties throughout the public health system, offer existing nurses professional development opportunities through multiple CUNY programs
- This work builds on a long-lasting partnership with CUNY:
  - Professional Development Fairs
  - Preceptorship Program at Kings County
  - 1,00 nurse students to support with COVID vaccine operations
- This partnership focuses on four pillars focus of career development:
  - On-the-ground clinical skills building
  - Professional nursing workforce development
  - Nursing Research & Evidence Based Practice
    Health Equity Policy Forum

Nurse Leader Workgroup launched September 2021

- The charge of the nurse leader workgroup is to create a nursing leadership development program based on the tenets of Patricia Benner's novice to expert theory, as well as the fifteen evidenced-based American Organization of Nurse Executives (AONE) nurse manager competencies. Seven workgroups will begin meeting focusing on
- Orientation, Nurse Leader Academy-strengthen the leadership skills of incumbent leaders, Nurse Leader Annual Competencies, Nurse Leader Diversity, Equity, and & Access opportunities, Nurse Leader

Continuing Education, Nurse Leader Mentoring and Succession Planning and Nurse Leader Job Descriptions, Diversity & Recruitment.

Culture of Safety

- BHA Academy launch October 25, 2021 to decrease injury patient and staff
- Agitated patients finalizing educational module
- EBSCO search engine for knowledge has gone live
- Stroke standardized curriculum for providers and nurses has gone live
- Elsevier repository of knowledge for ED and post anesthesia nurses has gone live
- AHA RQI digital resuscitation program is a paradigm shifts in delivering a digital resuscitation program- going from instructor led to digital has gone live
- CRRT records have not been integrated into our Electronic Medical Record and have now been integrated
- Covid Vaccination protocol has been developed and rolled out for booster shots and patients ages 8 and older (PODs and Pediatric Clinics).

Quality/Excellence/Outcomes

Quality

Laying foundation for the creation of a system level Nursing Quality Council and nursing quality dashboard

Facilitated NDNQI System Reports Dashboard agreement – Provided access to system NDNQI data for comparison and benchmarking, launched May, 2021

- Obtained facility inputs on nursing quality data management process and completed gap analysis
- Cross-walked nursing quality data definitions across regulatory agencies (NDNQI and NHSN)
- Working with system Data and Analytics (DnA) team to build data definition library to facilitate the creation of validated nursing quality metrics for internal and external reporting.
- Working on developing a curriculum for training Nursing Quality Directors (Nursing Quality Management). Expected launch November, 2021.

Nursing Clinical Ladder Program

- The letter of intent submission process opened on February 1st and closed on March 31st at 11:59pm.
- The deadline to submit professional portfolio was on October 1st at 11:59pm.

- Approved to participate in program: 1961
- Clinical ladder Program folder review sessions are in progress with goal to send out payments by December 31st 2021

Laying foundation by creating a system level Positive Practice Quality Research System Team (PQRST) committee

- Created a Positive practice committee including members from all acute care facilities for ANCC PTE, Magnet initiatives, launched September, 2021. Goal is 2 facilities will have their pathway application submitted by December 2022.
- Positive practice committee launch for Post-acute – November, 2021
- AACN Beacon recognition document preparation and guidance for all acute care facilities critical care nursing, started July, 2021. (Goal of 1 ICU from each facility will have their Beacon application submitted or awarded by December 2022).
- Completed nursing excellence award 2021 winner selections, September, 2021- Awards and recognition event planned for December, 2021.

Social Work:

- Social Work Shared Governance implementation kicks off in November with facility-based information sessions for frontline Social Work staff and leadership.
- Focused SW scope of practice and role refinement activities have begun in the following areas:
  - Women's Health, 3-2-1 IMPACT & CAPT
  - Ambulatory Care (partnership with new Community Health Worker role)
  - Behavioral Health specialty programs
  - Post-Acute & Community Care
- *Social Work Director's Council* charter has been revised to more closely align with established NASW and NYS Office of the Professions standards and practices. Identified priorities for 2021-2022 include:
  - Recruitment & Retention
    - In partnership with H+H Talent Acquisition, we've established quarterly Systemwide SW Recruitment Fairs. First one held on September 29th was successful.
  - Staff Recognition & Wellness
  - Professional Training & Development
  - Equity & Access
  - SW Student Affairs

Care Experience

CARE EXPERIENCE

- Podium/Poster Presentations in NYONEL, Tarrytown, NY in September 2021
    - Belaro, A., Cineas, N., Als, D., Gonzales, D. (2021). “Keeping Amazing Talent. NYCHH Nurse Residency Program Outcomes.” Accepted for podium presentation at the 2021 New York Organization of Nurse Executives (NYONEL) Annual Conference. Mamaroneck, NY
    - Belaro, A., Cineas, N. (2021). “Rapid Implementation of Professional Shared Governance in the Largest Public Health System in the U.S.” Accepted for podium presentation at the 2021 New York Organization of Nurse Executives (NYONEL) Annual Conference. Mamaroneck, NY
    - Belaro, A. (2021). “Quick and Easy Escape Room for a Virtual Nurse Residency Seminar.” Accepted for podium/poster presentation at the 2021 New York Organization of Nurse Executives (NYONEL) Annual Conference. Mamaroneck, NY

PROFESSIONAL SHARED GOVERNANCE

- Completed 3 system wide report (including 1 annual retreat) and 4 hospital wide report outs. 98% of councils have been organized with charters and consistently meeting on a regular basis on all sites. Next PSG Retreat on February 9, 2022. Councils in formation: Care Management Council, Social Work Council, PQRST Council

NURSE RESIDENCY PROGRAM

- Nurse Residency Program graduated 9 cohorts (200+ new nurses) to date. Enrolled 800+ residents to date. Retention rates for enrolled new nurses since program inception: **2019** 85% (n=196) => **2020** 95% (n=327) =>**2021** 100% (n=103).
    -
- First Evidence Based Practice (EBP) Symposium completed in April 2021 which showcased 60+ EBP Posters completed by residents across 5 cohorts. Annual EBP Symposium to continue in 2022 and beyond.

RN MENTORSHIP

- Launched in Bellevue, Coney Island
- 2 retiree mentors, 10 incumbent RN mentees
- Mentorship Training completed via Peoplesoft ELM
- Expansion of Retiree Mentor Pool
- Additional Arms:
    - NRP Alumni Mentors
    - Leader Mentors
    - Hybrid Mentors/Preceptors
- Embed into Clinical Ladder Program by 2022.

Board members complimented the doctor Cineas on the work done in her department.

METROPLUS HEALTH PLAN, INC.

Talya Schwartz, MD, Executive Director, MetroPlus Health Plan report on the following:

Regulatory Highlights

COVID-19

NYS declaration of emergency expired on June 24, 2021. Some of the COVID-19 related waivers and regulatory exceptions expired with this change including the waiver of recredentialing requirements for network providers and remote notarization. Video participation in board meetings for public entities where the public cannot be present at all video locations also expired but the new Governor issued a new rule allowing this to continue for the time being.
No cost-sharing for COVID-19 testing and vaccinations remain in effect until the end of the Federal PHE under the CARES Act. Federal government PHE has been extended for an additional 90 days.

Disenrollment moratoriums for Medicaid, EP, and CHP Advance Premium Tax Credit (APTC) will continue through December 31, 2021 and will be for a 12-month period. SDOH will work with plans to set up a recertification schedule that will not be too burdensome to manage. Through June, for these lines of business, disenrollment remains only for people who have moved out of the area, have passed away, or who have active insurance coverage through another product (effective February 2021). MLTC still has no end date for the ban on service refusal disenrollment.

New Federal Laws Impacting Information Access for Members

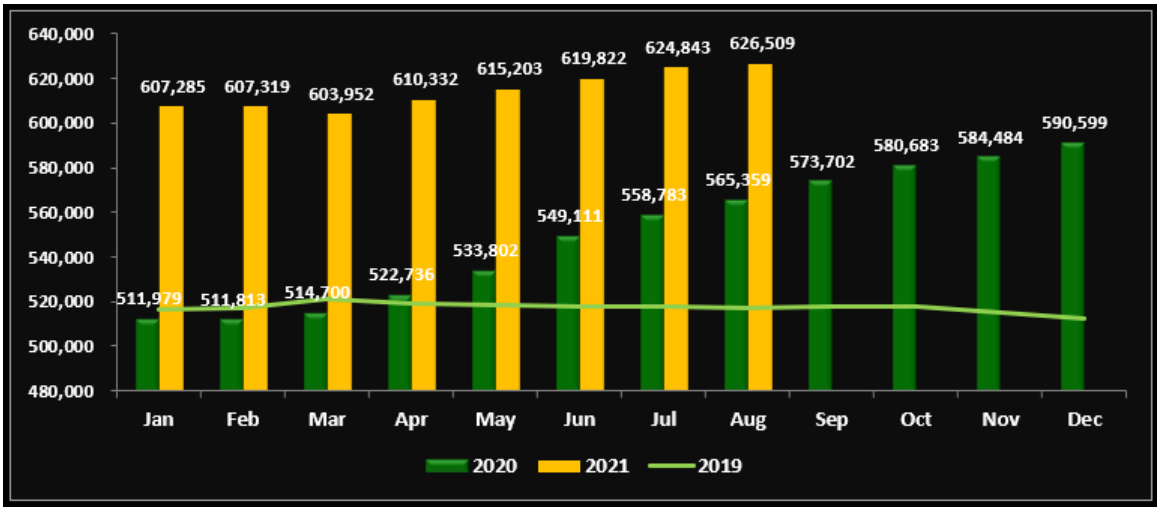
Two new Federal rules, Transparency in Coverage Act and No Surprises Act, are both designed to increase obligations on health plans to provide information about how much services cost a Plan to provide. The Transparency rules require group health plans and insurers in the group and individual markets to provide self-service tools to members to allow them to know what plans are paying their in-network providers. This includes providing machine readable files and a price comparison tool where members can see how much their out-of-pocket costs would vary by provider by June 2022 and a list of 500 shoppable services for out-of-pocket costs by January 2023.

The price comparison tool is impactful to any MetroPlus line of business where members may have cost-sharing rather than a set co-payment, such as QHP and Gold.

The No Surprises rule is extremely broad, but most requirements are already in place via existing NYS laws. CMS is currently evaluating the overlap between the Transparency rule and the No Surprises rule and compliance dates have been delayed as a result.

Membership

Membership has reached 626,509 members in August. Year to date membership is up 6.1% continually driven by growth in Medicaid and EP. Loses seen in QHP, SHOP and MLTC.



BH Services Transition

Effective October 1, 2021, MetroPlus successfully transitioned from Beacon Health Options, the management of members with behavioral health and substance use disorder conditions. Key functions now administered by MetroPlus include network relations and contracting, care management and coordination, utilization management, customer service, appeals and grievance management, claim processing, quality management and regulatory reporting, compliance, and oversight.

Clinical Approach

Current clinical staff is comprised of RN, LCSW, LMHC, LBA, PhD, Peers, and Medical Directors with specialization in child and adolescents, adult behavioral health, and substance use disorders. Clinical staff will continue to grow to a team of approximately 75 individuals through next year.

The teams utilize several platforms to manage the work associated with utilization and case management and have leveraged functionality supporting physical health activities as a baseline and then developed customization to meet the unique needs of behavioral health. This system integration allows for easier exchange of information between behavioral and physical health aspects.

The utilization and case management teams use industry standard tools to assist in the development of members transition and or plans of care. These first level screening tools are based in evidence-based practices and will support defined criteria to formulate decisions or whether further evaluation is required. These tools include Level of Care Determination (LOCADTR) used for substance use disorders, and InterQual ® criteria for Utilization Management and applied behavior analysis (ABA).

Over 4,000 members that were in varying stages of case management with Beacon were transitioned to our care management teams. MetroPlus utilization management and case management teams engaged with Beacon Health Options to discuss open case management cases to ensure identification of any high need members. Member cases were stratified, and our case managers began engaging members in behavioral health assessment.

Critical part of this transition is aligning with our network providers and specifically H+H. Case management collaboration, referrals and hands offs are being develop at present time. Our care management staff, specifically those focused on the HARP population and peers, are field based and able to serve as additional resource for members and providers.

BH Network
The network development and contracting team performed extensive data mining of Beacon Health Options claims data to identify provider, agencies and facilities that were utilized by MetroPlus members. The results of that analysis identified hundreds of organizations to be the foundation for our behavioral and substance abuse network. The Plan has successfully contracted and credentialed over 95% of the targeted organizations, which exceed the NY Department of Mental Health's requirement of 90% congruency with Beacon Health Options network. For members who are treated now by out of network providers, a 6-month transition of care benefit is in place to assist members in either concluding care and or transitioning to an in-network provider, whichever is appropriate.

4 Weeks In
The transition has been progressing smoothly, accommodating member and provider needs. As of now there are 10,000 BH claims and processing and paying for them with no problem. This quarter is focus on stabilizing the operation, to make sure the basics are working.

Foster Care Program

NYS transitioned Foster Care transitioned to managed care on 7/1/21 to promote continuity of care, collaboration across child serving systems, ensure health care services are comprehensive, timely, high quality, trauma-informed, and evidence based. Children/youth placed in foster care have higher rates of birth defects, developmental delays, mental/behavioral health needs, and physical disabilities. They utilize inpatient and outpatient mental health services 15-20 times more than mainstream Medicaid children.

Of the 9,300 children in the care of Voluntary Foster Care Agencies VFCAs) with 29-I licenses, about 11% (1,036) are currently enrolled with MetroPlus. The 29-I authorizes VFCAs to provide limited health services like nursing, skill building, discharge planning, PCP, HCBS, and mental health. MetroPlus contracted with 34 agencies.

Some of MetroPlus responsibilities include: coordinating PCP assignments as needed; ensuring access to health care, including mandated health assessments, DME, and referrals; assisting with court ordered services and fair hearings; following up on Gaps in Care to improve health outcomes: care managers review treatment plans and available clinical information to ensure timely gap closure and refer to children's health homes when indicated.

MetroPlus has been in communication with VFCAs and ACS for the past 3 years to develop working relationships and establish lines of communication to promote mutual understanding and adoption of state regulatory requirements, coordinate processes to enroll and update eligibility changes, collaborate to optimize quality outcomes, and share the value of collaborating with H+H and their 5 Foster Care Centers of Excellence.

H+H Centers of Excellence have been valuable sources of care and support to children in foster care. Many VFCAs have their own PCPs or utilize the PCPs of other VFCAs or community providers. Children not already in established care of a PCP are assigned to H+H Centers of Excellence (COE) to ensure the provision of comprehensive trauma informed care. Currently 10% of foster children are assigned to H+H PCPs.

Board member, Sally Hernandez-Piñero, complimented Dr. Schwartz on the work her and her staff has done, and complimented Dr. Barron in his support to Dr. Schwartz on the Behavioral Health piece. Board member Ms. Barbara Lowe, would like for there to be case finding of what happens to the siblings that witness fatality in their homes.

There being no further business, the meeting was adjourned 9:48 AM.

RESOLUTION

Authorizing the New York City Health and Hospitals Corporation (the "**System**") to execute a three-year contract with EAC Network ("**EAC**") for services to operate the Community Reentry Assistance Network ("**CRAN**") program to assist persons detained by the New York City Department of Correction as they leave detention and reenter the community with the System holding two 1-year options to renew for an amount not to exceed $25,000,000 over the entire potential five-year term.

WHEREAS, the City of New York (the "**City**") is obligated under the terms of the agreement that settled the Brad H litigation brought in 2000 to provide reentry services to incarcerated individuals with a mental health diagnosis which the City has attempted to do through the CRAN program; and

WHEREAS, the City assigned responsibility for providing health care to incarcerated individuals to the System and, more specifically, the System's Correctional Health Services unit ("**CHS**") including much of the responsibility for the Brad H settlement; and

WHEREAS, since 2017 EAC has provided the CRAN services serving approximately 1,800 individuals annually; and

WHEREAS, EAC is a not-for-profit corporation with a substantial history of providing social services in the City's metropolitan area; and

WHEREAS, in preparation for the expiration of the EAC agreement, the System conducted an open, competitive RFP process to engage a contractor to operate the CRAN program and, with the approval of the Contract Review Committee, once again selected EAC to operate the CRAN program but on a somewhat redesigned basis; and

WHEREAS, the System's Senior Vice President for CHS will be responsible for the management of the proposed agreement.

NOW THEREFORE, be it

RESOLVED, that the New York City Health and Hospitals Corporation (the "**System**") be and hereby is authorized to execute a three-year contract with EAC Network ("**EAC**") for services to operate the Community Reentry Assistance Network ("**CRAN**") program to assist persons detained by the New York City Department of Correction as they leave detention and reenter the community with the System holding two 1-year options to renew for an amount not to exceed $25,000,000 over the entire potential five-year term.

EXECUTIVE SUMMARY
SOCIAL AND CLINICAL SERVICES
FOR DETAINEES RELEASED FROM INCARCERATION
CONTRACT WITH EAC NETWORK

OVERVIEW: In Brad H, a class action was brought against the City over its treatment of certain incarcerated individuals and its settlement in 2000, imposes various obligations on the City. After its assignment of responsibility for the provision of healthcare for incarcerated persons, much of the responsibility for complying with Brad H, including the operation of the Community Reentry Assistance Network ("**CRAN**") has passed to the System's CHS unit. Since 2017, the System has contracted with EAC to operate the CRAN program. CRAN offers two program tracks: transitional Case Management services, typically initiated while a client is incarcerated, and Post-Release Services. CRAN works closely with clients in both tracks to facilitate achievement of health and reentry goals.

EAC NETWORK: EAC Network is a not-for-profit that has operated in the New York metropolitan area for over 50 years. Its programs serve children, seniors, justice involved persons and those with behavioral health challenges.

PROCUREMENT A competitive RFP was conducted through Supply Chain and under the review of the Contract Review Committee. The RFP was issued to five firms and was published in the City Record. Two vendors attended a pre-proposal conference but only EAC submitted a proposal. Other potential candidates lacked the considerable capacity of EAC and were unable to make a proposal. Apart from being the sole candidate, EAC offers the ability to satisfy all contractual obligations through working closely with CHS to improve and expand provision of services, demonstrated experience providing case management services to justice-involved populations, demonstrated experience providing services and support to individuals with serious mental illness, familiarity with Brad H requirements and a diverse and bi-lingual staff. The Evaluation Committee selected EAC as the best proposer and the CRC approved such selection.

PROGRAM: CHS has restructured the CRAN program and the RFP was issued explicitly on that basis. As redesigned, EAC will be required to conduct outreach in jail facilities to inform the detainee population of the services available. EAC will be required to accept not less than 75% of the case referrals made by CHS. Explicit performance measures are established against which EAC's performance will be regularly evaluated.

COSTS: Total not-to-exceed cost for the potential five-year contract will not exceed $25,000,000.

MWBE: Because EAC is a not-for-profit corporation, the MWBE subcontracting rules do not apply.

NYC HEALTH + HOSPITALS

To: Colicia Hercules
Chief of Staff, Office of the Chair

From: Keith Tallbe
Senior Counsel
Office of Legal Affairs

Tallbe, Keith
Digitally signed by Tallbe, Keith
Date: 2022.03.28 11:01:06 -04'00'

Re: Vendor responsibility, EEO and MWBE status

Vendor: EAC, Inc.

Date: March 28, 2022

The below chart indicates the vendor's status as to vendor responsibility, EEO and MWBE:

Vendor Responsibility	**EEO**	**MWBE Utilization Plan**
Approved	Approved	Exempt (non-profit)

The above status is consistent and appropriate with the applicable laws, regulations, and operating procedures to allow the Board of Directors to approve this contract.

Community Reentry Assistance Network (CRAN)

Application to
Enter into Contract
EAC Network

Medical & Professional Affairs Committee
April 11, 2022

Ellie Epstein
Sr. Director
Reentry and Transition Services
Correctional Health Services

Background

- CRAN provides reentry services for individuals who are incarcerated in NYC, with specialization in serving CHS patients with mental health diagnoses.

- CRAN offers two program tracks: transitional Case Management services, typically initiated while client is incarcerated, and Post-Release Services. CRAN works closely with clients in both tracks to facilitate achievement of health and reentry goals.

- Earlier iteration of this program was known as LINK and SPAN, which were launched pursuant to the City's responsibilities under the settlement agreement in Brad H. v. City of New York (2000).

- The current contract was procured via Request for Proposals and awarded to EAC Network.
  - Contract went into effect on July 1, 2017 for a term of 3 years with the option for two 1-year renewals and will expire June 30, 2022.

- The CRC approved an application to issue an RFP in November 2021.

Current Contract Summary

- Engagement in CRAN services is voluntary and directed by clients
- On average CRAN serves 1,790 clients each year
  - 2018: 2,742
  - 2019: 2,251
  - 2020: 1,129
  - 2021: 1,036
- 96% of all clients who engage with CRAN in the community receive at least one meaningful service (e.g., assistance with benefit applications, connection to care)
- In the past 3 years, CRAN has made over 3,000 unique service referrals to more than 200 different providers
- 2,500 patients attended a CRAN group information session while in custody
- CRAN program has and continues to meet all performance metrics required under the Brad H Settlement.
- Historical spending and budget:

Fiscal Year	Budget	Total Spend
FY21	$5,727,975	$4,516,533
FY20	$5,727,975	$4,572,052
FY19	$5,727,975	$4,845,419
FY18	$5,727,975	$4,045,142

All figures provided are based on data from calendar years 2019-2021 unless otherwise specified.

Lessons Learned

- Need for data collection and reporting systems to be in place at contract start
- Limitations under current contract:
  - Services limited to patients with mental health diagnoses (Brad H class members)
  - Difficulty engaging patients in post-release services
- Solutions to these issues were integrated into the new RFP by expanding:
  - Eligibility:
    - Case Management: all patients with SMI diagnosis and/or significant health care needs or functional impairment
    - Post-Release services: all individuals with recent incarceration in NYC jail system
  - Requirements for service awareness outreach
  - Support: cell phone provision/assistance; staff to meet clients in convenient community locations (in addition to CRAN offices or via telephone); services available on Friday nights and Saturdays

Contract Requirements

- Vendor is required to:
  - Provide assistance with obtaining prescription medications, completing benefit applications, housing assistance, transportation, and connections to health and behavioral health care.
  - Maintain walk-in availability for services during normal business hours, and provide on-call support and crisis intervention services on Friday evenings and Saturdays.
  - Conduct at least 6 outreach events per month (in jail facilities and in the community) to inform NYC Jail population, their friends/family, and staff from community organizations (legal and social service-oriented) about Post-Release Services.
  - Meet with and admit at least 75% of all CRAN Case Management referrals made by CHS, and provide case management services for up to six months upon release from custody.
  - Provide at least one meaningful service (e.g. complete a benefit application, provide housing assistance, connect to treatment provider) to a minimum of 85% of clients who connect with CRAN upon return to the community.
- Vendor must also meet requirements under Brad H. Settlement Agreement:
  - Maintain public-facing office space within a half mile of the court house in each borough.
  - Conduct outreach to all SMI clients within 5 days of release from custody.
  - Contact treatment providers, as identified on CHS discharge plans, for SMI clients within 5 days of release to determine connection to care.
- Failure to meet Performance Metrics can result in financial penalties. Continuous failure may be cause for contract termination.

Procurement Summary

- Sourced via public solicitation and sent directly to 5 vendors
- Solicitation was limited to firms with a 501(c)(3) designation (not for profit)
- The evaluation criteria was comprised of experience, quality of program plan, staffing plan, and cost
- Evaluation committee was comprised of various members of Correctional Health Services and Behavioral Health
- EAC Network was the only proposer and received a score of 8.9 out of 10
  Contract amount is capped at $5,000,000 a year
- Contract duration is three years with two one-year renewal options at the discretion of NYC Health + Hospitals at a not-to-exceed amount of $25,000,000

Vendor Selection

- EAC Network was selected for the following reasons:
  - Ability to satisfy all contractual obligations through working closely with CHS to improve and expand provision of services.
  - Demonstrated experience providing case management services to justice-involved populations
  - Demonstrated experience providing services and support to individuals with serious mental illness
  - Familiar with Brad H requirements
  - Diverse and bi-lingual staff
  - Provided 18 letters of support from other social service providers and court parties

- Non-responding vendors:
  - CASES – Limited bandwidth to pursue multiple opportunities
  - CTCNY – Insufficient capacity to support a City wide initiative

MWBE and Workforce Diversity

- EAC Network is a 501(c)(3) Organization.
- EAC Network has a current workforce of 437 employees throughout New York State with 49% identifying as persons of color.
- Able to communicate with clients in their primary language, thanks to multilingual staff and telephonic translation services.
- Will employ peers as part of the case management team.

M&PA Approval Request

- Correctional Health Services is seeking approval to enter into contract with EAC Network for CRAN:
  - **Contract Term:** 3 years with two 1-year options to renew
  - **Implementation / Roll out milestones:**
    - **June 2022:** Commence transition planning with EAC Network to begin hiring.
    - **July 2022:** New contract begins. EAC Network to adopt new eligibility criteria, begin offering services on Friday evenings and Saturdays, and amend outreach practices.
  - **Cost:** $25,000,000
  - **M/WBE Status:** Exempt

Medical & Professional Affairs
Chief Medical Officer's Report

Machelle Allen, Senior Vice President

April 11, 2022

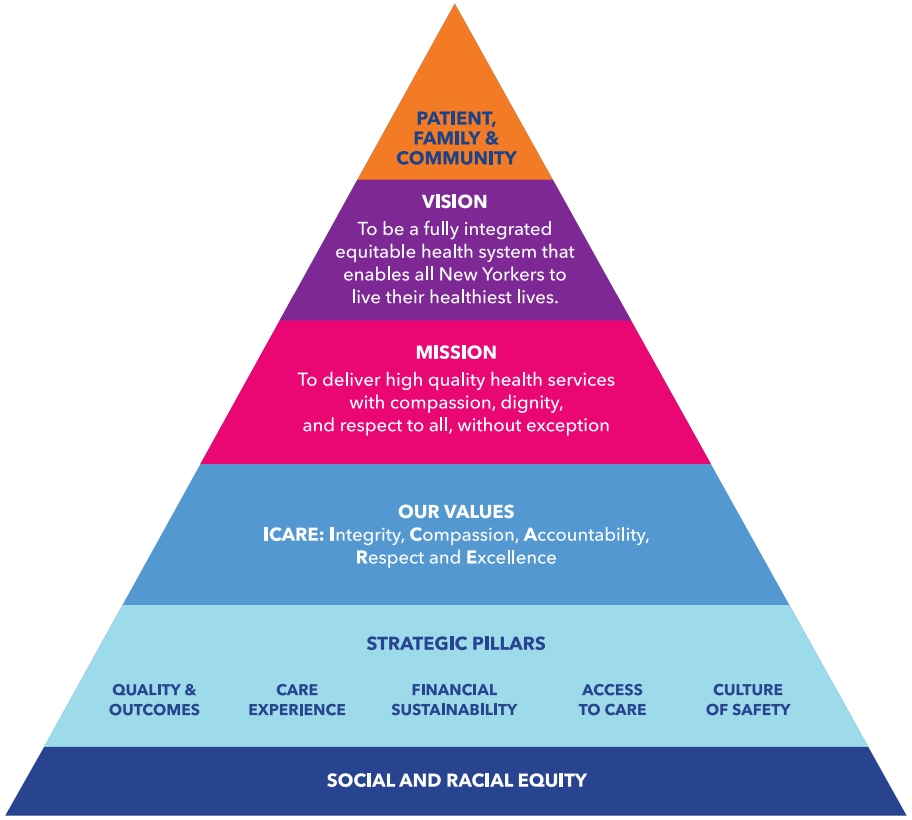
NYC HEALTH+ HOSPITALS

CLINICAL SERVICE LINES

Clinical Service Line	Last Name	First Name	Facility
Breast Surgery	McCalla	Sydney	Lincoln
Cardiology	Keller	Norma	Bellevue
Clinical Strategy	Wallach	Andrew	Bellevue
Critical Care	Boudourakis	Leon	Kings County
	Uppal	Amit	Bellevue
Dentistry	Badner	Victor	Jacobi
Emergency Medicine	Gulati	Rajneesh	Bellevue
	Kessler	Stuart	Elmhurst
Infectious Diseasaes	Masci	Joseph	Elmhurst
Internal Medicine	Faillice	Robert	Jacobi
Maternal Morbidity and Mortality	Wilcox	Wendy	Kings County
Nephorolgy	Wagner	John	Kings County
Oncology	Wu	Jennifer	Bellevue
Ophthalmology	Lieberman	Ronni	Qeens
	Ostrowsky	Ann	Bellevue
Palliative Care	Cohen	Susan	Bellevue
Pediatrics	Seigel	Warren	Coney Island
Pediatrics, Ambulatory	McCord	Mary	Gouverneur
Psychiatry, Child and Adolescent	Havens	Jennifer	Bellevue
Pulmonary	Reibman	Joan	Bellevue
Radiology	Hammill	Patrick	Kings County
Reproductive Health	Nadas	Marisa	Jacobi
Periop	Parikh	Manish	Bellevue
System CNO	Cineas	Natalia	System
Trauma	Teperman	Sheldon	Jacobi

Aligning M&PA Goals and Initiatives

- **Quality & Outcomes**
  - Maternal Home
  - 3-2-1 Impact Program



NYC HEALTH+ HOSPITALS | Medical & Professional Affairs

Maternal Mortality and Morbidity Reduction Program Update

3-2-1 IMPACT Program Update

Wendy Wilcox, MD
Jennifer Havens, MD
Mary McCord, MD

In 2018, the former mayor asked NYC Health + Hospitals to devise a multi-point program to reduce maternal morbidity and mortality in NYC.

At the time, more than 3,000 women experienced a life-threatening event during childbirth, and about 30 women died each year in New York City. Black, non-Hispanic women were 8 times more likely to die in childbirth than white women in NYC. Black, non-Hispanic women are still 3 times more likely to suffer a life-threatening event in pregnancy than white women.

NYC H+H Response:

Simulation Program

Build 6 simulation mini-labs in six of our acute care maternity hospitals.

Train the OB healthcare team in all 11 H+H maternity hospitals to manage the top 3 causes of maternal mortality

- Cardiovascular collapse
- Acute life-threatening blood loss
- Severe hypertension

Maternal Medical Home

Using licensed social workers and maternal coordinators, the Maternal Home provides support and "wrap-around" services for pregnant women who are at risk for a poor pregnancy outcome.
The maternal home has been established in all 11 H+H maternity hospitals.

Interval Pregnancy Optimization

Uses Epic to improve Women's Health around Pregnancy Intention

Mother – Baby Coordinated Care

Coordinates newborn visits with postpartum visits to reduce barriers for postpartum visit adherence.

NYC HEALTH+ HOSPITALS

Status Update--Simulation

OB Life Support	✓ Completed, met target
OB Hemorrhage	✓ Completed, met target
Severe HTN in Pregnancy	❑ Training has started
Counteracting unconscious bias in SUD screening in pregnancy	❑ Pilot of training

NYC HEALTH+ HOSPITALS

H+H is a leader in Obstetric Simulation!

- **H+H is continuing to address this important work to address postpartum hemorrhage**
  - To sustain trainee retention of information, H+H has partnered with a virtual proprietary company to create a virtual simulation course around maternal hemorrhage.
  - H+H provided the course content
  - H+H is in the process of implementing this training across all 11 maternity hospitals
- **H+H is presenting this work at the 2022 National ACOG Annual Conference**

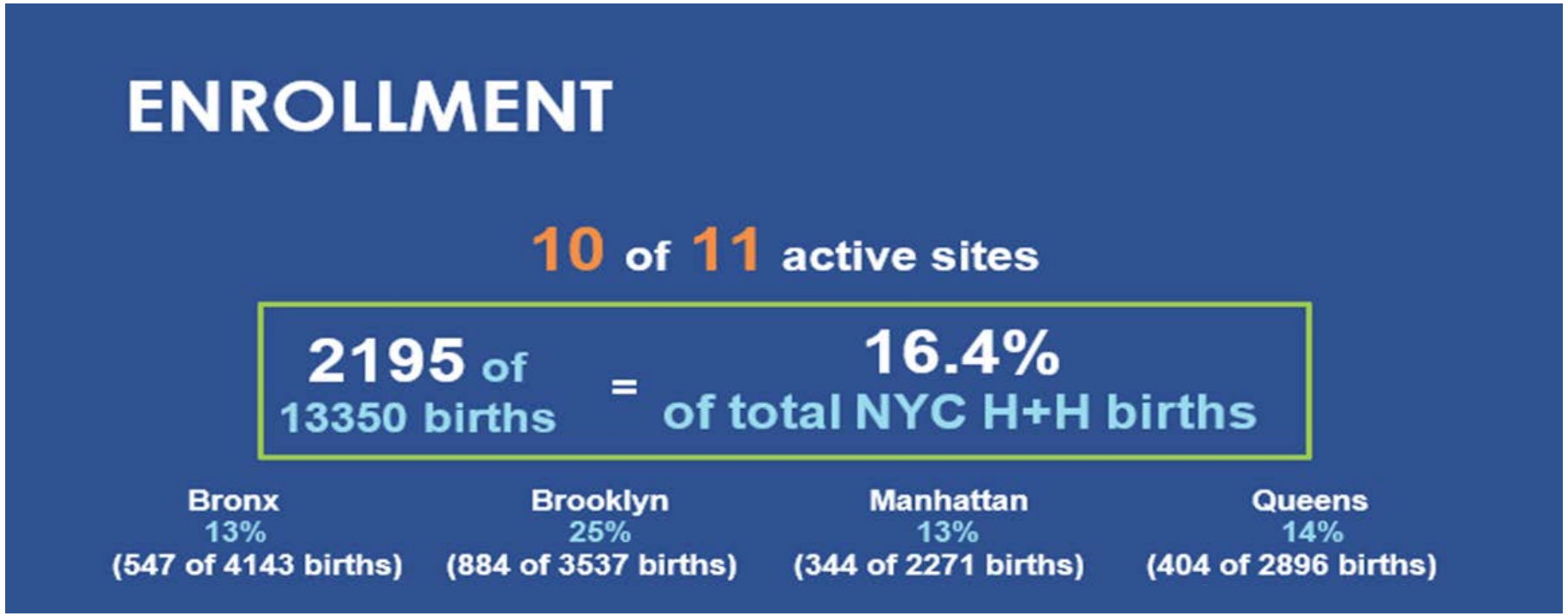
NYC HEALTH+ HOSPITALS

Status Update-Maternal Home

- The purpose of the Maternal Home is to provide support and comprehensive wrap-around services for pregnant persons who have need for this support due to clinical, behavioral health or factors related to social determinants of health.
- Started in 2018, the Maternal Home now employs 9 licensed social workers, 6 maternal care coordinators and 3 directors responsible for programming, administration and clinical oversight.
- The Maternal Home was an important program to help H+H patients throughout the COVID-19 pandemic
- The initial aim was to reach 2,000 high risk women in 5 years.
- The Maternal Home has been implemented in 11 H+H maternity hospitals. Due to staffing, it is now present in 10/11 maternity hospitals.

NYC HEALTH+ HOSPITALS

Status Update - Maternal Home



NYC HEALTH+ HOSPITALS

Status Update - Maternal Home

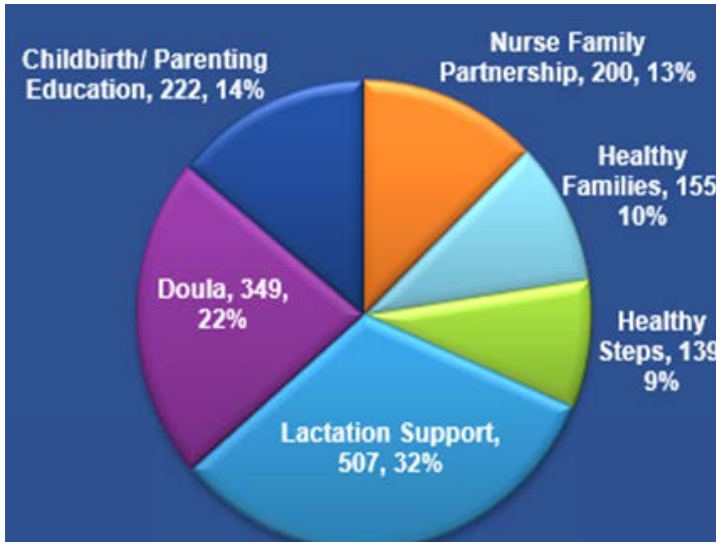
	2020	2021	
Unique patients served	736	2,189	+1,453
Referrals made	1226	6,284	+5,058

1,596 referrals were made to Community-based Organizations(CBO's) in 2021!

Status Update - Maternal Home

Medical Support/ Management

Pregnancy & Parenting Support



Social Determinants of Health

NYC HEALTH+ HOSPITALS

What is 3-2-1 IMPACT?

3·2·1 IMPACT

Integrated Model for Parents and Children Together

3 DISCIPLINES

Women's Health, Behavioral Health, and Pediatrics

2 GENERATIONS

To support the health and well-being of young children and their families

1 SINGULAR GOAL

NYC HEALTH+ HOSPITALS

3·2·1 IMPACT

3-2-1 IMPACT started as a pilot program funded by 3 sources

- Robin Hood/FUEL
- NYC H+H Venture Funds
- Mayoral Office NYC Opportunity

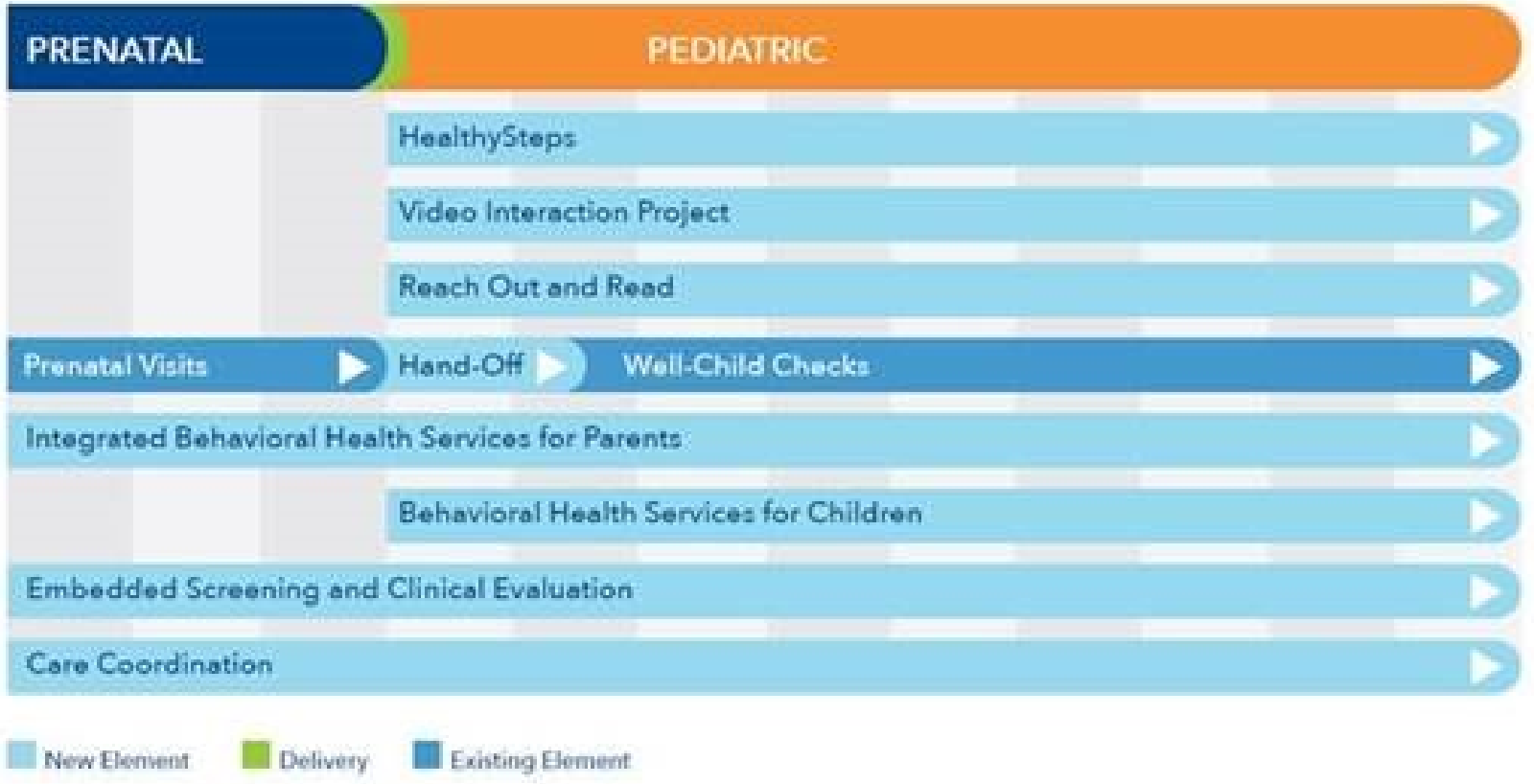
Funding from these sources covered:

- Key clinical and administrative program roles (e.g. CHWs, Site Coordinators, Social Workers, Psychologists, Psychiatrists) at Bellevue, Queens and Gouverneur
- Finance and Epic specialists to build clinical supports, analyze billing patterns, lead advocacy efforts and capture revenue
- Advocacy with NYS State and MCO partners to achieve advanced payment model by 2023

3-2-1 IMPACT - Program Components

1. Mother and Child both supported – link to WH.
2. All Primary care patients 0-3yo receive services
3. Risk Tiered Approach to Care
4. Clinical assessment AND Universal Screening
5. Connecting to Community Services
6. Parent Support and Education using evidence based models
7. Integrated Behavioral Health
8. Work with MCO's and State wide coalition towards Value Based Payment model

3-2-1 IMPACT - Program Components



NYC HEALTH+ HOSPITALS

3·2·1 IMPACT

Initial 6-Month Performance Data

Between October 2020 – March 2021 we saw **6,430** unique patients in the IMPACT population. In that same period, IMPACT had over **12,995** patient touches.

1 Risk Stratification

450 Tier 2-3 Families Served

- **310** Tier 2 Children Served
- **140** Tier 3 Children Served

2 Universal Screening

8,300+ Screens Completed[1]

- **2,200** PHQ9 Screens in Peds
- **800** SWYC Screens in Peds
- **1,100** SDOH Screens in Peds
- **TBD** PHQ9 Screens in WH

3 Integrated BH

3,000+ BH Contacts

- 2,200 BH Contacts in WH
- 1,000 BH Contacts in Peds

**Note, this is an overcount of BH-SW touches until IMPACT BH data tracking tools are available in EPIC*

4 Preventive Parent Support

- **385 VIP Sessions**
- **820 HS Contacts**

(subset of BH Contacts in Peds)

5 Care Coordination

- **490 EC CHW Contacts**

+New collaborations with NYCDOH (Early Intervention) and with ACS

6 Revenue Optimizations

- **$337K** Projected for FY21
- **$191K** Collected Jul-Mar 2021[2]

Not accounted for in Rev Projections:

- **10-20%↑** in 3 quality incentives
- **21% One-Year ROI**[3]

Data #1-#5 pulled in EPIC from 10/1/2020 ~ 3/19/2021. New IMPACT data infrastructure used to collect KPIs; some validation ongoing.

[1]*Estimated based on additional screening domains part of IMPACT (such as ACEs, MCHAT) and completed PHQ9 screens among linked mothers*

[2]*Revenue data pulled in EPIC for discharge dates in FY 2021 (July 2020 to March 2021). Payments for recent months (January to March) may not be fully processed due to typical claims/payer processing delays.*

[3]*Based on Manatt ROI Model; not included in CSP Revenue projections. More details available in Slide 10 and 11*

Ripple effects: H+H, City and State-Wide Impact

- Implementation of model endorsed by NY State DOH through its First Thousand Days on Medicaid initiative
- Working with NYU, Montefiore and Robin Hood to expand Early Intervention referral model and CHW model to other Health Systems
- H+H expansion with many components in use at most H+H Pediatric Primary Care sites
- MetroPlus and HealthFirst are active partners in VBP model development and NY State is engaged – goal is to have a payment model in place by 2023

Ripple effects: IMPACT across H+H

Early Intervention:

Total of 15 H+H facilities are currently engaged in a bi-directional, closed loop Early Intervention referral process, with an additional 5 sites planned in Spring 2022. **80% (254) of total H+H referrals made through December 2021 have successfully engaged in Early Intervention services.**

Screening:

200+ Welcome Tablets secured and implemented at 10 pediatric primary care sites in March 2022, with an additional 7 sites planned in Late Spring 2022. **Core screenings across all H+H Primary Care *increased by 15%* from 2020 to 2021.**

HealthySteps & Video Interaction Project

Total 5 sites using IMPACT HealthySteps infrastructure and 2 sites using IMPACT VIP infrastructure to support clinic operations

Community Health Workers

Since October 2021:

60+ Pediatric CHWs and supervisors hired

2,111 Unique Families Seen

5,200 Patient Touches

NYC HEALTH+ HOSPITALS

Systems change: Shared vision

In moving from “reactive to proactive” – both funders and the NYC’s safety net system must be willing to take risks

- Do not take no for an answer during vision phase
- Prevention pays it forward – despite that this undercuts the medical profit model
- Health care start up relies on multiple funding streams
- Requires continuing investment, with sustainability as a goal

NYC HEALTH+ HOSPITALS | NURSING

System Chief Nurse Executive Report
Medical & Professional Affairs Committee
March 29, 2022

General Accomplishments

Social Work Champion Luncheon help April 1, 2022

Celebrated the end of Social Work Recognition Month and awarded 42 Social Workers Champion Awards.

- Event speakers included Eva Sanders, Kara Simpson, Dr. Katz, Dr. Allen, Dr. Cineas and DC37.

NYS Staffing Committee has been launched at 11 Acute Care Hospitals and LTACH

Directors of Nursing Training

- Training including educating new Directors of Nursing Quality Best Practices, Infection Prevention, technology utilization and NDNQI data submission.
- Guest speakers included Office of Quality and Patient Safety, M&PA, Press Ganey, NDNQI and HANYS.

CUNY & H+H Academic Practice Partnership (CHAPP)

CUNY & H+H Academic Practice Partnership (CHAPP) Annual Health Equity Forum

Successfully launched CUNY & H+H Academic Practice Partnership (CHAPP's) first annual health equity forum:

- **Topic:** Health Equity: Implications for Nursing Practice during COVID
- **Date & Time:** March 18, 2022 – 9:30AM – 12PM
- **Attendance:** > 190 members from CUNY and H+H
- **Agenda:**
  - **Welcome & Introductions:** Drs. Natalia Cineas and Patricia Boyce
  - **Keynote Lecture:** Nursing Practice & Education from Dr. Beverly Malone.
  - **Workshops:** Health Equity Research, Practice & Education

- Elizabeth Gross Cohn (CUNY)
- Frankie Hamilton (H+H)
- Carolyn Sun (CUNY)
- Tiffany Johnson (H+H)
- So-Hyun Park (CUNY)
- Manjindar Kaur (H+H)

o **Breakout Sessions:**

- Race Matters in Healthcare Matters by Juliette Blount, NP
- The Future is You: Sharing Knowledge and Experience by Dr. Jamesetta Newland.

Nurse Leader Workgroups

The Nurse Leader Workgroup was launched successfully with twelve (12) different workgroups identified. The vision is to lead and establish a nurse leader best practice infrastructure at NYC Health + Hospitals.

Phase 1 Workgroup includes:

- Nurse Leader Orientation
- Nurse Leader Academy
- Nurse Leader Annual Competencies
- Nurse Leader Job Descriptions, Evaluations, & Recruitment
- Nurse Leader Continuing Education, Development & Certifications
- Nurse Leader Mentoring and Succession Planning
- Nurse Leader Diversity, Inclusion, Equity and Access Opportunities

Phase II Workgroup includes:

- Nurse Leader Conferences
- Nurse Leader Research & Grants
- Nurse Leader Organizational Memberships
- Nurse Leader Networking Opportunities
- Nurse Leader Recognition

Culture of Safety

COVID-19 Intensive Care Unit & Nephrology Collaboration:

- Developed Continuous Renal Replacement Therapy EPIC integration module to go live on the 3rd Quarter of 2022 at all 11 acute facilities

Agitated patient/Communication & Safety Skills Orientation:

- Developed orientation curriculum for nursing staff working in the non-behavioral health care settings, to recognize patients exhibiting agitation and aggression in order to perform prompt de-escalation interventions

Behavioral Health Associate Academy:

- Completed Cohort 1, 2, 3, & 4 with 58 graduates from November 2021 to March 2022. This was an interdepartmental initiative that includes Nursing, Behavioral Health, and Workforce Development

Sepsis Education:

- Completed & implemented Sepsis tip sheet as part of new EPIC Best Practices Advisory for Sepsis protocol

Systems Nursing

Learning Management System

The Office of Patient Centered Care headed by our System Vice President and Chief Nursing Executive allocated ~$ 4M to standardize nursing education and orientation across the NYC Health + Hospital system to improve patient care, patient outcomes. This learning management system will also help increase national nursing certifications.

Cornerstone is a learning management system that will hold all of our new educational content. It is internally named **SHINE**, which stands for **S**ystems **H**ealthcare **I**nnovation for **N**ursing **E**ducation.

EBSCO is a vendor that provides education materials for nursing staff. It is knowledge, skills and evidence-based practice search engine, which include core nursing skill competencies, research articles, and journal articles

- Identified 300(+) core Nursing skill competencies for 23 nursing specialties across the system to implement this Fall within SHINE.

Elsevier is a vendor that provides additional educational materials for nursing staff for nurses working in the Emergency Department and Post-Anesthesia departments. The goal is to improve patient care and outcomes along with increasing the national certification rates for nurses in these specialties

NICHE – (Nurses Improving Care for Healthsystem Elders) is a vendor that provides additional educational materials for nursing staff who care for adult and geriatric patients to improve patient outcomes, and increase the amount of GRN (Geriatric Resource Nurse) certification for this specialty

Association of Peri-Operative Registered Nurses (AORN) is an association that will provide additional education for nurses working in the Peri-Operative department. The goal is to improve patient care and outcomes along with increasing the national certification rates for nurses in this specialty

HealthStream is a vendor that provides additional educational materials for nursing staff working in Neonatal Intensive Care Units, Labor & Delivery, Pediatric, Mother Baby, and Critical Care units. The goal is to improve patient care and outcomes along with increasing the national certification rates for nurses in this specialty

Council of Nurse Educators (CONE)

Educator workshop:

- **Maria Mendoza** was the lead facilitator for this workshop. She is the Clinical Assistant Professor Program Director, at the NYU Rory Meyers College of Nursing
- Workshop was completed on February 1st, 2022 with 28 educators across the system who attended
- Developed and applied educator competencies based on scope and standards of practice by the Association for Nursing Professional Development

COVID 19 Response

- **Pronation Therapy EPIC Optimization**
  Developed Prone Therapy education program in PeopleSoft eLearning Program to facilitate standard documentation in EPIC systemwide

Root Cause Analysis Structure

- Created evidence-based Root Cause Analysis and Action (RCA2) guidelines to support standard RCA training of Cabinet Members, Department Leaders, Risk, Quality and Safety Facilitators systemwide in collaboration with Quality, Safety and Risk

- Designed standard resources to guide streamlined management of serious adverse events (SAEs) by Nursing Department/Unit Leaders and Risk Management Leaders systemwide including
  - Staff Interview Guidelines
  - RCA Checklist and Timeline
  - Risk Assessment Matrix

Safe Patient Handling Initiative and Mobility (SPHM)

- **SPHM Education Framework**
  Designed structure and content to support annual SPHM education systemwide. The framework includes six (6) key components focused on improving patient outcomes, staff safety, and reducing days out of work including: safe equipment use, ergonomics

training, SPH subject matter experts, mobility assessment, pronation, and SPHM Program.

- **Acute Care Standard Mobility Assessment EHR Optimization**
  Integrated Bedside Mobility Assessment Tool (BMAT) guidelines into EPIC to establish standard documentation of evidence-based mobility assessment in all Acute Care Facilities systemwide
- **Post-Acute Care Standard Mobility Assessment EHR Optimization**
  Integrated Bedside Mobility Assessment Tool (BMAT) guidelines into Point-Click-Care to establish standard documentation of evidence-based mobility assessment in all Post-Acute Care Facilities systemwide
- **SPHM Equipment Education Program**
  Developed standard SPHM equipment education program in PeopleSoft ELM to facilitate annual systemwide training and competencies to validate learning

Wellness

- Developed evidence-based strategies to improve Staff resiliency and reduce stress in Facilities systemwide

Quality/Excellence/Outcomes

Quality

Laying foundation for the creation of a system level Nursing Quality Council and nursing quality dashboard

- In March 2022, OPCC hosted a very successful 6-day Director of Nursing Quality training program attended by **17 participants** (Directors of Nursing Quality and NDNQI Coordinators) from each of the 11 acute care facilities and provided a detailed overview on regulatory agencies, NPSG, nurse sensitive indicators, NDNQI, NHSN, Data and Analytics (DnA), VOICE and EPIC reports
- The program included in-person lectures, case scenarios and training modules led by representatives from Nursing, Press Ganey, HANYS, Infection Prevention, Risk Management, and Quality and Safety departments

Excellence

Nursing Clinical Ladder Program

- The Nursing clinical ladder program for 2022 was opened on February 1, 2022. The deadline was extended to March 31, 2022. The new criteria added are:
  - Hand Hygiene Observer
  - Heal the Healers (H3) Champions
  - Alumni NRP Mentorship

Positive Practice Quality Research System Team (PQRST)

Laying foundation by creating a system level Positive Practice Quality Research System Team (PQRST) committee

- Created a Positive practice committee including members from all acute care facilities for ANCC PTE, Magnet initiatives, launched September, 2021.

Nursing Excellence

- AACN Beacon recognition document preparation and guidance for all acute care facilities critical care nursing, started July, 2021.
- Completed nursing excellence award 2021 ceremony in December.
- Facilitated Nursing Excellence Solutions System Reports Dashboard agreement –for patient experience, RN survey and NDNQI data for comparison and benchmarking, launched November 2021.

Daisy Award

- Daisy award for nurses advancing health equity
- First system level award, awarded to 4 nurses

Nursing Research/EBP/Innovation

- Established the foundation for Doctoral nursing student's capstone/dissertation research through a scientific review committee along with central office research administration.12 DNP projects and 3 PhD Nursing Dissertations were approved in 2021.
- Launched systemwide nursing research/EBP/innovation committee in January 2022 with the goal to promote nursing research studies at each facility as a requirement for ANCC Magnet application.
- Developed a Nursing Research framework to promote and engage frontline RNs in nursing research.

Social Work:

- The first phase of *Social Work Shared Governance* implementation began in November 2021 with facility & site-based information sessions for frontline Social Work staff and leadership.
- The *Social Work Director's Council* began focused workgroups in November to target its 2022 priorities, which include:
    - Recruitment & Retention
    - Staff Recognition & Wellness
    - Professional Training & Development
    - Social Work Student Affairs

  As the *Social Work Council* is formed by frontline staff via the aforementioned shared governance process, it will similarly identify priority areas. As such, *SW Director Council* workgroups will adapt where needed to harmonize and support their work.

- Focused Social Work scope of practice and role refinement activities continue to evolve in the following areas:
    - Women's Health
    - The 3-2-1 IMPACT (Integrated Model for Parents And Children Together) program
    - Behavioral Health's B-HEARD (Behavioral Health Emergency Assistance Response Division) pilot and Virtual ExpressWell, a 24/7 virtual behavioral health urgent care

- Expansion of partnerships with local graduate schools of Social Work to improve not only recruitment of Social Work trainees and fellows, but also recruitment of new graduates and alumni

Care Experience

PROFESSIONAL SHARED GOVERNANCE

- Completed 4 system wide reports (including 3 annual retreats) and 7 hospital wide report outs. 98% of councils have been organized (83% active) with charters and consistently meeting on a regular basis on all sites.
- Social Work Council and PQRST (Positive Practice, Quality, Research System Team) Council launched in February 2022.
- Next systemwide PSG Report Out in August, 2022. Councils in formation: Care Management Council, System Advanced Practice Nurse Council.
- Twice daily Coaching Calls for PSG frequently asked questions exceeded 92+ weeks (690+ hours) continuing every Mondays to Fridays.
- PSG Dashboards are in production. The dashboards will be used by all PSG Councils at all levels (unit, specialty, hospital, system) to report on performance and guide the alignment of work with hospital and system wide priorities.

NURSE RESIDENCY PROGRAM

- Launched in April 2019
- **8 active cohorts**. New cohorts launched every 3 months, 4x a year.
- **921 enrolled residents** to date.
- Graduated 13 cohorts (325+ new hire/new graduates) to date.
- Updated **retention rates**: **2019=84.6%; 2020=84%; 2021=96.75%** compared to pre-NRP Retention rate of 46% systemwide.
- Total of additional 391 retained RNs or $39.1M savings (at $100K recruitment / replacement cost per RN)
- Launching Wellness and Resiliency curriculum content (H3 Wellness Rounds) in 2022.
- ANCC PTAP accreditation in 2022-23

RN MENTORSHIP

- Launched in Bellevue, Coney Island
- 2 retiree mentors, 10 incumbent RN mentees
- Mentorship Training completed via Peoplesoft ELM

- Expansion of Retiree Mentor Pool
- Additional Arms:
    - NRP Alumni Mentors – launched in 2022
    - Leader Mentors
    - Hybrid Mentors/Preceptors
- Embedded into Clinical Ladder Program as of February 2022.

NP FELLOWSHIP

A partnership in a Learning Collaborative was secured in September 2020 with the Weitzman Institute's National Nurse Practitioner Residency and Fellowship Training Consortium (NNPRFTC) to help us with free coaching as part of a grant funded

Nursing Finance

Nursing Finance & Operations

Successfully onboarded over 400 Surge staff to support facilities with during the Winter COVID Volume planning. Facilities have staffed up to help support the increase in patient volume across the sites during the winter.

MetroPlusHealth Report to the Medical & Professional Affairs Committee

Dr. Talya Schwartz, President & CEO

Regulatory Highlights

Recertifications for Medicaid, Essential Plan, and Child Health Plus are still in a moratorium status, but NYS is using the working timeline of July 2022 to commence instituting their plans for recertifying the entire population within the 14-month window allotted by CMS. If the Federal PHE is extended beyond July, the 14 months will begin at the end of the PHE. CMS has indicated that all recertification processes must have commenced by the 12-month mark and conclude by the end of the 14th month.

The proposals for the NYS FY 2022-23 budget contain a significant number of coverage expansions. These include expanding income levels for Essential Plan eligibility from 200% to 250% FPL; extending postpartum coverage in Medicaid to 1 year following the last day of pregnancy; eliminating the CHP premium for households with income below 222% FPL; and funding coverage for low-income immigrant's ineligible for other government programs, known as Coverage4All. Both houses in the legislature, the governor's office, health plan trade associations, and MetroPlus are in favor of these coverage expansions, and they look very likely to pass into law.

New Federal Laws Impacting Information Access for Members

Two new Federal rules, Transparency in Coverage Act and No Surprises Act, are both designed to increase obligations on health plans to provide information about how much services cost a Plan to provide. The Transparency rules require group health plans and insurers in the group and individual markets to provide self-service tools to members to allow them to know what plans are paying their in-network providers. This includes providing machine readable files and a price comparison tool where members can see how much their out-of-pocket costs would vary by provider by June 2022 and a list of 500 shoppable services for out-of-pocket costs by January 2023.

The price comparison tool is impactful to any MetroPlus line of business where members may have cost-sharing rather than a set co-payment, such as QHP and Gold.

Financial Performance - 2021

Net Income

MetroPlus reported a net income of $26.2 million for the twelve months ending December 31, 2021. The overall net margin is 0.7%, as compared to 1.3% for 2020.

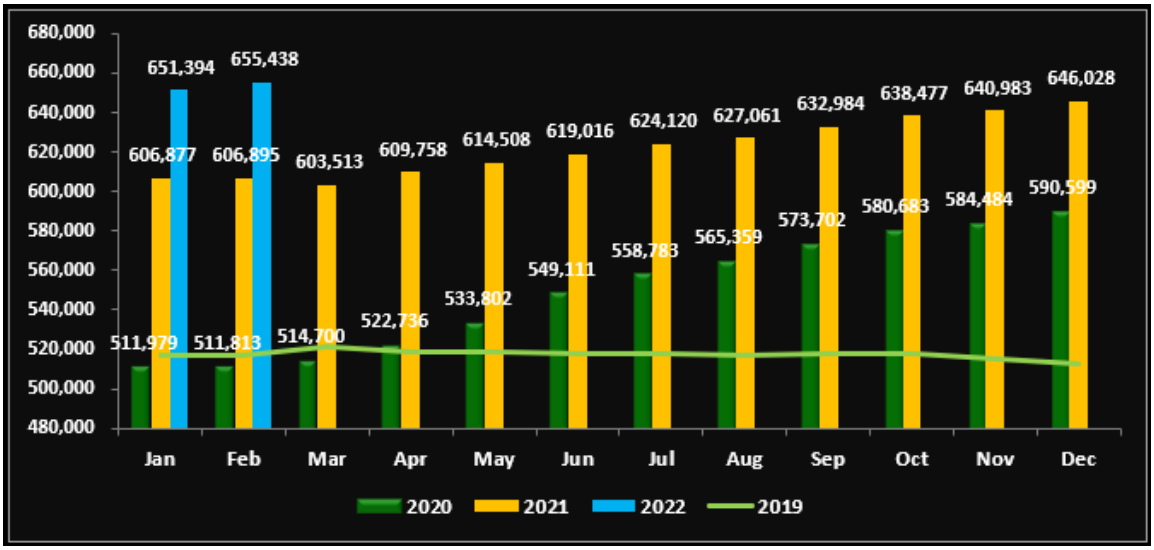
The 2021 year-end risk surplus has increased 3% from 2020 to 2021. The year over year increases were mostly due to increases in premium rates which more than offset the rising costs across all LOBs except for Medicaid.

QHP Applied Behavioral Analysis (ABA)

MetroPlus' QHP line of business saw an exponential increase in ABA costs in 2021. We have taken steps to manage the cost moving forward and assure that appropriate assessments are completed and drive appropriate services. Additionally, transitioning the ABA network form Beacon to MetroPlusHealth resulted in right sizing the provider network.

Membership

QHP renewal rate is currently at 95%(!). This rate was bolstered by an improved price position and significant outreach efforts by Retention. QHP has grown almost 12% from December 2021 to February 2022. Several tactics were devised and executed contributing to the overall high retention rate, such as launching text message technology, enhanced recertification webpage, and distribution of targeted outreach lists.



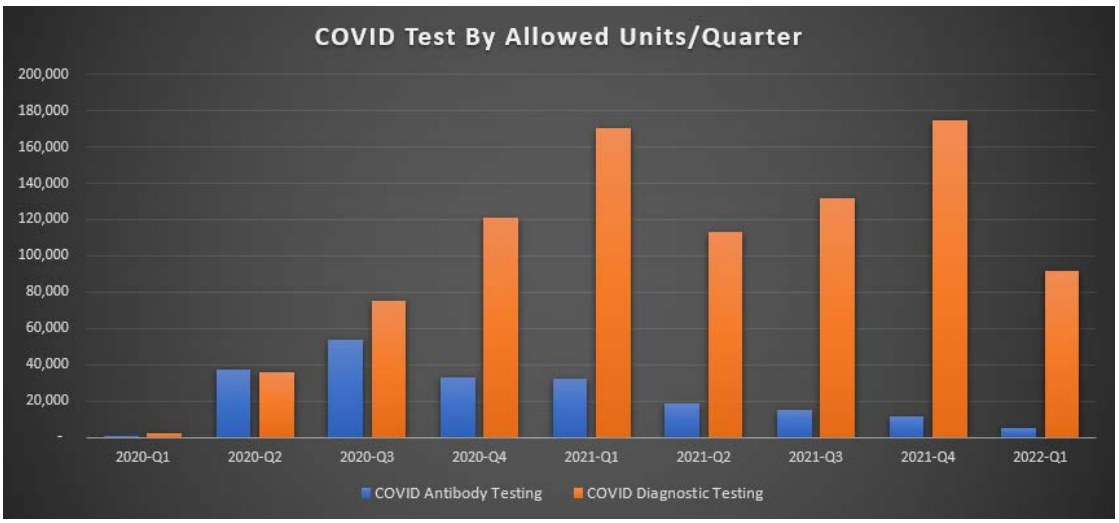
Market Share

Increased market share in CHP: 1.5% compared to December 2021 SNP, HARP, MCAD, MA, and MLTC market has remained steady.

COVID

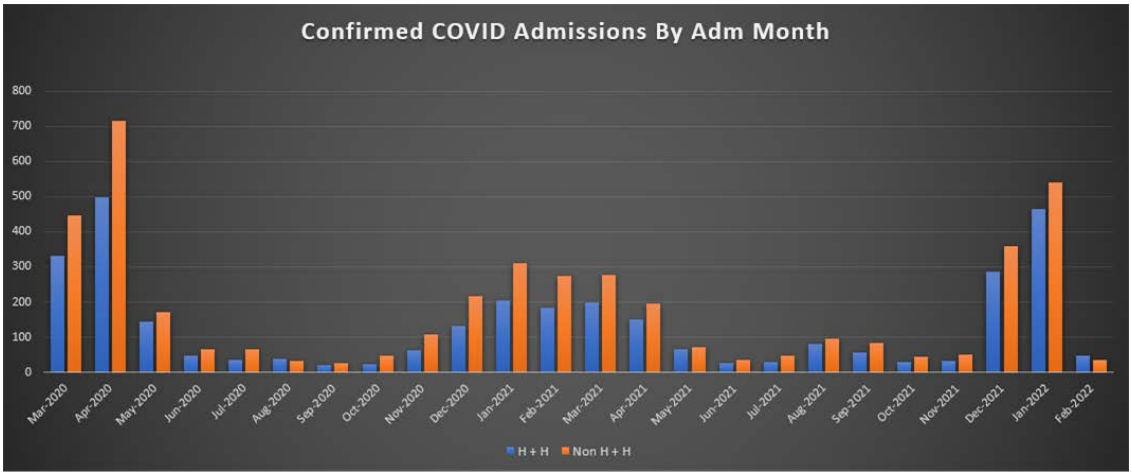
Testing Data

As expected, COVID testing peaked to its highest rates ever in the last quarter of 2021.



COVID Inpatient Data

January 2022 saw high inpatient rates for COVID cases, lagging after the high positivity rates the end of 2021. We expect this to trend downwards and remain low into Q2 2022.



Telehealth

In February, MetroPlusHealth implemented a new Virtual Visit telehealth platform powered by NYC Health + Hospitals / ExpressCare. Previously our Virtual Visit Platform was managed by AmWell. Upon reviewing and assessing our telehealth needs, we made the decision to partner with NYC Health + Hospitals / ExpressCare to provide services to our members. The partnership is just one way in which we leverage our relationship with NYC Health + Hospitals and the tools and services that they have available. To date, we

are pleased to report that the implementation of the new platform has been successful, and we continue to focus on refining our operational process. The service has seen approximately 200 calls per week, of those about 80% requested to be connected to a provider and of those approximately 20% were looking for a BH provider.

MetroPlus Health collaboration with H+H Post-Discharge Initiative

The COVID Omicron surge experienced by New York City acutely increased the demand for emergency room and inpatient services whilst simultaneously impacting staffing (e.g., staff shortages due to illness and required isolation protocols) at these places of service. Staffing was also impacted by the Statewide COVID vaccination mandate of all healthcare workers. As a result, NYC Health + Hospitals initiated intensive review of patients in the emergency room and inpatient units to see if patients could be safely discharged from the emergency room (without requiring transfer to an inpatient bed) or inpatient units (with accelerated discharge protocols). In doing so, nursing coverage was maintained to adequately manage the COVID surge and patients were able to leave the hospital as much as a full day earlier than anticipated. To ensure the safety of the patients during the discharge process, MetroPlus RN Care Managers assumed responsibility for conducting post-discharge follow up calls for patients hospitalized in H+H acute care facilities starting January 12, 2022. Of 1,207 patients identified for outreach, RNs were able to reach 439 (36%) and made attempts to reach an additional 429 (36%). There were multiple reasons why outreach could not be conducted including 339 (38%) who had invalid or missing contact numbers available, 150 (12%) who were discharged to skilled nursing facilities, and 57 (5%) who were in hospitals.

The MetroPlus RN Care Managers, who outreached patients regardless of payor status, utilized the ExpressCare Telehealth platform. This allowed them to conduct calls and transfer patients to physicians immediately if they required medical consultation and follow up with prescription issues. Other interventions conducted by the team included education, appointment scheduling, equipment ordering and transportation to future medical appointments.

Care Managers were able to seamlessly escalate any concerns to Virtual ExpressCare (vEC) providers as needed and did so for roughly 7% of these patients. vEC visits themselves also had moderate complexity and duration, underscoring their value.

In program debriefs, the MetroPlus Care Managers shared how blown away they were by the positive feedback from patients about their care received at NYC H+H hospitals. In all cases, discharge plans and instructions were reviewed. Patients were happily surprised to receive this follow-up call, and Care Manager teams were able to help patients with a number of clinical issues, including most frequently medication-related and referral/appointment follow-up issues." As the COVID surge abated, this initiative concluded on February 11, 2022, MetroPlus Care Managers resumed their regular work. NYC H+H is exploring avenues to continue delivering this service for their highest-need patients in the longer term. This initiative was yet another example of the strong

collaboration between MetroPlus team and Quality & Safety teams at NYC H+H during the COVID epidemic.

2020 HIV Special Needs Plan (SNP) Managed Care Quality Incentive Award

The New York State Department of Health (NYS DOH), Office of Health Insurance Programs (OHIP), announced that $17.4M has been made available for an HIV Special Needs Plan (SNP) Quality Pool. By virtue of the performance scores each plan achieved during 2019 on various quality, satisfaction, and compliance measures, each plan is entitled to receive a portion of the quality pool. The amount earned by MetroPlus was $6,507,164 and was received by the Plan in February 2022.