

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

**APRIL 14, 2015
10:30 A.M.
HHC BOARD ROOM
125 WORTH STREET**

AGENDA

I. CALL TO ORDER **JOSEPHINE BOLUS, RN**

**II. ADOPTION OF MARCH 10, 2015
STRATEGIC PLANNING COMMITTEE MEETING MINUTES** **JOSEPHINE BOLUS, RN**

III. SENIOR VICE PRESIDENT'S REPORT **LARAY BROWN**

IV. INFORMATION ITEM

i. PRESENTATION: 2015-16 STATE FISCAL YEAR BUDGET OVERVIEW

**WENDY SAUNDERS
ASSISTANT VICE PRESIDENT, OFFICE OF INTERGOVERNMENTAL RELATIONS**

V. OLD BUSINESS

VI. NEW BUSINESS

VII. ADJOURNMENT **JOSEPHINE BOLUS, RN**

MINUTES

STRATEGIC PLANNING COMMITTEE MEETING OF THE BOARD OF DIRECTORS

MARCH 10, 2015

The meeting of the Strategic Planning Committee of the Board of Directors was held on March 10, 2015 in HHC's Board Room located at 125 Worth Street with Josephine Bolus presiding as Chairperson.

ATTENDEES

COMMITTEE MEMBERS

Josephine Bolus, NP-BC, Chairperson of the Committee
Ram Raju, M.D.
Anna Kril
Robert F. Nolan
Bernard Rosen
Patricia Yang, representing Deputy Mayor Lilliam Barrios-Paoli

OTHER ATTENDEES

K. Raffaele, Analyst, Office of Management and Budget
J. Wessler, Guest

HHC STAFF

S. Abbott, Assistant Director, Corporate Planning Services
M. Belizaire, Assistant Director of Community Affairs, Office of Intergovernmental Relations
L. Brown, Senior Vice President, Corporate Planning, Community Health and Intergovernmental Relations
T. Carlisle, Associate Executive Director, Corporate Planning Services
E. Casey, Assistant Director, Corporate Planning Services
D. Cates, Chief of Staff, Office of the Chairman
M. Cooper, Director, Community Affairs, Intergovernmental Relations

C. Dunn, Senior Director of Marketing, Communications and Marketing
J. Goldstein, Senior Consultant, IS, Corporate Planning Services
D. Green, Senior Assistant Vice President, Corporate Planning Services
L. Guttman, Assistant Vice President, Intergovernmental Relations
J. Jurenko, Senior Assistant Vice President, Intergovernmental Relations
S. Kleinbart, Director of Planning, Coney Island Hospital
Z. Liu, Senior Management Consultant, Corporate Planning Services
P. Lockhart, Secretary to the Corporation, Office of the Chairman
A. Marengo, Senior Vice President, Communications and Marketing
R. Mark, Chief of Staff, President's Office
A. Martin, Executive Vice President and Chief Operating Officer, President's Office
I. Michaels, Director, Media Relations, Communications and Marketing
J. Omi, Senior Vice President, Organizational Innovation and Effectiveness
K. Park, Associate Executive Director, Finance, Queens Health Network
S. Penn, Deputy Director, World Trade Center Environmental Health Center
S. Ritzel, Associate Director, Kings County Hospital Center
S. Russo, Senior Vice President and General Counsel, Office of Legal Affairs
L. Sainbert, Assistant Director, Chairperson's Office
W. Saunders, Assistant Vice President, Office of Intergovernmental Relations
J. Wale, Senior Assistant Vice President, Behavioral Health
K. Whyte, Senior Director, Corporate Planning, Community Health and Intergovernmental Relations

CALL TO ORDER

The Strategic Planning Committee Chairperson, Ms. Josephine Bolus, NP-BC, called the meeting of the Strategic Planning Committee to order at 10:30 A.M. The minutes of the February 10, 2015 meeting of the Strategic Planning Committee were adopted.

SENIOR VICE PRESIDENT REMARKS

Federal Update

Ebola Funding

Ms. Brown reported that, on February 20, 2015, HHS had announced that New York City (NYC) would be awarded \$21.7 million for Ebola related expenses. New York State was awarded \$7.5 million in HHS funding. The funding awarded to NYC includes reimbursement for the cost that Bellevue Hospital incurred for treating the one Ebola patient. With the support of Senator Schumer, HHC is seeking funding for Bellevue Hospital's designation by the U.S. Department of Health and Human Services (HHS) as the Region II Ebola and Other Special Pathogen Treatment Center. Ms. Brown added that this designation would require that Bellevue Hospital accept all patients within HHS Region II for treatment related to infectious diseases. This designation requires specific levels of personnel and non-personnel readiness. Support from HHS in the amount of \$3 million per year would be required. Ms. Brown informed the Committee that HHC's Washington staff is working with Senator Schumer's office and the HHS Office of the Assistant Secretary for Preparedness and Response. Ms. Brown commented that HHC was very grateful for the Mayor's support on this issue.

Sustainable Growth Rate

Ms. Brown reported that the Sustainable Growth Rate (SGR) or "Doc Fix" deadline was March 31, 2015. She explained that the SGR referred to the rate that Medicare uses to reimburse physicians for medical procedures. Without the fix, Medicare physician payments would decrease by 21% in 2015. A one-year fix would cost an estimated \$16 billion. Ms. Brown informed the Committee that, in 1997, Congress crafted the SGR formula, which tied Medicare payment rates for doctors to the projected growth of the national economy. She explained that healthcare spending had quickly outpaced economic growth, opening a multibillion-dollar gap in funding for Medicare payments to physicians. Lawmakers had placed the first temporary patch on the SGR in 2003, and the quest for a permanent Medicare "Doc Fix" became an annual ritual ever since.

Ms. Brown reported that Congress had passed 17 temporary "patches." The latest SGR patch, which Congress adopted last winter, after failing to agree on financing a bipartisan SGR repeal-and-replacement deal, at a cost of \$128 billion, was set to expire on March 31, 2015. Congress is wrestling with how to pay for the SGR. Options explored often spell trouble for safety net hospitals as "pay-for" often target public hospitals that treat vulnerable populations.

Ms. Brown stated that a long-term fix would cost approximately \$170 billion, a 9-month patch would cost approximately \$12 billion and a 6-month patch would cost approximately \$8-9 billion. Ms. Brown stated

that there was strong reason to fear that any patch or long term solution would target Hospital Outpatient Department (HOPD) Medicare Evaluation and Management (E/M) Services, which could cost HHC \$186 million over 10 years or about \$18 million yearly. Ms. Brown informed the Committee that other options that have been raised to pay for the SGR fix have also included restructuring GME/IME funding and pushing Medicaid Disproportionate Share Hospital (DSH) funding cuts further into the out-years.

Supreme Court Hearing Regarding ACA Subsidies

Ms. Brown reported that, last week, the Supreme Court of the United States heard arguments in the case of King vs. Burwell. In this case, the question presented before the Court is whether the language of the Affordable Care Act (ACA) limits health care subsidies to enrollees who reside in states that have established their own health care exchanges. The plaintiffs argue that the "plain language" of the ACA states that subsidies are only available in states that have exchanges that are "established by the state." Ms. Brown reported that as many as 7.5 million persons could lose their health care subsidies if the plaintiffs prevail.

Ms. Brown informed the Committee that thirty-four (34) states have not established their own health exchanges with enrollees in these states using the Federal Exchange that is accessible through the healthcare.gov website. She added that, while this case could cripple the ACA, some Republicans realize that they need to have a "Plan B" should the Court rule that these subsidies are beyond the scope of the ACA. Ms. Brown added that lower courts were divided on the issue. Ms. Brown promised to keep the Committee apprised on this issue going forward.

Mr. Rosen, Board Member, asked when the King vs. Burwell case would be argued. Ms. Brown responded that arguments concerning this case began last week. President Raju added that the Supreme Court is expected to make a decision by the end of June.

Federal District Court Blocks President Obama's Immigration Actions

Ms. Brown reported that following President Obama's Immigration Policy announcement in November 2014, twenty-six (26) states across the country filed a lawsuit in a Texas Federal District Court in an attempt to prevent implementation of the new immigration actions. The Texas Federal District Court decided that the initiatives announced by President Obama, known as expanded Deferred Action for Childhood Arrivals (DACA+) and Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA) would be temporarily blocked from going forward. Ms. Brown added that the Court had based its decision on an argument that the Federal Government did not comply with rulemaking procedures under federal law.

Ms. Brown informed the Committee that the Court indicated that the strongest argument presented by the states that filed the suit focused on the costs that those states would incur to provide driver's licenses to recipients of expanded DACA and DAPA. Missing from the Court's analysis were the benefits to the state economy that providing DACA and DAPA to currently undocumented individuals would provide including increased state income and property tax revenues.

Ms. Brown reported that the first phase of President Obama's executive initiatives, which would affect undocumented immigrants who came to the United States as children, was scheduled to be implemented beginning on February 18, 2015. In addition, the Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA) initiative is scheduled to go into effect in May.

Ms. Brown stated that many state and local officials have filed amicus briefs in district courts that highlight the benefit that the immigration initiatives would bring to communities and the economy. Twelve states, the District of Columbia, 33 cities, 27 police chiefs, along with nonprofit organizations have filed briefs with the Court emphasizing the benefits of the Obama Administration's immigration initiatives. In addition, a request by the Justice Department for an emergency order to allow the Federal Government to issue work permits and provide legal protections to hundreds of thousands of undocumented immigrants, while it appealed the Judge's ruling to halt the programs to a Federal Appeals Court, had been rejected by the District Court. Ms. Brown's stated that she would keep the Committee apprised of new developments concerning this case.

STATE UPDATE

State Budget Update

Key Issues Important to HHC

Ms. Brown reported that, on March 9, 2015, each house had introduced their budget proposals. These proposals are the starting point for a series of budget negotiations. Ms. Brown stated that, based on the Consensus Revenue Forecast agreed upon last week, the legislative proposals would contain \$200 million in additional revenue above and beyond what was included in the Governor's Executive Budget. HHC staff is currently analyzing the Governor's proposals as well as two spending bills that were introduced on March 9th by each house.

Ms. Brown reported that, while there were many specific budget issues that would impact HHC, some of the key issues that HHC was focusing on were the following:

- Medicaid funding, which increased by 3.6% from \$58.752 billion to \$62.046 billion
- Global Cap on Medicaid funding
- Savings Allocation Plan
- Global Cap "dividend"
- Basic Health Plan
- Medicaid for new immigrants
- HHC Upper Payment Limit (UPL)
- Charity Care funding
- Capital Restructuring Financing Program -\$700 million targeted to Brooklyn
- Vital Access Provider Funding (Important to all safety nets including HHC)
- Hospital Quality Pool
- Value Based Payments
- Other Policy Changes

Ms. Brown reported that she and Dr. Raju visited Albany last week to meet with the Health Committee Chairs and other key legislators and focused most of their attention on two issues – HHC's Upper Payment Limit and the distribution of Charity Care funding. Ms. Brown stated that overall it was a very successful trip. They were asked to propose Charity Care language for inclusion in the Senate and Assembly Budget proposals. Ms. Brown added that HHC received positive responses from most downstate legislators. They also discussed the importance of Upper Payment Limit (UPL) and that language remains in the Assembly and the Senate budgets.

Behavioral Health Rates in Managed Care

Ms. Brown informed the Committee that, although behavioral health rates were not currently a budget issue, they spoke to legislators about the proposed premiums for behavioral health services in managed care. Ms. Brown reminded the Committee that she raised this emerging issue last month. She explained that the premiums that the state is providing for Medicaid patients who are transitioning from fee-for-service into managed care were too low because the state is basing those premiums on Medicaid fee-for-service rates, which have historically underfunded the cost of behavioral health care. HHC's current underfunding is approximately \$120 million.

Update on State Legislative Actions

Ms. Brown stated that, although Albany was focused on the state budget, there were state legislative actions that were of importance to HHC. Ms. Brown stated that the perennial introduction of bills during the budget season usually surfaced around nurse staffing ratios, medical malpractice and HHC-specific legislation. Ms. Brown informed the Committee that Senator Lanza had put forward a bill that would require HHC to financially support hospitals on Staten Island. This bill was reported out of the Senate Cities Committee and is now poised to pass the Senate. Ms. Brown stated that, although Assemblyman Cuisack had introduced the bills in the Assembly, no action was expected in that house. Ms. Brown informed the Committee that her staff would continue to monitor these bills as well as other emerging legislation that could affect HHC. Ms. Brown shared with the Committee that recently a letter was written to the Mayor requesting funding support for the Emergency Departments of the two Staten Island hospitals.

CITY UPDATE

Ms. Brown reported that nearly all of HHC's Community Advisory Boards had hosted legislative forums. Ms. Brown explained that these forums were important events that HHC Community Advisory Boards (CABs) hold each year to highlight new initiatives and to educate elected officials and their community about key legislative and budgetary issues. Over the last month, Ms. Brown and Mr. John Jurenko have been presenting at these forums, most recently at Bellevue and Coney Island Hospitals on March 6th. Ms. Brown reported that there was a very good turnout of local, state and federal elected officials and their representatives. Ms. Brown added that Mrs. Bolus had attended many of these forums and had spoken at some and exhorted community members in those forums to continue to be active in a civic way and to bring their message to their legislators.

Ms. Brown announced that HHC was expected to provide testimony at the NYC Council Health Committee's March 23rd Preliminary Budget Hearing. She informed the Committee that each year, facilities ask their Council Members and their Borough Presidents for capital funding. IGR coordinates these requests and works with Council Finance and key staff on maximizing these requests. In addition, IGR staff continues to work with facilities on capital requests that they make to the City Council and Borough Presidents.

INFORMATION ITEM

Presentation: Mayor's Management Report (MMR)

Dona Green, Senior Assistant Vice President, Corporate Planning Services

Ms. Brown informed the Committee that, for many years, data concerning HHC's performance on key indicators have been included in the Mayor's Management Report (MMR). Ms. Brown stated that it was important to present to the Strategic Planning Committee an overview of that report to educate Board Members about what story the MMR entailed. In addition, since the report is made public, Board Members will be able to see the report and understand the type and the meaning of the data collected within HHC.

Ms. Dona Green, Senior Assistant Vice President of Corporate Planning Services greeted Committee members, invited guests, and thanked them for the opportunity to present the HHC data that is collected and presented as part of the Mayor's Management Report (MMR).

Ms. Green began her presentation with an overview of the MMR. She explained that the MMR served as a public report card on City services affecting New Yorkers since 1997. It was mandated by the New York City Council. She added that final reports were submitted twice a year to the New York City Council for its review and were available online at <http://www.nyc.gov/html/ops/html/data/mmr.shtml>.

Ms. Green explained that preliminary reports covered the first four (4) months of the current fiscal year (July-October) and had to be submitted to the City Council no later than January 30th of the current fiscal year. The full fiscal year report covers the full fiscal year, which is from July through June. It is submitted to the City Council by no later than September 30th of the subsequent fiscal year. Ms. Green informed the Committee that Corporate Planning Services (CPS) collected data from various offices/departments throughout HHC. CPS staff inputs the data onto the NYC Performance Management Application Website.

Ms. Green explained that HHC reported data on a total of 15 indicators which are categorized into four main categories:

1. **Goal 1a:** Improve access to outpatient services – reducing costly and unnecessary emergency department use and making sure that their illnesses can be managed before they progress to acute stages.
2. **Goal 1b:** Expand enrollment in insurance programs – reduce the number of patients that delay care and reduce the number of uninsured patients using our services
3. **Goal 1c:** Achieve/surpass local and national performance standards for specific health interventions and efficient delivery of health services – quality and making sure that provided services are appropriate for the patients
4. **Goal 1d:** Reduce unnecessary emergency room visits and re-hospitalizations – care coordination and management

Ms. Green reported that, as a public report card, the use of the MMR was consistent with a management tool known as a balanced scorecard. She explained that a balanced scorecard uses a set of measures that are aligned with an organization's goals and mission to provide an organization with a comprehensive perspective on its performance. It also provides a feedback loop to enable improvement and the development of strategies to initiate change.

Ms. Green reported that HHC's immediate initiative is to make sure that the MMR is aligned with HHC's strategic priorities. Ms. Green described the alignment of HHC's strategic priorities and the MMR as described on the following table.

Mayor's Management Report Indicators (MMR)	HHC's Strategic Priorities
<ul style="list-style-type: none"> • Prenatal care patients retained in care through delivery • MetroPlus Medicaid, Child Health Plus and Family Health Plus enrollees • Total Medicaid Managed Care, Child Health Plus and Family Health Plus enrollees 	Grow market share
<ul style="list-style-type: none"> • % ER revisits by adult asthma patients • % ER revisits by pediatric asthma patients • Adult psychiatric patients 30 day readmission rate • HIV patients retained in care • Clinic cycle time (Adult, Pediatrics and Women's Health): Non-clinical patient time (minutes) • Mammography screening • Percent of two-year olds immunized 	Expand access to care: Right service; right place; right time
<ul style="list-style-type: none"> • Total Uninsured patients served (Expand enrollment in insurance programs) • Days in accounts receivable (net) • General Care ALOS 	Stabilize HHC's Financial Health
n/a	Focus on Workforce Development

Ms. Green explained that one of HHC's immediate strategic priorities is to ensure alignment of the goals of its Delivery System Reform Incentive Payment (DSRIP) program initiatives with the MMR. She reminded the Committee that the DSRIP Program is a healthcare reform initiative aimed at reducing unnecessary emergency room utilization; reducing unnecessary hospitalizations for conditions treatable in primary care settings; improving the healthcare experience through the coordination of healthcare providers across the continuum; and increasing primary care access. She stated that many of the MMR indicators aligned with DSRIP goals.

Ms. Green demonstrated the link between the MMR and DSRIP goals in the table provided below:

Mayor's Management Report Indicators (MMR)	DSRIP Goals
<ul style="list-style-type: none"> • Total uninsured patients served (Expand enrollment in insurance programs) • Prenatal care patients retained in care through delivery • MetroPlus Medicaid, Child Health Plus and Family Health Plus enrollees • Total Medicaid Managed Care, Child Health Plus and Family Health Plus enrollees • Mammography screening • Percent of two-year olds immunized 	Increase primary care access
<ul style="list-style-type: none"> • % ER revisits by adult asthma patients • % ER revisits by pediatric asthma patients • HIV patients retained in care 	Reduce unnecessary emergency room utilization
<ul style="list-style-type: none"> • Adult psychiatric patients 30 day readmission rate • HIV patients retained in care 	Reduce unnecessary hospitalizations

Mayor's Management Report Indicators (MMR)	DSRIP Goals
<ul style="list-style-type: none"> General Care ALOS Clinic cycle time (Adult, Pediatrics and Women's Health): Non-clinical patient time (minutes) Mammography screening Percent of two-year olds immunized 	Improve the healthcare experience
<ul style="list-style-type: none"> Days in accounts receivable (net) 	N/A

Ms. Green described the indicators that were included on the MMR. She explained how the data charts were organized and the meaning of specific terms presented on the data charts. She stated that the term "owner" referred to the HHC division/department charged with providing performance data for a specific indicator. "Data availability" referred to the time frame for which the data is collected. For instance, data is collected quarterly and annually for all indicators. Ms. Green described some of the indicators presented for Goal 1a in the following table.

Goal 1a: Improve Access to Outpatient Services

Indicator Name	Owner	Data availability	Most Recent Data	Target	Desired Direction	Recent Direction	Comparable
Prenatal patients retained in care through delivery (%)	CPS	Quarterly & Annually	88.8%	90%	Up	Up	None
HIV patients retained in care (%)	CPS	Annually	86.8%	90%	Up	Up	69.8% NYS 2009
Cycle Time Adult (Min)	M&PA	Quarterly & Annually	45	30	Down	Change in formula	30 IHI Goal
Cycle Time Pediatrics (Min)	M&PA	Quarterly & Annually	43	30	Down	Change in formula	30 IHI Goal
Cycle Time Women's Health (Min)	M&PA	Quarterly & Annually	44	30	Down	Change in formula	30 IHI Goal

Ms. Green informed the Committee that Corporate Planning Services (CPS) is the owner of the "Prenatal Care" indicator. She explained that, for this indicator, the numerator is the number of patients who delivered at an HHC facility and the denominator is the number of women with two or more prenatal care visits in a quarter.

Ms. Green reported on the "HIV Patients Retained in Care" indicator which is owned by CPS. She explained that the numerator for that indicator is, of the number of patients in the denominator, those who had at least one visit in each half of the calendar year and the denominator is the number of patients with an HIV visit. Ms. Green explained that this indicator is also a NYS HIV monitoring indicator. The data for this indicator is collected over a full twelve months because the definition of "retained in care" is an HIV patient

who had at least one visit in the first six months of the calendar year and at least one visit in the last six months of the calendar year. Ms. Green emphasized that one could not run data for that indicator for only four months and still adhere to the present definition. For that reason, not applicable (N/A) is noted in the column titled, "4-month Actual" on the Preliminary MMR Report. Mrs. Bolus commented that Ms. Green should include this explanation as part of her report. Both Ms. Brown and Ms. Green agreed to include this explanation as a footnote.

Mr. Robert Nolan, Board Member, asked if 86.8% of the HIV patients had made the required two visits during the course of the year. Ms. Green responded affirmatively. Ms. Brown added that this was an indicator that the HIV patients were being retained in care. Mr. Rosen asked if "retained in care" meant that these patients were coming to HHC's clinics. Ms. Brown responded that it meant that they there were returning to HHC's facilities to be treated for HIV. Mr. Nolan asked who came up with the requirement that the visit should be twice a year. Ms. Brown responded that the AIDS Institute of the New York State Department of Health (NYSDOH) had established that standard. She clarified that the visits were not twice a year but rather once in every half of the year. Mrs. Bolus commented that that this explanation should also be added to the report.

Ms. Green stated that the Office of Medical and Professional Affairs owned the "Cycle Time" indicators for adults, pediatrics and women's health. Ms. Green explained that, in the past, the definition for "Cycle Time" was "time of registration to the time of discharge." Ms. Green explained that the recently adopted definition is "scheduled appointment time until time actually seen by provider." Ms. Green stated that the target for this indicator is 30 minutes. She informed the Committee that CPS will notify MMR staff of this new change in time for the full Fiscal Year 2015 Report. In addition, the indicator will be collected via Sorian. Ms. Green informed the Committee that, in the near future, the indicator will go back to full cycle time.

Mr. Nolan asked Ms. Green to clarify the meaning of "Cycle Time." Ms. Green explained that "Cycle Time" means the time that the patients come into the facility until the time that they leave or until the time they see a provider. The purpose of these indicators is to identify the patients' non-value added time during their appointments. Ms. Green added that, if patients are waiting an inordinate amount of time in the waiting room before seeing a provider, it gives HHC an opportunity to improve the wait time. She clarified that the 45 minutes listed on the chart indicated that the patients waited 45 minutes before they saw a provider. She emphasized that the goal is to reduce the wait time to 30 minutes. Mrs. Bolus asked if the "Cycle Time" also included the registration of vital signs and all of the other activities conducted in between. Ms. Green responded affirmatively. She explained that it is the time the patients come into the facility until they see a provider.

Mr. Rosen asked how realistic was the goal of a 30 minutes cycle time. Ms. Brown answered that there is an expected standard from the Institute for Health Improvement (IHI) and others stating that with the help of certain systems and processes, people should be able to see their doctors within a half hour of their presenting to a clinic or a doctor's office. Dr. Raju added that it could be done. Dr. Raju explained that a major concern is that some patients are not following their scheduled times. He mentioned that, with the notion of first come, first served in mind, some patients show up well ahead of their scheduled time and end up waiting for a long time. Dr. Raju commented that, for this indicator to be successful, patients need to show up at their scheduled time. In addition, Dr. Raju stated that a large number of "no shows" do not help to improve cycle time. He added that there is a lot of work to be done to educate the providers as well as the patients.

Ms. Brown added that several years ago a large body of work and most recently the ambulatory care redesign project, under Dr. Christina Jenkins' leadership with consultants, have been focused on improving access. There are certain systems that must be put in place. For example, when a patient comes in, the provider team should already know that the patient is coming and patient lab results should be readily available as part of the visit. In addition, the team must show up on time so that when the patient comes in they are already there for them. Patients should not have to wait. Ms. Brown added that, if new patients who are coming into the system through the Affordable Care Act experience frustration and long waits they are going to go elsewhere, which would defeat HHC's goals of increasing market share and improving patients experience. Mrs. Bolus commented that patients need to be educated because they tend to feel that they would be seen earlier if they come earlier. With this mentality, on-time patients become frustrated as they experience an excessive amount of wait time. Mrs. Bolus referenced provider commercials advertising "no wait times" for their services.

Mr. Rosen agreed with Ms. Brown that it was important to ensure that all the prep work that needs to be done by members of the health care team, other than the physicians, are completed before the scheduled time of the patient. Ms. Brown added that improvements were needed in both the healthcare team's behavior and the patients' behavior.

Ms. Green described the Goal 1b indicators as outlined in the following table.

Indicator Name	Owner	Data Availability	Most Recent Data	Target	Desired Direction	Recent Direction	Comparable
Uninsured Patients Served	Finance	Annually	469,239	A target for this indicator will be set once there is sufficient data about the implementation of the NYS Healthcare Marketplace and its impact on HHC's uninsured population.			None
# of Medicaid Managed Care, Child Health Plus and Family Health Plus enrollees	Finance	Quarterly & annually	532,910	513,400	Up	Down	None
# of MetroPlus Medicaid, Child Health Plus and Family Health Plus enrollees	Finance	Quarterly & annually	411,385	446,932	Indicator Name	Down	None

Ms. Green reported that the "Uninsured Patients Served" indicator is owned by the Finance Division. She stated that HHC's current number of uninsured patients is 469,239. A target has not yet been established for this indicator and there are no comparables. Ms. Green stated that the final two indicators, "The Number of Medicaid Managed Care, Child Health Plus and Family Health Plus Enrollees" and "The Number of MetroPlus Medicaid, Child Health Plus and Family Health Plus Enrollees" are also owned by the Finance

Division. She added that data for these indicators are captured quarterly and annually from managed care reports.

Ms. Green highlighted the table below and described the indicators for Goal 1c: Achieve/Surpass Local and National Performance Standards for Specific Health Interventions and Efficient Delivery of Health Services:

Indicator Name	Owner	Data Availability	Most Recent Data	Target	Desired Direction	Recent Direction	Comparables
Percentage of two-year olds immunized (with 1 visit prior to 2 nd birthday)	M&PA	Annually	95%	98%	Up	Down	76.2 ^a
Mammography screening (women with a primary care visit at HHC within the past 2 years, aged 40-70)	IT	Quarterly & annually	74.9%	70%	Up	Down	81.1% target Healthy People 2020
General care average LOS	Finance	Quarterly & annually	5.1	4.7	Down	Up	6.06 ^b
Net days of revenue in A/R	Finance	Quarterly & annually	55.44	56	Down	Down	50.2 ^c

Ms. Green reported that the indicator "Percentage of Two-year olds Immunized" is owned by the Office of Medical and Professional Affairs (M&PA) and is based on a three-month sample from the Board Report. She explained that with an achievement of 95% and a target of 98%, HHC's performance was very far above the comparable of 76.2%.

Ms. Green stated that the Information Technology Department (IT) was the owner for the Mammography screening data indicator. The data for this indicator is collected quarterly and annually. The numerator is the number of those patients in the denominator with a mammogram in the past two years and the denominator is the number of those female patients age 40-70 on their last visit in Medicine or GYN during the reporting period. Ms. Green explained that, while the most recent achievement of 74.9% exceeded the target of 70%, it was still below the 81.1% target that was established by Healthy People 2020. Ms. Green explained that Healthy People 2020 is a national organization that conducts a lot of research in healthcare to look at what should be happening across the nation to achieve a healthy population.

Mr. Nolan asked, of the 74.9% of women who do get mammography screenings, what percentage of these women were from the Bronx. Ms. Green responded that the data was collected on a per facility basis and that she would provide Mr. Nolan with the data for the Bronx facilities.

Ms. Green reported on the "General Care Average LOS" indicator. She stated that the Finance Division was the owner of this indicator and that the data was collected quarterly and annually. The most recent performance is 5.1 and the target was 4.7. While the desired direction is down, the recent performance was up. Ms. Green explained that the comparable NYS ALOS for 2011 was 6.06. Ms. Green stated that HHC has reduced one day stays which has helped to reduce lengths of stay. Ms. Green highlighted that HHC's performance is still below the state's average.

Ms. Green reported on the "Net Days of Revenue in A/R", an indicator owned by the Finance Division. She explained that the most recent performance went down to 55.44 and the target is 56. She highlighted that the 50.2 comparable was taken from Standard & Poor (S&P) data and that HHC was moving towards it.

Ms. Green described the current indicators of Goal 1d: Reduce Unnecessary Emergency Room Visits and Re-hospitalizations, which are highlighted in the following table:

Indicator Name	Owner	Data Availability	Most Recent Data	Target	Desired Direction	Recent Direction	Comparables
% of ER revisits for Adult Asthma patients	M&PA	Quarterly & annually	6.9%	5.0%	Down	Up	None
% of ER revisits for Pediatric Asthma patients	M&PA	Quarterly & annually	2.9%	3.2%	Down	Down	None
Adult psych 30 day readmission rate	M&PA	Quarterly & annually	7.4%	5.0%	Down	Up	21.6% Medicaid Pts ^a

Ms. Green stated that all three indicators were owned by the Office of Medical and Professional Affairs (M&PA) and that data were collected quarterly and annually. Ms. Green highlighted that the 6.9% of ER revisits for adult Asthma patients must be reduced to achieve the target of 5.0%. She also reported that the percent of ER revisits for pediatric Asthma patients decreased to 2.9% and exceeded the target of 3.2%. However, the "Adult Psych 30-day Readmission Rate" indicator needs to be improved because it exceeds the target of 5.0%. Ms. Green stated that the comparable performance for Medicaid patients is 21.6%.

Dr. Raju commented that the "Adult Psych 30-day Readmission Rate" indicator needs to be correlated with lengths of stay. He explained that HHC's performance is still good compared to the state. There is a need to bring down the lengths of stay for behavioral health patients even though that number had significantly gone down compared to the past. He emphasized that HHC serves special needs patients that require longer lengths of stay. Mrs. Bolus asked why the comparable were Medicaid patients. Ms. Green responded that it is Medicaid patients only because it is the data that was available.

Ms. Green shared with the Committee examples of the MMR's Preliminary and Full Fiscal Year 2014 Reports for HHC as presented below:

**Example –
Preliminary Fiscal Year 2014-HHC MMR**

Service 1: Provide medical, mental health and substance abuse services to New York City residents regardless of their ability to pay.

Goal 1a: Improve access to outpatient services.

Performance Indicators	Actual			Target		4-Month Actual	
	FY11	FY12	FY13	FY14	FY15	FY13	FY14
★ Prenatal patients retained in care through delivery (%)	86.4%	85.8%	83.0%	90.0%	90.0%	89.8%	84.2%
★ HIV patients retained in care (%)	87.4%	87.4%	84.3%	85.0%	85.0%	NA	NA
★ Average time spent by patient for a primary care visit at hospitals and diagnostic and treatment centers (minutes) - Adult medicine	61.0	75.0	69.0	60.0	60.0	72.0	72.0
★ Average time spent by patient for a primary care visit at hospitals and diagnostic and treatment centers (minutes) - Pediatric medicine	60.0	59.0	61.0	60.0	60.0	63.0	64.0
★ Average time spent by patient for a primary care visit at hospitals and diagnostic and treatment centers (minutes) - Women's health	61.0	75.0	67.0	60.0	60.0	81.0	70.0

★ Critical Indicator "NA" - means Not Available in this report ⬇️ ⬆️ shows desired direction

**Example-Full Fiscal Year 2014
HHC MMR**

Goal 1a Improve access to outpatient services.

Performance Indicators	Actual					Target		Desired Direction	5yr Trend
	FY10	FY11	FY12	FY13	FY14	FY14	FY15		
★ Prenatal patients retained in care through delivery (%)	86.5%	86.4%	85.8%	83.0%	81.4%	90.0%	90.0%	Up	Neutral
★ HIV patients retained in care (%)	87.1%	87.4%	87.4%	84.3%	86.6%	85.0%	85.0%	Up	Neutral
★ Average time spent by patient for a primary care visit at hospitals and diagnostic and treatment centers (minutes) - Adult medicine	59.0	61.0	75.0	69.0	77.0	60.0	60.0	Down	Up
★ Average time spent by patient for a primary care visit at hospitals and diagnostic and treatment centers (minutes) - Pediatric medicine	58.0	60.0	59.0	61.0	60.0	60.0	60.0	Down	Neutral
★ Average time spent by patient for a primary care visit at hospitals and diagnostic and treatment centers (minutes) - Women's health	61.0	61.0	75.0	67.0	73.0	60.0	60.0	Down	Up

★ Critical Indicator "NA" - means Not Available in this report ⬇️ ⬆️ shows desired direction

Ms. Green informed the Committee that the MMR was available online and that it was a very large report. She concluded her presentation by informing the Committee that Corporate Planning Services (CPS) worked with multiple HHC divisions to collect the data for the MMR. She added that most MMR indicators were reported monthly or quarterly on the Citywide Performance Report (data is available to the public). In addition, any new indicator required 3-5 years of prior data in order to establish the foundation for patterns and projections. Ms. Green added that, moving forward CPS would be monitoring the MMR metrics and

would also be working with senior leadership to ensure that the MMR continues to be aligned with HHC's Guiding Principles and strategic priorities as presented below:



Mr. Nolan, Board Member, asked if there were any new indicators that were added or dropped during the transition from the Bloomberg to the DeBlasio Administration. Ms. Green responded that indicators may have been changed not dropped because they do or do not align with HHC's strategic priorities. She emphasized that indicators have not changed because the Administration has changed but that the indicators have to reflect the goals of the agency. Ms. Brown added that the body of work that was done to communicate HHC's goals and Dr. Raju's priorities and why HHC would propose to continue to have some or modify others in terms of the individual metric took place early on in the Administration and these indicators were accepted. Mr. Nolan inquired about the flexibility of the staff of the Mayor's Office of Operations in terms of negotiating modifications or changes regarding MMR indicators. Ms. Brown responded that they were very reasonable but cautioned that they have rules. If HHC needs to make a change, HHC must show prior data for five years.

Mrs. Bolus asked what is being done to inform the public that HHC is working to reduce its waiting time so that the public would know that these issues are being addressed. Ms. Brown stated that the HHC Insider has featured stories on HHC's access work over the last couple of years. She assured Mrs. Bolus that this information has been shared in the CAB reports. Ms. Brown added that, when the facilities have their annual public meetings, the leadership of the facilities present initiatives they have worked on that year and they share their goals in terms of access, waiting time and ER utilizations among many other issues. Ms. Brown commented that how often that information is shared is facility or neighborhood specific but those are some ways in which the public is informed.

Mrs. Bolus commented that it was imperative for the public to be aware that HHC is working on the waiting time problem. She re-stated that the television commercials of providers that promote "no waiting time" stays with the public. Ms. Anna Kril, Board Member, commented that she has been showing up unannounced with patients at various HHC facilities and have been very impressed and proud of the facilities. She stated that staff members try very hard to move the patients with their appointments. She added that she had also observed and admired their courtesy and consideration for their patients.

ADJOURNMENT

There being no further business, the meeting was adjourned at 11:33 AM.



2015-16 State Fiscal Year Final Budget Overview

STRATEGIC PLANNING COMMITTEE
APRIL 14, 2014

Wendy Saunders
Assistant Vice President

2015-16 Executive Budget



2

- On-time budget for fifth year
- \$142 Billion Budget
- Increases overall spending by 1.7%
- Increases education spending by \$1.3 billion
- Includes ethics reform
- Allocates \$5.4 billion in settlements with financial institutions

Medicaid Spending



3

- Includes \$86.1 billion in Medicaid spending
- No inflation increase for Medicaid providers
- Extends Global Medicaid Cap for one year (along with SDOH's "superpowers" to make cuts to stay under Cap)
- Continues Global Cap Dividend

Key HHC Issues



4

- **HHC Upper Payment Limit (UPL)**
- **Voluntary Outpatient UPL**
- **Charity Care Funding – Indigent Care Pool**

Medicaid Cuts



5

- Medicaid-Medicare Crossover
- 340-B Pharmaceuticals in Managed Care
- Obstetrical Services Tax
- Restoration of prior years' cuts
 - Potentially Preventable Negative Outcomes (PPNOs)
 - Obstetrical Services Across-the-Board Reduction

Capital Funding



6

- **Allocates \$1.4 billion in new funding for Capital projects including:**
 - \$700 million for Central and East Brooklyn
 - \$300 million for Oneida County
 - \$355 million for rural communities
 - \$19.5 million revolving loan fund for the Primary Care Development Corporation (PCDC)
- **SDOH to reissue \$1.2 billion DSRIP-related Request for Applications from 2014**

Hospitals



7

- \$245 million in Vital Access Provider (VAP) funding

HHC is NOT eligible for this funding

- \$91 million Quality Improvement Incentive Pool
- Excess Medical Malpractice Insurance
- Notice Requirements for Medicaid Rate Changes

Long Term Care



8

- **Nursing Home Reimbursable Assessment**
- **Home Care Episodic Payments**
- **Universal Coding for Long Term Care**
- **Hospital-Home Care-Physician Collaboration Program**
- **Advance Home Health Aides Rejected**

Other Issues



9

- **D&TC Uncompensated Care Fund**
- **Basic Health Plan**
- **New DSRIP Requirements**
- **Funding for New York State of Health**

Not Included



10

- **Private equity pilot proposal**
- **Limited services “retail” health clinics and urgent care centers**
- **Certificate of Need (CON) changes**
- **Audit of Resident Work Hours**



Questions?