STRATEGIC PLANNING COMMITTEE MEETING
OF THE BOARD OF DIRECTORS

MAY 8, 2012
10:00 A.M.
HHC BOARD ROOM
125 WORTH STREET

AGENDA

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

II. ADOPTION OF APRIL 3, 2012 STRATEGIC PLANNING COMMITTEE MEETING MINUTES — **JOSEPHINE BOLUS, RN**

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

IV. INFORMATION ITEM:

i. **RAPID IMPROVEMENT EVENT: POST DISCHARGE CARE COORDINATION AT METROPOLITAN HOSPITAL CENTER**

PATRICIA JONES, RN, MN
ASSOCIATE EXECUTIVE DIRECTOR, REGULATORY AFFAIRS & QUALITY MANAGEMENT
METROPOLITAN HOSPITAL CENTER

SUSAN LEHRER
ASSOCIATE EXECUTIVE DIRECTOR, CARE MANAGEMENT & TELEHEALTH
HHC HEALTH AND HOME CARE

V. OLD BUSINESS

VI. NEW BUSINESS

VII. ADJOURNMENT — **JOSEPHINE BOLUS, RN**

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

MINUTES

STRATEGIC PLANNING COMMITTEE MEETING OF THE BOARD OF DIRECTORS

APRIL 3, 2012

The meeting of the Strategic Planning Committee of the Board of Directors was held on April 3, 2012, in the Board Room located at 125 Worth Street with Josephine Bolus, RN presiding as Chairperson.

ATTENDEES

COMMITTEE MEMBERS

Josephine Bolus, RN, Chairperson of the Committee
Alan Aviles
Anna Kril
Robert F. Nolan
Bernard Rosen
Michael A. Stocker, M.D., Chairman of the Board
Ian Hartman-O'Connell, representing Deputy Mayor Linda Gibbs in a voting capacity

OTHER ATTENDEES

L. Bill, Assistant Director, New York State Nursing Association
J. DeGeorge, Office of the State Comptroller
M. Dubowski, Analyst, Office of Management and Budget
C. Fiorentini, Analyst, New York City Independent Budget Office
M. Meagher, Budget Analyst, Office of Management and Budget
J. Wessler, Commission on the Public's Health System

HHC STAFF

M. Belizaire, Assistant Director of Community Affairs, Intergovernmental Relations
J. Berman, Senior Counsel, Legal Affairs
D. Cates, Chief of Staff, Office of the Chairman
D. Green, Senior Assistant Vice President, Corporate Planning Services
T. Hamilton, Director, Corporate Planning Services/HIV Services
E. Hernandez, Director, Media Relations, Communications and Marketing

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
T. Mammo, Deputy Chief of Staff, President's Office
A. Marengo, Senior Vice President, Communications and Marketing
A. Martin, Executive Vice President and Chief Operating Officer, President's Office
H. Mason, Deputy Executive Director, Kings County Hospital Center
K. McGrath, Senior Director, Communications and Marketing
J. Ng, Senior Management Consultant, Corporate Planning Services
J. Omi, Senior Vice President, Organizational Innovation and Effectiveness
K. Park, Associate Executive Director, Finance, Queens Health Network
S. Penn, Deputy Director, WTC Environmental Health Center
S. Russo, Senior Vice President and General Counsel, Legal Affairs
W. Saunders, Assistant Vice President, Intergovernmental Relations
D. Thornhill, Associate Executive Director, Strategic Planning, Harlem Hospital Center
J. Wale, Senior Assistant Vice President, Behavioral Health
R. Wilson, M.D., Senior Vice President/Chief Medical Officer, Office of Medical and Professional Affairs

CALL TO ORDER

The meeting of the Strategic Planning Committee was called to order at 10:00 a.m. by the Strategic Planning Committee Chairperson, Josephine Bolus, RN. The minutes of the March 13, 2012, Strategic Planning Committee meeting were adopted.

SENIOR VICE PRESIDENT REMARKS

Ms. Bolus informed the Committee that the Senior Vice President Remarks would be deferred until next month, upon Ms. Brown's return. Mrs. Bolus announced a change in the order of the information item presentations. She informed the Committee that Dr. Ross Wilson, HHC's Senior Vice President and Chief Medical Officer would present first on New York State Health Homes and HHC. His presentation would be followed by an overview of the enacted state fiscal year 2012-13 budget which will be presented by Ms. Wendy Saunders, HHC's Assistant Vice President of the Office of Intergovernmental Relations.

INFORMATION ITEM #1:

New York State Health Home and HHC

Ross Wilson, M.D., Senior Vice President/Chief Medical Officer
Office of Medical and Professional Affairs

Dr. Wilson informed the Committee that he was asked to address the Health Home initiative from a strategic point of view. He defined Health Home as a model of care coordination designed to improve the care of patients, particularly those with chronic medical or serious/persistent mental illnesses. He explained that the State would focus its Health Home program on Medicaid high utilizers.

Dr. Wilson reported that the Affordable Care Act (ACA) established the authority for states to develop Health Home programs and to receive federal reimbursement for those services. He noted that the focus on improving care for Medicaid high utilizers would continue to be a priority, whether on a clinical or a financial level or a combination of both. He explained that Medicaid high utilizers would continue to be an issue not only for New York State but the entire country. He added that Health Home programs would be focused on providing better care management for patients who are sicker or who are most in need.

Dr. Wilson described the implementation of the Health Home initiative as being a very complicated and dynamic process. It alters the relationship with community providers and health systems; the relationship between patients and care managers; and it potentially alters the relationships between care plans and delivery systems. He explained that the Health Home program would inform what a future delivery system could look like if the health care delivery system shifted in the direction of Medicaid Accountable Care Organizations (ACO).

Dr. Wilson reported that, in New York State, planning for the implementation of the Health Home program began with an evaluation of the State's 5.4 million Medicaid recipients. This analysis focused on those recipients who accounted for the greatest cost to the State and for whom improvements in care delivery could be made. Dr. Wilson described the categories of Medicaid recipients that accounted for the State's greatest Medicaid program cost as the following:

- 50,000 developmentally disabled recipients accounted for a cost of $6.8 billion
- 200,000 long term care recipients accounted for a cost of $10.5 billion
- 400,000 behavioral health recipients accounted for a cost of $6.3 billion; and

- 300,000 chronic medical patients accounted for a cost of $2.4 billion

Dr. Wilson reported that New York State's Health Home program would be focused on chronic medical and behavioral health patients. He noted that the remaining groups of recipients would be targeted for other Medicaid redesign activities and other plans. To underscore the very dynamic nature of the Health Home implementation process, Dr. Wilson commented that the State is currently discussing the inclusion of the long term care group in a future Health Home model. Dr. Wilson explained that, based on the State's rules, it was projected that there would be 128,000 patients who would be eligible for Health Home services across the Corporation. Accordingly, plans were developed based on that large number. He reported that the number of patients that would be assigned to HHC may be less than 10 percent of that original estimate; and at the moment, HHC is still trying to determine the size of the program. That is, would it be 5,000 – 10,000 patients or 130,000 or more patients.

Dr. Wilson reported that HHC had applied for and received Health Home designation for the Bronx, along with Montefiore Hospital, Visiting Nurse Service of New York and Bronx Lebanon Hospital. He explained that HHC's application was a joint delivery system and health plan application, which included up to 50 community partners. HHC has also applied and received Health Home designation in the borough of Brooklyn. HHC is one of four designated Health Homes in Brooklyn. Dr. Wilson commented that HHC is the only Health Home that appears in both boroughs, the Bronx and Brooklyn. HHC has also applied for Health Home designation for the boroughs of Manhattan and Queens. The result of those applications should be announced within several weeks.

Dr. Wilson shared with the Committee a State bulletin on the status of the Health Home program that was updated on January 27, 2012. The bulletin highlighted that the Health Home applications for Manhattan and Queens were due on February 15, 2012, and implementation would begin on April 1, 2012. Dr. Wilson noted that the deadline for implementation had passed with no announcement of the designated Health Homes.

Dr. Wilson informed the Committee that the State is engaged in complex conversations and discussions about how to pay for the program. Dr. Wilson reported that the State, at one stage, had planned to place 500,000 patients in Health Homes but that target number was revised to be a lot smaller. He noted that the State is now concentrating on the sickest groups of recipients, which would be determined by an acuity score by diagnosis or a CRG acuity score. This score indicates the highest risk based on an algorithm that would predict the likelihood that a patient would require hospitalization. Another criterion would be patients who have had little or no reliable contact with ambulatory care. That is, those patients who use emergency rooms (ERs) as their main source of care.

Dr. Wilson stated that the key to the whole process is the care manager who will work with each patient to help them navigate their health care system. Dr. Wilson reported that the State had estimated that a care manager's cost would be $71,000; and that a care manager could be a registered nurse (RN) or a social worker. He noted that the State had made various other cost projections concerning program administration and capital requirements, which had been determined by HHC to be insufficient to run the program. He informed the Committee that, HHC had estimated the cost of administering this program; and that HHC would be continuing its discussions with the State on that issue. Dr. Wilson commented that, HHC would not want to start a new program if HHC would be paid less than the true cost to run that program.

Dr. Wilson shared the State's metrics for determining the program's efficacy. He explained that success would be defined by a reduction in hospitalizations, preventable ER visits and nursing home admissions. He reported that the metrics for monitoring and reporting, resulting from improved care management and care coordination, would include reduced hospitalizations, inpatient stays, ER visits, with some or no

impact on nursing home admissions. He commented that, this was the model by which the Health Home initiative would pay for itself in the longer term in a capped managed care environment.
Dr. Wilson described the State's algorithm for assigning the first wave of patients to HHC. The State's criteria will include higher predictive risk for negative event (inpatient, nursing home, death); lower or no ambulatory care connection; provider loyalty (ambulatory, case management, ED and inpatient); and geographic factors.

Dr. Wilson emphasized that the first wave of patients would be a very high acuity group of patients. Dr. Wilson informed the Committee that, over the last two years, HHC had been working with a high acuity group of patients through its Chronic Illness Demonstration Project (CIDP), led by Dr. Maria Raven at Bellevue Hospital Center. He explained that this was a very successful program that started at Bellevue Hospital and was expanded to include Elmhurst Hospital Center and Woodhull Medical and Mental Health Center. Through this program, HHC demonstrated its ability to improve care for a very sick group of patients. Approximately 50% of the patients that were enrolled in the CIDP had precarious housing. A majority of those patients had a mental health diagnosis and a social disability. Dr. Wilson stated that HHC is fully aware that the Health Home initiative would be an incredibly intense activity. Notwithstanding, HHC has the knowledge and experience to manage these patients (i.e., in terms of care managers, supervision, transportation, access to housing etc). He noted that HHC's discussions with the State had been predicated on the lessons that had been learned from the CIDP. A key finding of the CIDP is that for every 100 patients that HHC was assigned, HHC was able to locate approximately 25% of those patients. Of that group, HHC had been successful in engaging most of those patients in the project.

Dr. Stocker, HHC's Board Chairman, asked if the dollars would go directly to the providers and not filtered to the health plan. Dr. Wilson clarified that the dollars would go both ways. That is, the dollars would be directed to the health care delivery system but largely depended on whether or not patients are enrolled in managed care or the fee-for-service program. Dr. Wilson explained that, if a patient is enrolled in managed care, like MetroPlus Health Plan, that health plan would obtain an additional per member per month financial component that would come through the plan to the delivery system. Dr. Wilson clarified that the care manager would work for and would be co-located with the health care provider. Dr. Stocker inquired if this was a good thing. Dr. Wilson responded that, this was one of the tensions that had been created through this model. He explained that managing care had always been a function of health plans and the delivery system. This model is now forcing a review of this interface with many questions to address including:

1. Who is actually responsible for managing care?
2. What should the plan and the delivery system do in the longer term?
3. Who will be better and more efficient at it?

Dr. Stocker commented that, most physicians are very removed from the care managers that health plans employ. Dr. Wilson responded that the care manager in the Health Home model would have a closer relationship with the primary care doctor and other providers engaged in the patient's care. Care managers are active participants in negotiating the patient's health plan and health goals. They help to break down the barriers that patients have accessing care. Essentially, the care manager in this model would be working more closely with the delivery system to advocate for the patient. Dr. Stocker commented that he presumed that other doctors would like this model. Dr. Wilson responded affirmatively and stated that HHC's doctors are attracted to this model because their relationship with health plans' utilization and care management staff had not been close. He commented that, their interaction with health plan staff generally occurred when things are not going well, which is not always a positive experience.

Dr. Wilson concluded his presentation by sharing a diagram with the Committee that showed that the Health Home program is just one of the many initiatives that HHC is conducting across the Corporation that is more suited to honor patients' needs and also the health reform law. Dr. Wilson explained that the diagram showed a health care system which is designed to build a relationship with patients over time connected through primary care. In the center of the diagram is the Primary Care Medical Home or PCMH initiative. This initiative focuses on the redesign of primary care, which is an ongoing effort across the Corporation. Dr. Wilson reported that HHC had achieved National Committee for Quality Assurance or NCQA designation at the highest level (level 3) for all of its primary care sites. He added that the primary care site is where patients connect to HHC's system; and it is where the whole patient assessment is conducted and where the patient's view is set.

Dr. Wilson briefly described other key HHC initiatives that were represented on the diagram. These initiatives included the following:

- HEAL NY 17 initiative to connect schizophrenic patients to primary care through the use of technology
- FQHC designation project to convert HHC's six diagnostic and treatment centers into a federally qualified health center (FQHC) Look-Alike entity
- MetroPlus Health Plan's new managed long term care initiative and work with the homeless population
- Establishment of the Physician Affiliate Group of New York (PAGNY) to address how HHC employs its physicians and their alignment with HHC's strategic direction
- Care Management initiative, led by Dr. Sullivan, to focus on inpatient and ER care managers and the care management process.
- Integration Clinical Information System or ICIS Project to improve the electronic health record and information systems

Dr. Wilson stated that these initiatives all fit together, and the Health Home program is one of these initiatives.

Dr. Stocker asked if all these various programs could be coordinated in a coherent way. Dr. Wilson responded affirmatively and stated that it was a deep struggle. He added that, at the moment, identifying the right platform or mechanism to do this had not yet been finalized. However, it is the subject of ongoing and broader discussions on the strategic direction of the organization. Dr. Wilson noted that, historically, HHC's structure dictated its function. However, the structure that is needed is not yet delineated. Over the next couple of years, HHC will know the right structure. He explained that structure is only one part of HHC's capacity to manage these programs. HHC's current structure enables it to manage these initiatives at the current time; but this would change five years from now.

Dr. Stocker asked what the large academic hospitals were doing and if they were having similar conversations. Dr. Wilson responded that, they are a little concerned about this issue. This is not where they have traditionally focused their research, teaching or revenue generation initiatives. It is untested territory for them. Dr. Stocker commented that, if the large academic medical centers got engaged in this initiative, they would be forced to generate a lot of new primary care capacity. Dr. Wilson reported that this was one implication and the other is what they would do with their inpatient facilities.

Ms. Bolus asked if there were substantial challenges with each of the various projects. Dr. Wilson responded that each project was on track. Ms. Rosen inquired about the number of patients to be served by HHC's Health Home. Dr. Wilson responded that his best estimate would be less than 10,000.

Ms. Bolus inquired about the status of the FQHC project. Ms. Green, HHC's Senior Assistant Vice President for Corporate Planning Services provided an update. She reminded the Committee that this

project would secure FQHC Look-Alike (LAL) designation for HHC's six diagnostic and treatment centers, thereby strengthening their long-term financial viability. Ms. Green informed the Committee that the Certificate of Need (CON) application had been submitted to the State to establish the FQHC-LAL Co-Applicant. A draft Co-Applicant Agreement and By-Laws have been finalized, which the FQHC-LAL Board and HHC's Board must review, comment and sign. A Certificate of Incorporation has been submitted to New York State's Secretary of State. Some key next steps include the selection of the remaining Co-Applicant board members; achieve CON approval at the July/August Public Health and Health Planning Council Meeting; conduct first FQHC-LAL Board meeting in August pending CON approval; and submission of HRSA application in October 2012 after FQHC-LAL Board meets three times. Ms. Green explained that the Board has to come together and meet three times before the application can be submitted to HRSA.

INFORMATION ITEM #2:

2012-13 State Fiscal Year Enacted Budget Overview

Wendy Saunders, Assistant Vice President, Office of Intergovernmental Relations

Ms. Saunders informed the Committee that, on March 30, 2012, the 2012-13 State Fiscal Year (SFY) Budget was enacted ahead of the April 1, 2012, deadline. This is the second year in a row that the State budget was passed on time. Ms. Saunders reported that, on the issues that are of importance to HHC, the enacted budget largely reflected the proposed budget that the Governor had promulgated in January. She noted that her presentation would focus primarily on those areas of interest to HHC that are now different.

Ms. Saunders reported that, overall, the enacted budget was a less controversial budget than it had been in recent years. Concerning health care, the enacted budget reflected the second year of the two year agreement on Medicaid. Per that agreement, Medicaid spending was increased by four percent (4%). Ms. Saunders reminded the Committee that last year's budget included significant Medicaid cuts that had been continued in this year's budget. These cuts include a two percent (2%) across the board rate cut; and elimination of the inflation factor for providers. The total impact of these cuts on HHC is a revenue loss of $174.5 million. Mr. Aviles, HHC's President, explained that the four percent (4%) increase is not a rate increase. It is simply an increase of the existing cap to accommodate more of the anticipated increases in expenditures that would likely result from increased enrollment in the Medicaid program. He added that, it provides a little more leeway in terms of not piercing that cap, which could then lead to unilateral rate cuts by the State Health Commissioner. Ms. Saunders added that the budget that was enacted this year included the extension of the Global Cap on Medicaid spending by one additional year, to three years total. It also includes a 4.2% increase in Medicaid spending for 2013-14 and continues the "superpowers" of the State Department of Health's (SDOH) Commissioner should spending exceed projections. Ms. Saunders reported that, spending had been on target through January 2012. She explained that spending increases resulting from enrollment increases must also be covered under the Global Cap.

Ms. Saunders reported that, a lot of the new items that had been included in the enacted state budget were proposals that came out of the Phase 2 work of the Medicaid Redesign Team (MRT). As an update, Ms. Saunders informed the Committee that the final MRT Report was still not available but was expected to be released soon.

Ms. Saunders reported that, the enacted state budget included a series of new Medicaid benefits for patients including some new funding for translation services, harm reduction, lactation consultants, and coordinated Hepatitis C care amongst others. The enacted budget also included the elimination of some

Medicaid benefits that had limited or no clinical value for patients. These benefits include arthroscopic knee surgery, hormone therapy for Idiopathic Short Stature (ISS), elective C-sections and inductions less than 39 weeks without medical indication and percutaneous coronary intervention (PCI). President Aviles asked when the requirement of language accessible prescriptions would take effect. Ms. Saunders responded that the State Health Commissioner would issue regulations on language accessible prescriptions by the fall. President Aviles further inquired if the regulation would specify the required languages or would it depend on the languages spoken in the local community. Ms. Saunders clarified that it would be the languages spoken by the local community. Ms. Aviles commented that the major pharmaceutical chains, in the past, had not done a lot on this issue in spite of the fact that software to generate labels and medication instructions in English and principally Chinese was available. He noted that the other languages were simply not covered and wondered how the major pharmaceutical chains would comply with this requirement. Ms. Saunders commented that there had been a lot of conversations concerning this provision. She added that the requirement applied to both chain and mail order pharmacies.

Ms. Saunders announced that the enacted budget included a new Primary Care Service Corps for non-physician primary care providers like dentists, physician assistants, midwives and social workers. She explained that the Doctors Across New York program was a robust program focused on increasing the supply of primary care physicians. Similarly, this new program would also include loan forgiveness. Dr. Stocker, HHC's Board Chair asked if HHC participated in this program and if it was important for HHC to participate. Ms. Saunders responded that, it is a new initiative and it is worth exploring. HHC has physicians serving in medically underserved areas that benefit from government programs such as loan forgiveness and the JI-Visa Waiver/Limited License program. A total of 33 HHC physicians participate in the loan forgiveness program and 81 physicians are enrolled in the J1-Visa Waiver/Limited License program. Dr. Stocker asked if the program required that those providers would be assigned to particular areas. Ms. Saunders explained that the program would target medically underserved areas; some of these areas are located in the City of New York and in rural parts of the State.

Dr. Stocker asked if the funding for supportive housing would help HHC with the Coler-Goldwater project. Ms. Saunders explained that there are two separate provisions related to supportive housing. The Supportive Housing Reinvestment Program is a future program that would be created based on the savings generated from the closures/downsizing of both hospital and nursing home beds. The second provision is funding for affordable housing. Ms. Saunders explained that, originally, the Governor had proposed $75 million in Medicaid funding to be hopefully matched by the federal government for a total of $150 million. Ms. Saunders noted that, while the enacted budget still included a funding pool of $150 million, the actual amount of funding available in the enacted budget is $60 million for that program. She explained that, a week prior to the passage of the budget, the State Department of Health (SDOH) had released an allocation plan that included $7.3 million for HHC's 99th Street project. HHC would benefit from this funding as long as the State follows its allocation formula.

Ms. Saunders reported that, a total of $1 million in new funding was included in the final budget to improve SDOH's ability to both collect and analyze data to address health care disparities more effectively. Additionally, a small increase in funding was approved for the movement to mandatory managed long term care. Specifically, to fund the anticipated increase in Fair Hearing requests by individuals who would be required to go into managed long term care programs. This was a recommendation made by the MRT to ensure adequate staffing to respond to Fair Hearing requests. Ms. Saunders also explained that a provision for both managed long term care plans as well as regular managed care plans to offer consumer directed personal care to their enrollees had also been included in the final budget. Additionally, people who are enrolling in mandatory managed long term care will be able to access facilitated enrollers (i.e., those that are currently available for the non-long term care population) for assistance with plan selection and the enrollment process.

Ms. Saunders reported that, regarding the administration of the Medicaid program, the Legislature had approved the Governor's proposal for the takeover and the growth of the local share of Medicaid spending. Ms. Saunders reminded the Committee that, several years ago, the amount that localities could be responsible for had been capped at three percent (3%). Going forward, this cap would be reduced to two percent (2%) in calendar year 2013 and to one percent (1%) in 2014. In 2015 and thereafter, localities would not be responsible for any additional growth in Medicaid spending. This action is expected to save localities approximately $1.5 billion over a five year period.

Ms. Saunders informed the Committee that, over the next six years or by 2018, the State is expected to fully assume responsibility for administering the Medicaid program, thus eliminating local responsibility for program administration. The State will assume activities including processing Medicaid applications, making eligibility determinations, and conducting reviews of requested benefits and authorizing benefits. In support of this goal, the State would cap the amount that localities would be able to receive for administering the program at the 2011-12 fiscal year level. Ms. Saunders added that, a redistribution formula had been included in the enacted budget to allow for the redistribution of some of these funds back to localities, if the expected spending of localities for administering the program is less than the 2011-12 level.

Ms. Saunders added that, as proposed by the Governor, electronic verification of assets for non-long term care Medicaid patients was included in the final budget. Mr. Rosen, Committee Member, inquired if language concerning the State takeover of the Medicaid program administration was also included in the enacted budget. Ms. Saunders responded affirmatively and clarified that this initiative started three years ago with a study. At this stage, SDOH will be laying out a plan on how it would proceed with State takeover of Medicaid administration, which will be completed by the end of 2018. Additionally, SDOH may contract with localities and allow them to still perform some of those functions, if mutually agreed upon. It was asked, who objected to the State taking over of the growth in Medicaid. Ms. Saunders explained that the Senate had sought to accelerate the speed with which the takeover of the growth of Medicaid would be assumed. In their budget proposal, the Senate presented an accelerated schedule that went immediately from one percent (1%) to zero, starting next year for non New York City localities. New York City had a much slower phase-in schedule, which included no change for the first two years, followed by a two percent (2%) reduction.

Ms. Saunders reported that there had been several proposals that affected behavioral health services. The Governor had proposed consolidating all of New York City's Children Psychiatric Centers under one umbrella organization of management. The Legislature accepted this proposal. Ms. Saunders noted that there had been a lot of discussions concerning the Kingsboro Psychiatric Center. It was decided that, for the psychiatric centers around the State, a hard cap of 400 beds would be enforced. However, before any changes are made, the Legislature, Chief Executive Officer or Mayor would be notified to allow enough time to address concerns about the proposed change. Ms. Saunders reported that the Legislature had also accepted the Governor's proposal to create a new framework for the SDOH and the State Office of Mental Health (SOMH) to jointly operate behavioral health agencies with broad authority that would allow these agencies to waive requirements and deem compliance. The Legislature included one caveat that the agencies could not waive State law or make any changes or issue any approvals that would be contrary to State law. Ms. Saunders added that the enacted budget also included a four year extension to 2016, of the authorization for the Comprehensive Psychiatric Emergency Program (CPEP). This was originally proposed by the Governor.

Ms. Saunders reported on other non MRT proposals that had been included in the enacted budget. She stated that, one of the few cuts that had been included in the final budget, related to a cut of $40 million in funding for nursing home bed holds. She explained that bed hold reimbursement referred to the payment that a nursing home receives to keep a bed open and unoccupied when a patient goes to the

hospital or placed on therapeutic leave. There was a similar provision that was enacted as part of last year's budget; however, it was rejected by the Centers for Medicare and Medicaid Services (CMS). The Governor had originally proposed that the Commissioner would issue regulations in this area; and even if those regulations weren't approved by CMS, the State would go forward and take savings from nursing homes in a manner that it deemed fit. Ms. Saunders informed the Committee that the Legislature did modify that proposal. The finalized provision that was included in the enacted budget was a limit of 14 days for adult residents over 21 of combined therapeutic and hospital leave days in a year and 10 days for other reasons, for a total of 24 days of bed hold payments that a nursing home could receive. SDOH is required to report on whether or not this proposal would achieve the $40 million savings target. If that target will not be achieved by this plan, SDOH would then take a per capita reduction from nursing homes to achieve that goal. The impact on HHC's nursing homes is not yet known until more details are provided.

Ms. Saunders reported that the Governor had proposed and the Legislature did extend the potentially preventable readmissions cut for another year, until 2013; and for SDOH to implement an adverse events policy in outpatient settings. She reminded the Committee that, behavioral is not covered in this provision. Additionally, the Governor had proposed allowing the SDOH to implement some changes on potentially preventable complications and to include quality measures. The Legislature revised that proposal to require that only those measures used by CMS could be used to ensure compliance with what Medicare is doing for hospital acquired conditions.

Ms. Saunders reported that there were a few other proposals that the Legislature had adopted in the enacted budget that were not included in the Governor's original budget proposal. These proposals include the:

- Creation of a Workgroup on medically fragile children
- Creation of a Prescription Pain Awareness Program, including the development of a continuing medical education (CME) program for health care providers and new reporting on opiod overdoses
- Institution of "prescriber prevails" for atypical antipsychotics
- "Grandfathering" of existing providers in the Excess Medical Malpractice Liability Pool and requires a study by 11/1/12
- Requirement that SDOH would report on transition to mandatory managed long term care
- Requirement that SDOH would develop transition and continuity of care requirements for mandatory managed long term care
- Requirement that SDOH would consult with stakeholders on reimbursement for nursing homes' capital costs in managed long term care
- Requirement that SDOH would facilitate the use of triage systems in emergency rooms and report results

Ms. Saunders concluded her presentation by highlighting those proposals that had been rejected and were not included in the final budget. They include:

- No changes for reimbursement of charity care/ Disproportionate Share Hospital (DSH) funding
- No Health Benefits Exchange legislation. The Governor has indicated that he may issue an Executive Order to create a New York Exchange
- No new authority for SDOH to close health facilities or replace operators or board members for repeat violations of health law, significant mismanagement or criminal activity
- No closure of Kingsboro Psychiatric facility yet the fate of this facility remains unclear

Mr. Aviles asked if the pendency of the Supreme Court decision concerning the ACA would have an impact on the State Legislature's willingness to go forward with reform of the Bad Debt and Charity Care Pool in this legislative session. Ms. Saunders responded that she did not expect that the Supreme

Court's decision would have impact because every proposal to date, outside of the ACA, had been focused on Disproportionate Share Hospital (DSH) funding. She noted that, it is clear that the Legislature would want to make changes regardless of the Supreme Court decision outcome concerning the ACA. While the most immediate changes related to the reimbursement for Bad Debt are included in the ACA, Ms. Saunders stated that the Legislature would want to pursue separate legislation on the federal level.

ADJOURNMENT

There being no further business, the meeting was adjourned at 11:00 a.m.

Post Discharge Care Coordination

NYCHHC Metropolitan Hospital Center

Rapid Improvement Event

July 25-29, 2011

Breakthrough
the HHC improvement system
at Metropolitan Hospital Center

Collaboration between Metropolitan Hospital Center, Health and Home Care, and Metroplus

Team

Team:
Patsy Jones, Team Leader
Fiona Larkin, Home Care
Iris Seymoure, Social Work
Frances St. Louis, Nursing 6A
Marcie Rubin, Ambulatory Care
Catherine Chen, Nutritionist
Helen Amatrano, Utilization Review
Susan Spalluto, Cardiology
Ferdinand Visco, MD, Cardiology
Lynda McPartlan, Metroplus
Osvaldo Villafane, Addiction Counselor
Daniel Landesberg, fresh eyes
Jean Claude Delly, Quality Management
Courtney Kalof, Ambulatory Care

Process Owner: Ferdinand Visco, MD
Facilitator: Richard A. Siegel
Executive Sponsor: Valerie Henriques

Special Thanks: **Carol Ng, Chike Igboechi, Margaret Daniel, Maria Ladios, Maria Davila, Susan Lehrer, Fran Keogh, Mr. H (our patient)**

1. Reason for Action

Metropolitan Hospital seeks to be a **center of excellence** for individuals with congestive heart failure (CHF) and a national leader in preventing unnecessary complications after hospitalization. However, the current rate at which CHF patients previously discharged from the hospital's inpatient medicine service are hospitalized again for the same condition within 30 days of treatment is **30%.** Many of these readmissions are preventable and unnecessarily increase costs and disrupt patient lives while increasing risks of hospital-associated morbidity complications and mortality. Recognizing these factors, beginning in FY 2014 CMS will decrease hospital payments for patients that are re-admitted to the hospital with the same or similar complaint within 30 days of their last admission.

In scope: CHF (systolic only)

Trigger: CHF (systolic) identified as problem for admitted patient

Done: Patient still home at 31 days post D/C

Why is this important?

Quality and Safety Contact with patient/family after discharge decreases re-hospitalization, and adverse events. Contact with the patient /family post discharge will increase patient satisfaction scores on the HCAHPS survey.

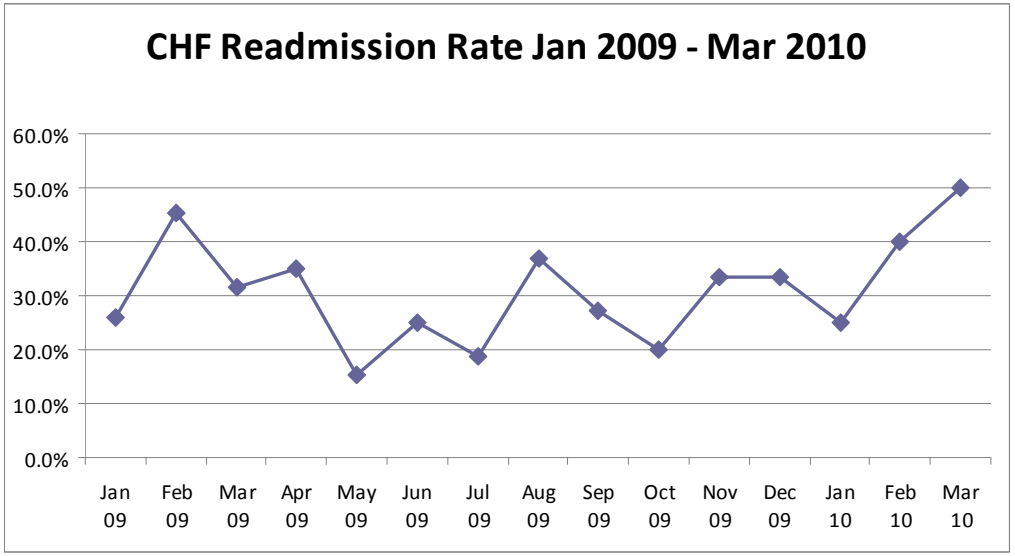
Human Development: Training of all staff in new discharge planning process

Delivery: Better coordination of post-hospital care reduces overuse of the ER and decreases crowding and dwell times. Acute care resources are also more readily available for necessary hospitalizations.

Cost: Payments for avoidable inpatient care will be lower.

2. Current State

Congestive Heart Failure			
Month/Year	Readmit	Admit	Rate
Jan 09	6	23	26.1%
Feb 09	5	11	45.5%
Mar 09	6	19	31.6%
Apr 09	7	20	35.0%
May 09	2	13	15.4%
Jun 09	5	20	25.0%
Jul 09	3	16	18.8%
Aug 09	7	19	36.8%
Sep 09	3	11	27.3%
Oct 09	2	10	20.0%
Nov 09	3	9	33.3%
Dec 09	2	6	33.3%
Jan 10	2	8	25.0%
Feb 10	6	15	40.0%
Mar 10	5	10	50.0%
Total/Rate	64	210	30.5%



30% of patients with CHF are re-admitted within 30 days

3. Target State

To provide optimum care for our patients and become a recognized center of excellence for heart failure:

- Avoid premature discharge
- Establish accurate and complete cardiac diagnosis
- Identify & address (1) exacerbating / precipitating factors for HF; and (2) impediments to compliance including ETOH and other addiction issues
- Initial follow up within one week of discharge
- Titration of HF drugs to the target dosages used in the HF trials
- All dosage forms of HF medications available
- High quality, highly specialized home care
- Intensive patient monitoring including self monitoring, e.g. proactive vs. reactive
- Education and continuous re-education of the patient through the continuum of care
- Patient understands medications and how to take them and what to do if condition worsens

	Baseline	Target	% + / -
30-Day HF Re-admission Rate	30%	18%	-40%

Primary target population: Patients admitted for Acute De-compensated Heart Failure (ADHF) with an Ejection Fraction (EF) of < 40%
Secondary target population: All patients who have an EF of < 40%
Tertiary target population: Patients admitted for ADHF with EF > 40% (Diastolic HF)

3. Target State

Metrics	True North	Initial	Target
% CHF patients re-admitted within 30 days	Quality	30%	**18%**
% of CHF patients with participating insurance that come to first appointment *(All patients will be given an appointment within 1 week of discharge)*	Quality	39% (any appointment)	**100%**
% of CHF patients that receive post discharge contact - call or visit within 72 hours	Quality	***(Note 1)****	**85%**
% of patients with substance abuse history or toxicology that are offered a referral to treatment	Quality	***(Note 3)***	**100%**
% of CHF patients with a substance abuse history and are referred to our program that attend program	Quality	***(Note 2)****	**50%**

1. 50% of re-admitted CHF patients were referred to home care
2. 25% of re-admitted patients had history of substance abuse
3. 75% is a reasonable inference

* 3 months data (January to March 2010)

4. Gap Analysis

Gap	Root Cause
Not Using Standardized Educational Tool	Lack Of Understanding Of The Positive Effect Of Unified Education On Patient Outcome
No Discharge Checklist No Process Control Board	Connection Between Discharge Planning and Long Term Outcomes Not Clear
No System For Medications For Uninsured Who Are Discharged On Weekends And After 5 PM.	Policy Does Not Exist No Specific Focus On CHF
No Follow Up Calls After Discharge	No Best Practice Criteria Established For Contacting CHF Patients After Discharge
No Connection Between Substance Abuse Program And Inpatient Medical Care	No System Set Up For Referrals

5. Solution Approach

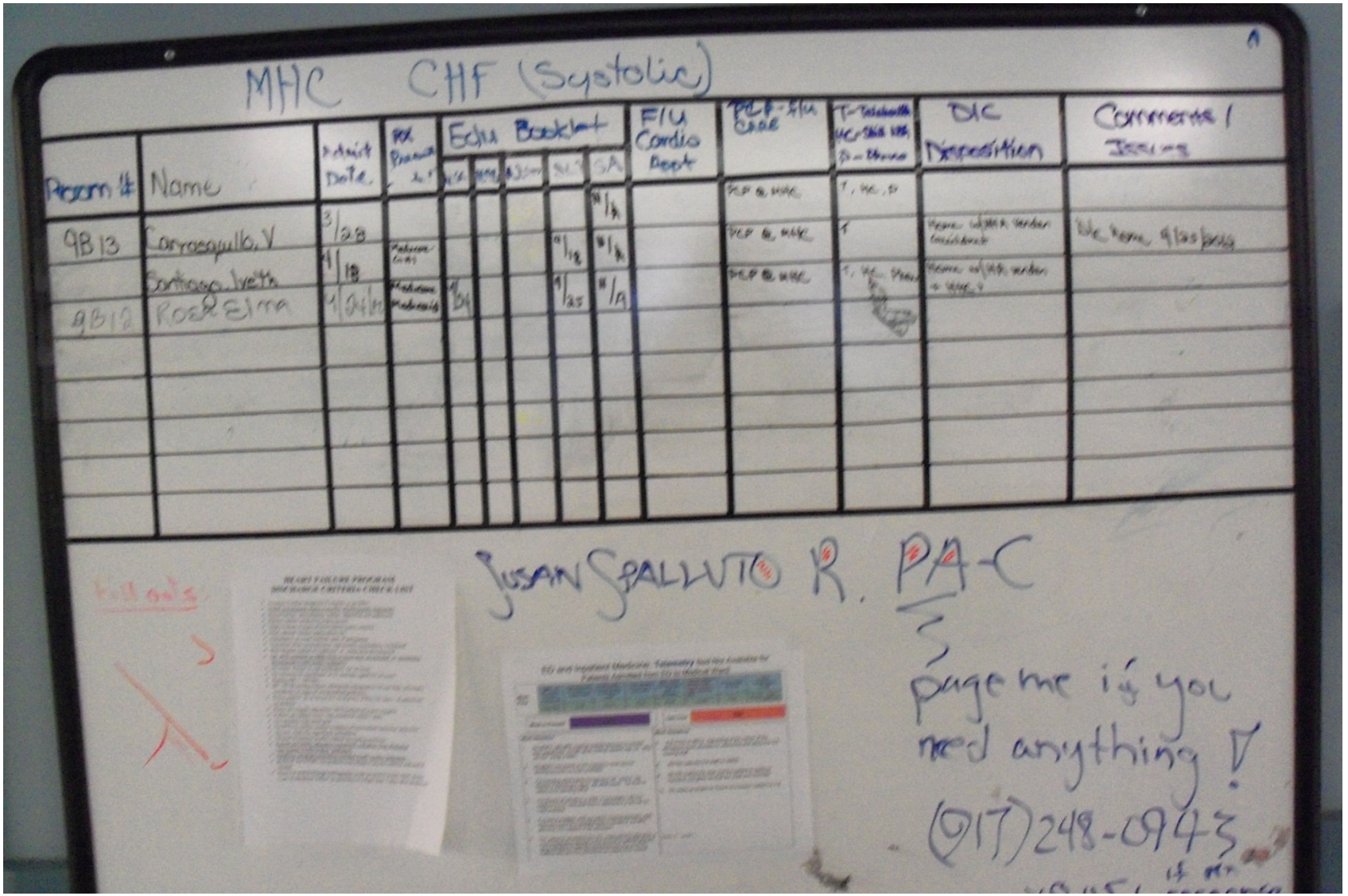
If We…	Then We…
Standardized the education tools to be used by all team members	Empower patient self management Improve outcomes Decrease re-admissions
See CHF patients in Cardiac Clinic within one week of discharge and coordinate care with the PCP in the medical clinic	Improve outcomes Decrease re-admissions Improve Quality of Life
Develop a discharge checklist and process control board	Ensure completion of patient education Decrease re-admissions Improve long term outcomes Provide key patient information to all team members
Make follow up calls or home care visits within 72 hours post discharge	Improve self management Identify problems early Decrease re-admissions
Have bedside counseling and screening by addiction counselors	Increase % of patients that accept substance abuse treatment and AA self help Integrate substance abuse care into team approach Increase quality of life and improve outcomes

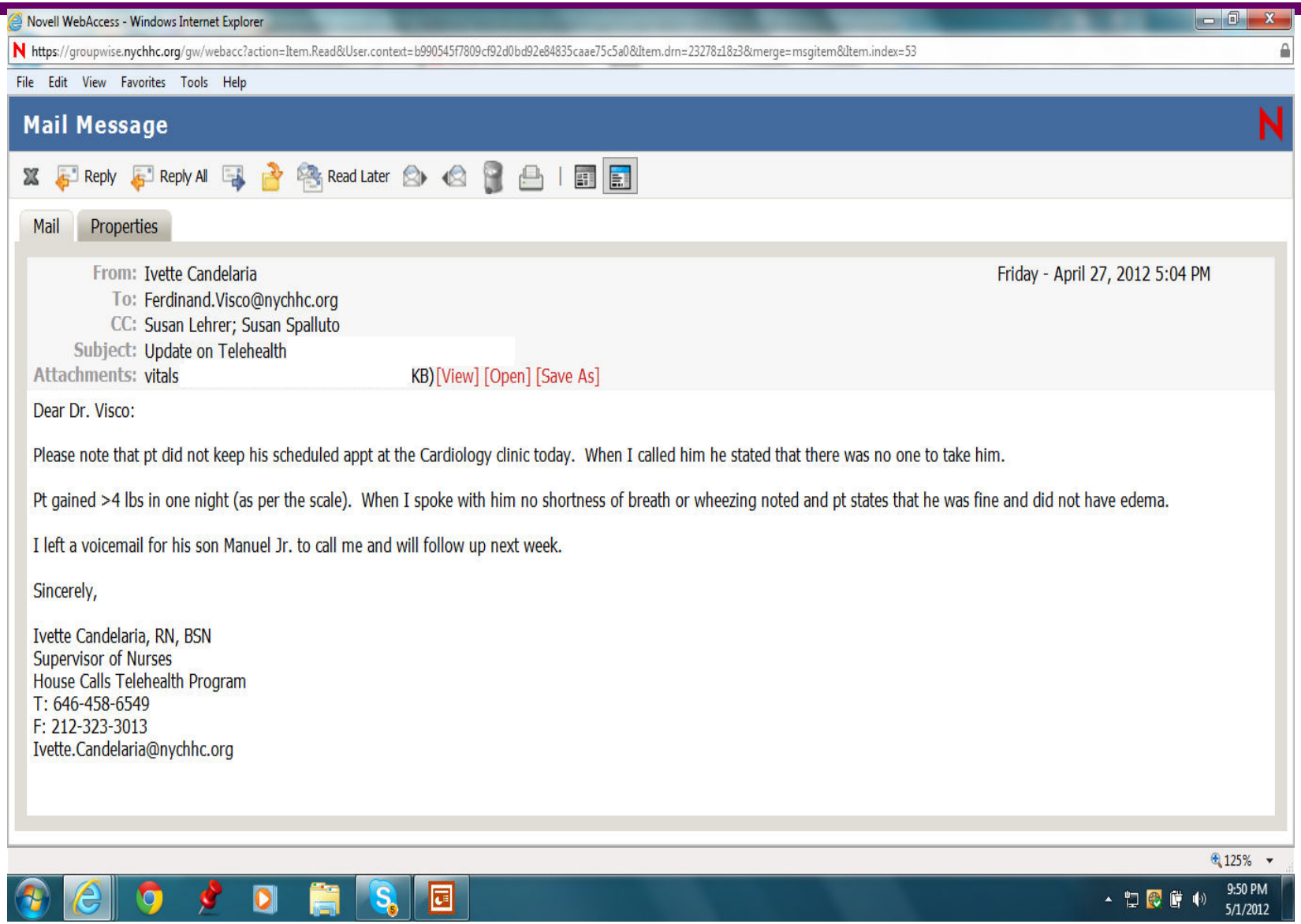
6. Rapid Experiments

WHAT	WHO	EXPECTED RESULT	ACTUAL RESULT	CYCLES
Implement the teaching booklet and teach back	Catherine Frances Iris Susan	- Patient's adherence to medication management and diet will increase - Patient prepared for self management	Patient very receptive. Agreed to transfer care here. Teaching booklet helpful.	1
Develop Discharge Checklist and Process Control Board	Team	Multi-disciplinary assessments and education completed prior to discharge	Only one patient with CHF in house Board developed and revised to improve communication	1
Make follow up calls within 72 hours of discharge	Fiona	- Reinforcement of discharge teaching and recommendations - Prevention of re-admissions	Not tested	0
Substance abuse assessment by addiction counselor at bedside as needed	Osvaldo	Connect patients to substance abuse services	Not tested No CHF patient with substance abuse problems in hospital	0

6. Rapid Experiments

Daily tracking of HF Patients




Novell WebAccess - Windows Internet Explorer
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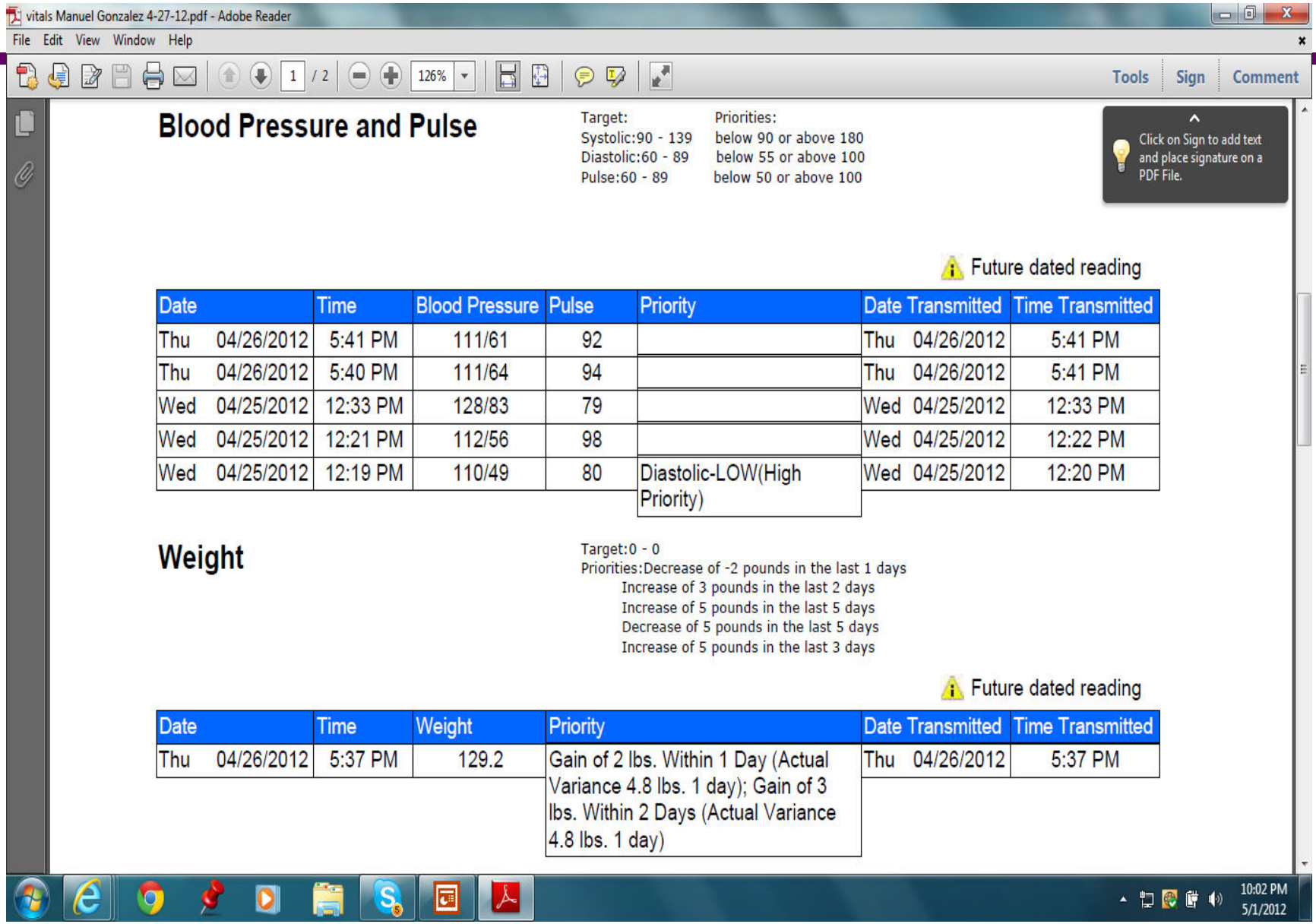
File Edit View Favorites Tools Help
Mail Message
Reply Reply All Read Later
Mail Properties
From: Ivette Candelaria
Friday - April 27, 2012 5:04 PM
To: Ferdinand.Visco@nychhc.org
CC: Susan Lehrer; Susan Spalluto
Subject: Update on Telehealth
Attachments: vitals KB) [View] [Open] [Save As]
Dear Dr. Visco:
Please note that pt did not keep his scheduled appt at the Cardiology clinic today. When I called him he stated that there was no one to take him.
Pt gained >4 lbs in one night (as per the scale). When I spoke with him no shortness of breath or wheezing noted and pt states that he was fine and did not have edema.
I left a voicemail for his son Manuel Jr. to call me and will follow up next week.
Sincerely,
Ivette Candelaria, RN, BSN
Supervisor of Nurses
House Calls Telehealth Program
T: 646-458-6549
F: 212-323-3013
Ivette.Candelaria@nychhc.org
125%
9:50 PM
5/1/2012


vitals Manuel Gonzalez 4-27-12.pdf - Adobe Reader
File Edit View Window Help
1 / 2
126%
Tools
Sign
Comment
Click on Sign to add text and place signature on a PDF File.
Blood Pressure and Pulse
Target:
Systolic:90 - 139
Diastolic:60 - 89
Pulse:60 - 89
Priorities:
below 90 or above 180
below 55 or above 100
below 50 or above 100
Future dated reading
Date
Time
Blood Pressure
Pulse
Priority
Date Transmitted
Time Transmitted
Thu 04/26/2012 5:41 PM 111/61 92 Thu 04/26/2012 5:41 PM
Thu 04/26/2012 5:40 PM 111/64 94 Thu 04/26/2012 5:41 PM
Wed 04/25/2012 12:33 PM 128/83 79 Wed 04/25/2012 12:33 PM
Wed 04/25/2012 12:21 PM 112/56 98 Wed 04/25/2012 12:22 PM
Wed 04/25/2012 12:19 PM 110/49 80 Diastolic-LOW(High Priority) Wed 04/25/2012 12:20 PM
Weight
Target:0 - 0
Priorities:Decrease of -2 pounds in the last 1 days
Increase of 3 pounds in the last 2 days
Increase of 5 pounds in the last 5 days
Decrease of 5 pounds in the last 5 days
Increase of 5 pounds in the last 3 days
Future dated reading
Date
Time
Weight
Priority
Date Transmitted
Time Transmitted
Thu 04/26/2012 5:37 PM 129.2 Gain of 2 lbs. Within 1 Day (Actual Variance 4.8 lbs. 1 day); Gain of 3 lbs. Within 2 Days (Actual Variance 4.8 lbs. 1 day) Thu 04/26/2012 5:37 PM
10:02 PM
5/1/2012

7. Completion Plan

What	Who	When
AA Representatives get floor access (ID)	Osvaldo	🔴
Present Heart Failure Program, including discharge criteria, to the Department of Medicine	Dr. Visco	🟢
Track weekend discharges of HF patients without medication	Richard	🟢
Home Care RN's access to documentation in Q-med	Patsy	🟢
Home Care Algorithm Home Care Form for calls Train Home Care staff	Fiona	🟢
Create and post data tracking charts	Patsy	🟢

8. Confirmed State (90 Days post RIE)

Metric	Baseline	Target	RIE (July '11)	+30 Days (Aug'11)		+60 Days (Sept '11)		+90 Days (Oct '11)	
				Projected	Actual	Projected	Actual	Projected	Actual
% patients re-admitted within 30 days	31%	18%	31%	25%	0	20%	0	18%	0
% patients with participating insurance that come to first appointment	39%	100%	39%	50%	33%	75%	83%	100%	66%
% CHF patients that receive post discharge contact – within 72 hours	50%	85%	50%	65%	*100%*	80%	50%	85%	40%
% of patients with substance abuse history or toxicology that are offered a referral to treatment	25%	100%	25%	65%	*100% (only 1 patient)*	85%	0	100%	0
% of CHF patients with a substance abuse history and are referred to our program that attend	25%	50%	25%	35%	*0 (only 1 patient)*	40%	0	50%	0

9. Insights

What Went Well	What Could Improve
■ Dr. Visco's leadership ■Team worked very well together ■ All team members contributed ■ Professional expertise of various team members ■ Right disciplines were chosen	■ Pre-event data collection ■ Staying focused on scope ■ More efficient use of team members
What Helped	**What Hindered**
■ Breaking into sub groups to increase efficiency ■ Going to the Gemba ■ Experiments ■ Learning how everyone fit into the process ■ Real time answers from subject matter experts ■ Patient's cooperation ■Visual tools	■ Not having data ■ Only one Heart Failure patient in house during experiments ■ No patients with HF and substance abuse in house during experiments