

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

**JUNE 10, 2014
10:00 A.M.
HHC BOARD ROOM
125 WORTH STREET**

AGENDA

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

**II. ADOPTION OF MAY 13, 2014
STRATEGIC PLANNING COMMITTEE MEETING MINUTES** **JOSEPHINE BOLUS, RN**

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

IV. INFORMATION ITEM:

- i. ED CARE MANAGEMENT INITIATIVE: PREVENTING AVOIDABLE ED/INPATIENT USE**
A CENTER FOR MEDICARE & MEDICAID INNOVATION (CMMI) HEALTH CARE INNOVATION
AWARD ROUND TWO FUNDING OPPORTUNITY

ANTHONY DIVITTIS
ASSOCIATE DIRECTOR OF GRANTS, WOODHULL MEDICAL AND MENTAL HEALTH CENTER

MARLAINA NORRIS, MD, MBA
DIRECTOR OF CARE/CASE MANAGEMENT, QUEENS HEALTH NETWORK

V. OLD BUSINESS

VI. NEW BUSINESS

VII. ADJOURNMENT **JOSEPHINE BOLUS, RN**

MINUTES

STRATEGIC PLANNING COMMITTEE MEETING OF THE BOARD OF DIRECTORS

MAY 13, 2014

The meeting of the Strategic Planning Committee of the Board of Directors was held on May 13, 2014 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.
Robert F. Nolan
Bernard Rosen
Patsy Yang, representing Deputy Mayor Lillian Barrios-Paoli

OTHER ATTENDEES

J. DeGeorge,
M. Dolan, Senior Assistant Director, DC 37
J. Wessler, Guest

HHC STAFF

M. Belizaire, Assistant Director of Community Affairs, Office of Intergovernmental Relations
C. Barrow, Assistant Director, Lincoln Medical and Mental Health Center
S. Bratu, MD, HIV Medical Director, Kings County Hospital Center
L. Brown, Senior Vice President, Corporate Planning, Community Health and Intergovernmental Relations
E. Casey, Assistant Director, Corporate Planning and HIV Services
D. Cates, Chief of Staff, Office of the Chairman
Z. Chow, Medical Director, Bellevue Hospital Center
K. Depass, Assistant Controller, Coney Island Hospital
J. Goldstein, Senior Consultant, IS, Corporate Planning Services
L. Guttman, Assistant Vice President, Office of Intergovernmental Relations

T. Hamilton, Assistant Vice President, Corporate Planning Services
L. Haynes, Assistant Systems Analyst, President's Office
L. Isaac, Assistant Director, Corporate Planning Services
J. Jurenko, Senior Assistant Vice President, Office of Intergovernmental Relations
B. Keller, Deputy Counsel, Office of Legal Affairs
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
I. Michaels, Director, Media Relations, Communications and Marketing
T. Miles, Executive Director, World Trade Center Environmental Health Center
J. Omi, Senior Vice President, Organizational Innovation and Effectiveness
K. Park, Associate Executive Director, Finance, Queens Health Network
C. Pean, Associate Director, Harlem Hospital Center
N. Peterson, Senior Associate Director, Woodhull Medical and Mental Health Center
W. Saunders, Assistant Vice President, Office of Intergovernmental Relations
R. Solomon, Associate Director, Lincoln Medical and Mental Health Center
N. Stine, Chief Medical Officer, HHC Accountable Care Organization
K. Whyte, Senior Director, Corporate Planning, Community Health and Intergovernmental Relations

CALL TO ORDER

The meeting of the Strategic Planning Committee was called to order at 10:32 a.m. by the Strategic Planning Committee Chairperson, Josephine Bolus, NP-BC. The minutes of the April 8, 2014 meeting of the Strategic Planning Committee were adopted.

SENIOR VICE PRESIDENT REMARKS**State Update**New York State MRT Waiver Amendment Delivery System Reform Incentive Payment (DSRIP) Plan

Ms. Brown began her remarks by providing the Committee with an update on the Delivery System Reform Incentive Payment (DSRIP) Program component of the MRT Medicaid Waiver. Ms. Brown informed the Committee that she would circulate comments that HHC staff had submitted a few weeks ago to the State concerning the DSRIP Program. She also informed the Committee that Ms. Judy Wessler, the former Director of the Commission on the Public Health System and others had also provided the State with comments on the waiver, which would be shared with the Committee. Ms. Brown announced that a presentation on HHC's Planning Application would be presented to the Committee at the July 2014 Strategic Planning Committee meeting. Ms. Brown informed the Committee of key waiver time frames, which are the following:

- **May 16, 2014:** Due date for submission of "Letter of Intent" to articulate HHC's and its facilities' intent to participate in the waiver. The identification of potential partners should also be included with that letter. List of partners is not binding. HHC has been engaged in a series of activities to identify and engage potential partners including other Safety-Net providers, hospitals, health centers, nursing homes etc.
- **May 31, 2014:** Due date for the Application for Interim Access Assurance Fund (IAAF). HHC hopes to get as much of the \$250 million available to all of the public hospitals statewide through this funding mechanism. HHC expects to submit a comprehensive proposal to secure as much of this funding as possible.
- **June 26, 2014:** Due date for DSRIP Planning Application

Mrs. Bolus asked about the number of potential partners that would be affiliated with HHC. Ms. Brown responded that a final count could not yet be determined. She explained that the State had been very explicit that no application for DSRIP funding would be considered from either a Public Hospital or a Safety-Net entity alone. All applications must include other partners. She added that HHC had determined that, while it would identify some of the projects that the State had recommended for the entire enterprise, HHC would also be submitting distinct applications for DSRIP projects and funding, minimally by borough. Ms. Brown introduced the term Performing Provider Systems (PPS) to the Committee. This is a new term that was introduced by the State in the context of the waiver. She added that HHC intended to have local PPSs. As an example, Ms. Brown explained that the Queens Health Network had been encouraged to become a PPS. As such, Queens and Elmhurst Hospital would submit a PPS application, which would also include other non-HHC hospitals such as Jamaica Hospital. Ms. Brown clarified that these hospitals would also submit an application as they could be partners

under a PPS; and, if they were considered Safety-Net hospitals, they could also apply to be their own PPSs.

Ms. Brown reported that HHC would also partner with citywide organizations, such as the Visiting Nurses Services (VNS). Ms. Brown explained that HHC may work with them on different issues depending on the borough. As an example, Ms. Brown stated that VNS may want to do some work in the Rockaways. She explained that, while HHC does not have an acute care facility in the Rockaways, Rockaway residents use the Queens Health Network and Kings County Hospital Center. Therefore, VNS would be in HHC's partnership and HHC would also be included in their program. Ms. Brown announced that HHC would be meeting with the Metropolitan Home Jewish Services (MHJS) on May 14, 2014. She explained that MHJS was interested in partnering with HHC on an initiative to ensure the continuity of services for some of their nursing home and assisted living residents who are hospitalized at Coney Island Hospital and at Bronx facilities. Ms. Brown noted that it was important to include MHJS in HHC's PPS and MHJS may also participate in other entities' PPS as well.

Mrs. Bolus asked if potential partners had been reaching out to HHC and if HHC was also reaching out to them. Ms. Brown responded that it was bilateral. HHC has been reaching out to many organizations and many organizations have also reached out to HHC. Ms. Brown stated that HHC had informed its partners that they could express their interest as a placeholder in the form of a Letter of Interest and that detailed discussions would follow in the month of June.

Ms. Brown further explained that the Federally Qualified Health Centers (FQHCs) would be very important partners for HHC. In some boroughs, some FQHCs are linked to a voluntary hospital or a PPS and are not interested in being part of HHC's partnership. Ms. Brown added that there were FQHCs that were interested in partnering with HHC. Ms. Brown informed the Committee that HHC's Letter of Intent would include a list of community health centers and supportive housing providers. She added that, while they may not be "Medicaid healthcare providers," they are an extremely important component for achieving success, as one of the major objectives of the State in this waiver is to reduce avoidable hospitalizations and readmissions.

Mrs. Bolus asked if there would be a limit on how many partners that could be submitted with HHC's Letter of Intent (LOI). Ms. Brown responded that there was no limit. However, she added that after the dust settled with the submission of the LOI, HHC would be judicious in its consideration of which entities would make best partners because once partners have been identified, those relationships would have to be maintained over the five years of the waiver.

Mrs. Bolus asked about the distribution of funds among the partners. She asked how the number of partners would impact the amount of funding that would be available to HHC. Ms. Brown responded that the most critical issue is what is to be achieved. She added that HHC needed to be prudent in selecting those initiatives that have been identified by the State as having the highest scores and with choosing partners that serve a large number of Medicaid beneficiaries. Ms. Brown explained that if HHC partnered with an entity with 65,000 Medicaid patients, and HHC had 135,000, this partnership would collectively agree to take responsibility for 200,000 members. She added that the value of HHC's award would be driven by that population. Another important consideration in terms of choosing non-Medicaid provider partners is that HHC has to be successful not only in implementing the projects but also, in reducing avoidable hospitalizations and in producing better quality outcomes. Ms. Brown explained that key partner selection criteria should include that the partner would be helpful to HHC,

the number of Medicaid patients and uninsured patients, and ability of partnership/collaborative initiative to keep patients out of the hospital if it is not necessary for patients to be admitted. Ms. Brown stated that HHC would be seeking to partner with nursing homes. She explained that the State was also interested in initiatives that would strengthen care at nursing facilities to limit the frequency of admissions of nursing home residents. Ms. Brown informed the Committee that HHC's Care management and Home Health program would play an important role in this new body of work. Ms. Brown summarized that, in choosing partners, an entity must look at the overarching goal, the number of Medicaid beneficiaries and the strengths or skill sets of those potential partners.

Mrs. Bolus commented that HHC should be very cautious in choosing its partners. She asked if HHC would be obligated to increase the quality of care of its partners. Mr. Bernard Rosen, Board Member, added that it was also possible that the partners may also choose HHC because of its large number of Medicaid beneficiaries. Ms. Brown responded that HHC and its partners would have to take responsibility for a cohort of Medicaid beneficiaries. She informed the Committee that the State had emphasized that this would be a shared responsibility. She referred to Mrs. Bolus' inquiry concerning the number of partners and stated that it does not make sense to select 100 partners. HHC would look for organizations that have some shared values and experience with serving patients in a linguistically and culturally responsive way. Ms. Brown reminded the Committee that there are many organizations with similar missions that are committed to patient-centered care. Ms. Brown added that, in addition to these subjective attributes in choosing a partner, some objective attributes in terms of their depth, infrastructure, number of Medicaid beneficiaries and skill sets should also be taken into consideration.

Mrs. Bolus asked if HHC's IT Department would be expected to work with these partners. Ms. Brown responded that a key component that would tie all the partnerships together would be the ability and the capacity of patient information flow and shared electronic health records (EHR) with a mechanism for sharing that information electronically. Ms. Brown explained the funding flow. There is an expectation that HHC would be paying some partners for some of the services that they would provide in this partnership. If, on the other hand, HHC is part of another entity's PPS, HHC would expect reimbursement for the services that it would provide.

Ms. Brown noted that HHC would not only be taking full advantage of the opportunity that the waiver presented but would also determine how to do so in a strategic and smart way within a very compressed timeframe.

State Update

Ms. Brown reported that the New York State Legislature had returned from their April recess ready to make progress on post-budget issues. She noted that there were three priorities high on the agenda cited by Governor Cuomo: ethics reform, including public campaign financing; the DREAM Act to provide undocumented students from immigrant families with access to higher education; and Cuomo's 10-point Women's agenda.

Ms. Brown reported that several major health care issues had been resolved as part of the Budget, including Safe Patient Handling and Out-of-Network Health Insurance billing. She added, however, that the Legislature would likely consider other key issues affecting HHC in the six remaining weeks of the Legislative Session. Ms. Brown reported that legislation to increase the statute of limitations for medical malpractice claims had made its way to the floor of the Assembly. She noted that a similar bill

was introduced in the Senate last week. Ms. Brown explained that this legislation could result inasmuch as a 15-25% increase in malpractice coverage costs due to the need to account for expected increases in claims. In addition, it would significantly increase the exposure of health care systems like HHC. Ms. Brown stated that robust discussion was anticipated on a variety of other liability and malpractice issues.

Ms. Brown reported that staff was also keeping a close eye on legislation that would mandate stringent nurse staffing ratios for hospitals and nursing homes. It would require thousands of new nurses to be hired at an estimated statewide cost of \$3 billion annually for hospitals and nursing homes. It is estimated that it would cost HHC nearly \$388 million annually. Ms. Brown noted that, although supporters of the bill argue that hiring additional nurses would lead to increases in quality, the latest peer-reviewed research showed that simply imposing new staffing mandates would not in itself result in improved patient care.

Ms. Brown informed the Committee that HHC would continue to remain vigilant on these and other proposals affecting HHC as the session draws to a close.

City Update

Executive Budget Released

Ms. Brown reported that Mayor de Blasio had released the FY2015 Executive Budget on May 8, 2014. She informed the Committee that the \$73.9 billion spending plan would balance the budgets for FY 14 and FY15. However, gaps would begin at \$2.2 billion in FY 16 and grow in the out years. Ms. Brown reported that the Mayor's budget:

- Laid the ground work for labor settlements along the lines of the agreement reached with the teacher's union which featured salary increases over an extended period along with savings from healthcare spending,
- Included Pre-K funding of \$300 million in FY 15 for 53,000 seats of the Universal Pre-K expansion,
- Included funds for the Affordable Housing plan to expand/preserve 200,000 units over 10 years,
- Included funds for the Vision Zero traffic safety initiative, and
- Sought to end budget dance of prior years with cuts by Mayor and restorations by Council

Concerning HHC, Ms. Brown reported that the plan:

- Demonstrated that overall City support for HHC has been maintained,
- Avoided the annual "budget dance" items that the Council traditionally restored, which were base-lined last year and funding continues in this budget. This funding includes \$6 million for the Unrestricted Subsidy, \$5 million for Child Health Clinics, \$2 million for HIV testing and more than \$1 million for behavioral health programs, and
- Retained the budgeted increase in HHC Subsidy which goes from \$78 million in FY 14 to \$81 million in FY 15

Ms. Brown underscored that, in their preliminary budget response released last month, the City Council had budgeted an additional \$2 million increase for HHC's Unrestricted Subsidy. She added that under their proposal, it would increase from \$6 million to \$8 million. Ms. Brown announced that HHC's

Executive Budget hearing was scheduled for Tuesday, May 27th at 11:00 AM in the Council Chambers to discuss the budget and other issues.

INFORMATION ITEM

HIV Services Update Presentation

Terry Hamilton, Assistant Vice President, Corporate Planning & HIV Services
Simona Bratu, MD, HIV Medical Director, Kings County Hospital & HIV Services Clinical Advisory Group

Ms. Brown introduced Ms. Terry Hamilton, Assistant Vice President, Corporate Planning & HIV Services and Ms. Simona Bratu, MD and invited them to present an update on HHC's HIV Services. Ms. Hamilton informed the Committee that her presentation would provide both an update and an overview of HIV services over the last 10 years and the two key themes that drive this work. These themes are evidence and research, which have played a key role in how opportunities for increasing access to care have been developed by expanding testing opportunities; and how HHC has improved the quality of care it delivers by creating a corporate-wide HIV Quality Improvement Learning Network. Ms. Hamilton noted that she would provide the Committee with specific examples of how early on HHC had employed the use of evidence and research to help expand access to screening; she would describe how HHC was doing with expanding access to screening and would also describe how HHC has utilized the Quality Improvement Learning Network in the past and today to help improve the quality of care.

Ms. Hamilton began her presentation by asking Committee members to picture in their minds a descending set of stairs. This descending set of stairs visually demonstrated the state of HIV in the United States today. It is called the HIV Care Continuum or cascade, which is it is built on the work of Dr. Laura Cheever who began work in 2007, looking at a continuum of patients engaged in care and those not engaged in care. This work was refined by Dr. Edward Gardner in 2011 but was further refined by the Health Resources Services Administration (HRSA) to provide this picture today. She described HRSA's Care Continuum as the following:

State of HIV/AIDS in the United States: HRSA Continuum

- 1.2 million people living with HIV in the United States
- 50,000 new infections each year
- Of the people living with HIV/AIDS (PLWAs) only 82% know they are infected
- Only 66% are linked to care
- Only 37% stay in care
- Only 33% are on ART
- Only 25% are adherent to medication and virally suppressed

Ms. Hamilton asked, "What does this mean to us?" She explained that there had been a sharp drop off between the percentage of patients who had been linked to care and the percentage of patients who actually remained in care. This drop off is approximately 30%. The other very important point about the percentage of patients who are virally suppressed is that, if a patient is virally suppressed that patient is most likely to be living a healthier life, which is achieved by taking the medication and seeing a physician on a regular basis. What the numbers presented in the care cascade or continuum does not show are the health care disparities. That is, when you look at African Americans, the health care outcomes in terms of viral suppression are worse than the population in general. For younger patients,

the health care outcomes are worse than the population in general. For adults older than 50 or 60, the health care outcomes are actually a little bit better. Ms. Hamilton commented that, we are losing people nationally from the time that they know that they are infected to when they are linked to care to being retained in care and then becoming virally suppressed.

Ms. Hamilton informed the Committee that a care cascade or continuum for New York State and for New York City had been developed and had a very similar downward step of progress, similarly to the care continuum developed by HRSA. In 2012, the estimated number of New Yorkers who had been infected and ever diagnosed was 86% and the percentage of those patients who were virally suppressed was 41%. Ms. Hamilton reported that the New York State Department of Health had created a partnership with the New York City Department of Health and Mental Hygiene, which had been designated a Special Projects of National Significance (SPNS). SPNS is a special HRSA program effort to demonstrate how entities might be able to change care for the better. This partnership between the State and the City is part of the work that HHC is engaged in. Ms. Hamilton is a member of the Steering Committee for that SPNS Project. Ms. Hamilton explained that the SPNS Project's aim is to specifically look at linkages to and retention of patients in care, not just by focusing on an individual organization but community-wide and across organizations. The goal is to improve the ability to link and retain patients in care. Ms. Hamilton added that findings from recent SPNS Project data for 2013 had revealed that the top 25% of SPNS Project organizations had far lower suppression rates of roughly 85%, which meant that these organizations did very well working on this effort. She commented that there was still more work to be done.

Ms. Hamilton explained why screening was an important aspect of improving access to care. Screening is very important because research shows that once people know that they are positive, they lessen their risk behaviors, which in turn lessen the opportunity to become re-infected or transmit the disease to others. Ms. Hamilton added that, HHC has expanded its Quality Improvement Learning Network (QILN) efforts beyond focusing on clinicians to encourage all staff including billing, case management, social workers and program administrators to learn about the methods of quality improvement. She added that the Institute for Healthcare Improvement's model for improvement and Breakthrough/Lean tools have been used to support this work.

Ms. Hamilton described the basic goals that have been set nearly ten years ago for the HIV Testing Expansion Initiative. These goals are to help patients to learn their HIV/AIDS status and to get them into care early if they were found to be positive. Ms. Hamilton explained that research showed that patients who received care early and who were retained in care had better health outcomes. She added that the goals and the monthly reporting measures were kept very simple. Ms. Hamilton introduced her colleague Dr. Bratu to further describe HHC's HIV efforts before and after the implementation of the HIV Testing Expansion Initiative.

Dr. Bratu informed the Committee that, as a clinician, high quality care meant that she does everything possible to improve the individual patient's health benefit, while at the same time being responsible for the community overall. This is a common goal. She explained that, it begins with the care of the individual patient then continues to care of the community. When patients are identified, they are tested and treated. Dr. Bratu stated that the major concept in HIV care is to use treatment as prevention. That is, treatment for the individual would not only benefit the patient but would also serve as prevention in terms of the overall health of the community. Dr. Bratu reported that, seventeen years (17) ago, strong data were not available but there was more of a conceptual understanding of the

benefits of the approaches that have been implemented over time. Before 2005, HIV testing was primarily conducted based on individual circumstances, with the exception of OB/GYN patients. Additionally, testing was also performed based on race. Dr. Bratu explained that this was the old narrative. In 2005, testing based on race was no longer appropriate and was no longer a standard practice because race cannot be assessed as an accurate risk factor for HIV. She informed the Committee that HHC had moved away from the idea of race-based testing and has been focusing on individual-based testing.

The expansion of HIV testing at HHC facilities began with looking at every opportunity to capture patients who were receiving care in inpatient care units, the emergency room and in outpatient care settings. Dr. Bratu reported that, from 2005 through 2006, there were 40,000 additional tests per year. The number of tests per year increased further to reach an average of 200,000 tests per year. Dr. Bratu reported that, at HHC, an estimate of 1,300 patients per year would be diagnosed with HIV/AIDS, through the rapid testing methodology. This testing methodology was very successful at HHC facilities. She added that there was no mandate to use rapid testing but providers recognized the advantage. The rapid testing methodology allows for the test to be conducted through a blood test or an oral swab with the results provided within 20 minutes. Dr. Bratu commented that this was very valuable because it gave the provider the opportunity to establish a different rapport with the patient. It allowed time for the provider to have a dialogue with the patient and to ease their anxiety. Most importantly, it provided the opportunity to lead/link that patient immediately to care to the best of their ability. The earlier the provider meets a patient, the higher the chance of success in retaining the patient in care.

Dr. Bratu described the efforts that had been made to improve the efficacy and efficiency of the HIV testing initiative. She informed the Committee that some researchers have tried to determine how many new patients would have to be treated in a certain community to significantly decrease the number of new HIV patients and to ultimately reduce the number of patients with AIDS to zero. To establish a goal, HHC reviewed 7 years of its data in order to establish a target. HHC's HIV Services' team published a report last year in the medical journal, *The Lancet* that documented that it was not necessary to test 100% of the target HIV population. At the target of 20% testing of the target HIV population, the number of new HIV patients to be identified would start to decrease. At 40%, there would likely be close to zero AIDS diagnosis. This paradigm offered HHC a new working frame which is very valuable. Instead of establishing a target number of tests for each facility that they would have to achieve annually, it was most efficacious for the facility to test a proportion of their HIV patient population.

Dr. Bratu described efforts to link patients to care. She stated that the data showed that the earlier a patient is linked to care the better the results. The next step is retention. Dr. Bratu stressed that this was a journey – from diagnosis to linkage to care and retention in care. All steps are equal and they cannot work without the other. Once a patient is diagnosed, the patient is linked to care but often lost in the follow-up. For instance, the patient never returns or the patient returns after many years when they are critical and dying. Dr. Bratu emphatically stated that, "We don't want that...we want the patient to be diagnosed, to be studied and to stay with us in order to have their HIV controlled and to benefit from the best care that we can provide." Dr. Bratu added that retention was a critical piece and that most HHC facilities had a retention rate of approximately 75%. She added that we can do better and we want to do better because as we test more HIV patients we have to keep these patients in care. Mr. Bob Nolan, Committee Member, asked if linkage to care meant that you have identified someone with a problem and that individual returned regularly. Dr. Bratu responded affirmatively. She said that a

typical example would be a patient who showed up to the emergency room for a minor ailment but requested an HIV test and that patient X was found to be HIV positive. Following the preliminary test, the patient is provided with a counseling session with HHC counselors to explain the result. The counselor escorts the patient to the clinic and the patient is introduced to the head nurse, social worker and provider. The team orders all necessary screening tests and arrange for a follow up visit with in a week or two weeks at the most. Ms. Brown commented that this was the definition of linkage. Dr. Bratu agreed. Dr. Bratu added that what we do as a first encounter is to establish a very strong initial rapport and to reduce their fear. The next step is that the patient receives an appointment to return the following week. If the patient does not return, a staff member calls the patient and then sends a letter to the patient. If all efforts fail, the Care Service Unit is contacted. This unit has the ability to find out if this patient may be receiving care at another health care facility. The ultimate goal is to have the patient in care somewhere. Mr. Nolan asked how often patients would have to return during the first 90 days and would it depend on the condition. Dr. Bratu added that at the beginning patients are seen quite fast. The first visit is very extensive to collect data that would help the patient to change their risk factor. Dr. Bratu explained that this was crucial in HIV Services because they have a dual responsibility to the patients and to the community. She provided the Committee with an example.

"I have a patient that came to me after he was discharged from the hospital where he had a long costly stay. He almost died. He had two very severe respiratory infections in the context of AIDS. He was so immune suppressed that he could not get the regular antibodies that are detected on the usual test. He had to get a lung biopsy to find the infections then go back to do additional tests that showed that he ultimately had AIDS. After discharge, he came to my clinic, and I saw him twice. I started him on antiviral therapy then he disappeared. We called him and the phone was not working. We sent him telegrams but he wouldn't answer. Then a few months later, he showed up again. We would start all over again and he would do it again. We made all efforts to engage him and it turned out that this was a young man who was terribly scared. Every time, he showed up, the clinic was almost closed and no one was there except the head nurse and me. Apparently, he was terrified that someone would recognize him and figure out his illness. This was one of the reasons why he would not come for care. At this point in time, this gentleman is taking his medications and he comes back. He refuses to discuss anything about his partners. One day, he came to me and asked what would be the best and fastest way to test his partner. He was afraid that she would be positive. He wanted her to get tested and to come to the clinic. This is a very complex picture. It's not only the medical but the social issues and stigmas that we work very closely with the patients. We have a special relationship with the patients and offer them ample opportunities to come back."

Mr. Nolan asked if HHC exceeded every other institution in terms of testing. Ms. Brown responded that HHC performed better than the New York State average, which included all of the facilities throughout the State and beyond New York City. Ms. Hamilton added that HHC had the largest testing program within a single health care agency in the United States. Ms. Brown clarified her comment by stating that HHC had the single largest testing program in the country. Ms. Brown reminded the Committee that, several years ago, HHC had been recognized for its extensive efforts by the Centers for Disease Control (CDC) at Gracie Mansion.

Dr. Bratu continued her presentation by explaining what was meant by viral suppression. She described viral suppression as having all the patients who are engaged in care well controlled on antiviral therapy. HHC cares for everyone regardless of how immune suppressed they are and without regard to their viral load. It is also important to understand that HIV produces a very profound change on impacted

patients, not only as a result of the related AIDS defining diseases but also due to the non-AIDS defining diseases. HIV can cause an inflammatory state that has far reaching consequences including cardiovascular related diseases, the risk of cancer along with the unexpected consequences of having longstanding HIV infection. Notwithstanding, HHC treats everyone.

Ms. Hamilton informed the Committee that HHC had been involved in a variety of community-wide activities, which include a longstanding, strong collaboration with the New York State Department of Health (SDOH). These collaborations are highlighted below:

Community-wide Activities

- NYS DOH *Three Years of Rapid Testing* Conference, Special Project of National Significance (SPNS)
- CDC HIV testing consultations
- HRSA Ryan White grantee presentations
- DOHMH Bronx Knows, Brooklyn Knows campaigns
- Health and Human Services Ryan White Part A Planning Council
- HIV Prevention Planning Group

Ms. Hamilton informed the Committee that Ms. Eunice Casey, a member of the Central Office HIV Services Unit, served as a member of the Steering Committees for Bronx Knows and Brooklyn Knows; and that HHC had been involved in these efforts from the very beginning.

Ms. Hamilton reported that HHC's HIV Services' collaborations extended beyond community-based collaborations to include national and international collaborations as highlighted below:

National Collaborations:

- United Nations hosted international seminar at first UN Special Session on AIDS and presented at a women's conference sponsored by Non- Governmental Organizations
- New Approaches to the Epidemic in Vulnerable Populations of the African American Community with the *National Coalition of 100 Black Women*
- UN sponsored international seminar on screening and care; also presented at women's seminar sponsored by a UN NGO.
- CBO HIV Testing Collaboration with the NYC Council and Community Partners
- *Institute for Healthcare Prevention* - community health screenings- HIV screening partnered with other screenings at community event at KCH

International Delegations:

HHC was asked for advice and consultation by international colleagues and HHC staff learned from them as well. These consultations were with the following international entities:

- United Kingdom, Terrence Higgins Trust
- Singapore Ministry of Health
- USAID Project Ethiopian Delegation
- Bangkok Ministry of Health Delegation

Ms. Hamilton reported that the Quality Improvement Learning Network (QILN) was the second strategy that HHC had employed to improve and standardize the quality of care across all of the facilities. The QILN hosts monthly topical conference calls; it provides quality improvement training on a regular basis throughout the corporation; and it focuses on providing and sustaining feedback to the facilities. For nearly ten years, this work has been done in partnership with the NYSDOH.

The QILN conducts quality reviews of the projects that HHC facilities submit. The QILN has helped to refine the way that funding support is allocated to facilities, which utilizes a dissemination strategy that takes into consideration quality improvement performance measures. Ms. Hamilton added that, the work that had been supported and strengthened through the use of quality improvement tools to help HHC to improve the quality of care it delivered. Ms. Hamilton provided the Committee with three examples of some of the quality improvement projects that HHC had conducted:

1. Renaissance Diagnostic & Treatment Center launched an initiative to add HIV screening as part of its annual flu shot campaign.
2. Morrisania Diagnostic & Treatment Center staff developed a brochure that encouraged patients not to leave their appointments without having all of their questions unaddressed. The clinicians and staff felt strongly that the more questions patients asked, the more information they would be able to collect/gather to help improve the quality of care.
3. Harlem Hospital Center developed a nutrition and exercise program to improve health outcomes for HIV patients. Ms. Hamilton stated that she encouraged a Nutritionist at Harlem Hospital to apply for some funding from the HIV Innovation Fund. Ms. Hamilton explained that part of her budget included City Council funding, which is used primarily for testing patients. She added that HHC has been working to refine how it delivered care to patients and continuously improve those outcomes.

Ms. Hamilton informed the Committee that HHC's HIV Services was also exploring newer ways to look at the connection between access and improving outcomes.

Dr. Bratu described the provider driven nature of screening. She informed the Committee that this was part of a model that was nationally oriented. It is a Gilead Sciences funded program with focused attention placed on systems and healthcare teams focusing on HIV care. The concept is called the "growthmeister." That is, getting people and providers outside of their comfort zone and challenging them a little bit in terms of HIV. Dr. Bratu informed the Committee that at HHC facilities, HIV testing was primarily being offered by counselors but asked, "Was this the best model?" At the end of the day, the Primary Care Provider, the OB/GYN, and/or the Psychiatrist are the first line providers to encounter patients on a regular basis, year after year. Ideally, the concept is that they would be the most valuable members of the team. As such, these providers should be offering HIV testing to their patients. Dr. Bratu informed the Committee that this was what was currently being done at Kings County Hospital, which had a system of champions from the highest level. According to Dr. Bratu, the most interesting champion at Kings County Hospital was Dr. Jamaledine. At Kings County Hospital, a Chief of Service meeting was held to educate staff on the importance of discussing partner education. Now, in every single primary care team across HHC facilities, providers are offering screenings. As a result of this program, last year, Kings County Hospital achieved its 20% testing level of its target HIV population.

Dr. Bratu informed the Committee that work to continue to improve access would also entail strategies on how to implement the recently revised New York State regulation, which would permit oral consent for HIV screening; and the move toward the use of advanced technology such as 4th generation screening. Dr. Bratu informed the Committee that HHC used 4th generation HIV screening at Kings County. Fourth (4th) generation screening for example picks up earlier acute infections in certain patients who have acute infections. Dr. Bratu commented that it was a good test but it has its shortcomings. There will have to be discussions about its role. Ms. Bolus, Committee Chair asked if the 4th generation HIV screening required a blood sample. Dr. Bratu responded affirmatively. Dr. Bratu added that the rapid test can be used both by swab and by blood test. Most patients choose to have a blood test because they trust a blood test more than a swab test. As such, the 4th generation HIV screening should not create a problem for HHC's patients. Dr. Bratu highlighted several additional issues to be considered as part of their work, which include being responsible for the community and being part of a great effort to stop AIDS. She explained that, in addition to testing, there were other methodologies to prevent further transmission of HIV infections.

To illustrate these other methodologies to prevent further transmission of HIV, Dr. Bratu provided the Committee with several scenarios. For instance, you may have patients who visit the emergency room and inform the provider that they had sexual intercourse or shared needles with somebody and they were afraid that the person might be HIV infected. In that scenario, the patient would be offered post exposure prophylactics (PEP). This is a good thing and it could be a good methodology to prevent infection. However, there are some questions that arise because in some settings there are patients who show up every month. What do you do with those patients? Is this the best methodology to manage such cases? Dr. Bratu added that, maybe counseling and changing their risk behavior would be a better option, so it's an open discussion.

Dr. Bratu shared another scenario with the Committee. For instance, you may have a couple, one partner is HIV infected and the other is HIV negative. What can they do to prevent long term transmission of HIV? There is an option now to offer antiviral therapy to the non-infected partner. However, the antiviral therapy would have to be taken for life and the non-infected partner would have to obtain regular HIV screening tests and ongoing regular monitoring of the side effects. This is necessary because of the unknown and unforeseen potential consequences of long term antiviral therapy.

Dr. Bratu informed the Committee of a New York State's law that was recently passed, Public Health Law 2171, which required providers to offer persons who were born between 1945 and 1965 a Hepatitis C screening test. This is extremely important now. Why? In the past, Hepatitis C could not be treated. Now, there has been a complete shift in the evolution of Hepatitis C treatment. It's the right time to diagnose, treat and cure. There are some similarities with HIV treatment yet there are more complex issues, including the cost of medications and the need for more systems to be developed to have successful programs.

Concerning the issue of aging with HIV, Dr. Bratu informed the Committee that there were elderly patients who had been infected with HIV. In addition to having HIV and AIDS related problems, these patients have more complex issues including diabetes, hypertension, depression, bone disease and so many others. One advantage is that most of HHC's HIV services have been incorporated into HHC's medical home model, which functions as a close knit system with support services.

Ms. Bolus referred to the earlier discussion concerning the new Hepatitis C law and asked why those specific years had been chosen. Dr. Bratu responded that those patients were at higher risk for behaviors during those years for drug use. Ms. Hamilton added that individuals who were born during those years, as they aged into adulthood used injecting drugs more frequently, than another age cohort and the generation before them. A greater proportion of the population was experimenting with injecting drugs and other behaviors that put them at a higher risk for Hepatitis C.

Ms. Hamilton discussed the two frameworks that would guide the future work/focus of HIV services. She informed the Committee that, one framework was the National AIDS Strategy. After 30 years of work, in July 2010, the President signed a National AIDS Strategy for the United States, which has three goals:

- To reduce the number of people who become infected with HIV
- To increase access to care and improving health outcomes for people living with HIV
- To reduce HIV-related health disparities

Ms. Hamilton commented that, it was her hope that through the presentation that they had successfully demonstrated how evidence and research have been used to help HHC to achieve these goals. She informed the Committee that, there was a large community-wide collaboration with the NYSDOH AIDS Institute that had been established with the very specific aim of ending AIDS in New York State. A list of recommendations has been developed but several of those recommendations are focused on using new technologies and surveillance strategies to better handle issues concerning surveillance. If a provider is not linking a patient to care, the question becomes is the patient linked to care somewhere else. The State Department of Health (SDOH) may have this information in its surveillance data but currently the surveillance information is not shared with other parts of the department. With the modification of the law, SDOH will now be able to inform providers if a patient is actually in care somewhere or not in care. This information will help to better target HHC's efforts.

Ms. Hamilton concluded her presentation by stating that, it is often said that the dollar should follow the care need. One of the things that New York State has looked at very particularly is health care disparities. She stated that, when we look at the state of HIV in New York State, the most affected groups are men who have sex and African American women. Ms. Hamilton explained that the 50,000 new infections each year in New York State/New York City are within these four groups:

- White men who have sex with men
- African American men who have sex with men
- Hispanic men who have sex with men
- African American women

Ms. Hamilton informed the Committee that HHC had been recognized for its commitment to improving access to HIV screening over the past ten years. Some of these recognitions are highlighted below:

HHC's HIV Services' Recognition:

- NYS Health Foundation Inaugural Award- Evaluation of Expanded HIV Screening
- National Quality Center Award for Quality Leadership
- NYS DOH AIDS Institute Senior Leadership in Quality Award-first ever to a non-clinician
- CDC recognizes- HHC's testing 1 million unique patients for HIV

- Lancet accepts an abstract for presentation at the international translational conference on Ending AIDS
- National Association of Public Hospitals and Health Systems- Safety Net Award for Reducing Health Care Disparities related to HIV Testing
- Participated/presented at more than 30 consultations on HIV screening, care and quality improvement
- The CDC Letters says- advancing public health, HHC has a willingness to adopt ambitious measures of success and hold itself accountable.

Ms. Hamilton thanked her staff including Ms. Eunice Casey and Dr. Lydia Isaac and all the remaining HHC staff who worked every day in HIV Services. She stated that there were so many dedicated people and the available resources were very modest for this huge task that we have taken on but the staff has done very well.

Ms. Brown thanked Ms. Hamilton for a great presentation. She added that HHC's ability to achieve so much with so very little resources is the commitment and continuity is attributable to Ms. Hamilton's leadership of the office. Her approach in working with the HIV medical leadership throughout the organization and as a team identifying the focus and the strategies throughout this big ship assures that HHC patients receive the highest quality of care.

Ms. Bolus asked if the new Public Health Law 2171 concerning Hepatitis C contained a provision that would allow providers to know if a person had been treated elsewhere and how does that law bypass HIPPA. Ms. Brown explained that the new Public Health Law 2171 mandated that if you are a health care provider in New York State and you have a patient in front of you who was born between those years you must offer that patient a Hepatitis C screening test. Ms. Bolus commented that the test may be offered but the patient doesn't have to take it. Ms. Brown clarified that the law does not mandate that the patient has to take it; the law mandates the provider to offer it.

In response to Ms. Bolus' question, Ms. Hamilton clarified that there had been some changes in the law that allowed greater flexibility for sharing patient information but that this provision was not included in the Hepatitis C law. This is actually something that providers have wanted for years. Physicians have been frustrated in knowing that they have tested patients, not being able to locate patients and not being able to ascertain if they are currently receiving care. Ms. Hamilton stated that this flexibility had been long fight by many advocates. She added that providers were very pleased that the State now had this flexibility.

Ms. Hamilton added that, in terms of HIPPA, the law suggested that as long as the provider was working in concert in trying to support the care of the patient, the provider would be able to do specific things. Ms. Brown clarified that this law was separate from the Hepatitis C law. Ms. Hamilton added that this was the new interpretation of HIPPA that was more helpful to providers. Ms. Bolus asked if this interpretation had already been tested in court. Ms. Hamilton responded that she was not aware of any challenges. Ms. Hamilton commented that, it was being very respectfully handled by HHC facilities, and the New York City Department of Health and Mental Hygiene. Ms. Hamilton commented that the state departments would come down very hard on organizations who abuse the privilege of having this cooperation.

Mrs. Bolus thanked Ms. Hamilton and Dr. Bratu for a comprehensive presentation.

ADJOURNMENT

There being no further business, the meeting was adjourned at 11:50 AM.

Presentation to the Strategic Planning Committee

ED Care Management Initiative: Preventing Avoidable ED/Inpatient Use

A Center for Medicare & Medicaid Innovation (CMMI) Grant Funded Project
Health Care Innovation Award Round Two Funding Opportunity

June 10, 2014

Overview of CMS Health Care Innovation Awards Round Two Funding Opportunity

2

- Funding opportunity announced on May 15, 2013
 - Letter of Intent (LOI) submitted on June 28, 2013
 - Application submitted on August 15, 2013

- Purpose of grant request was to fund new payment and service delivery models and reduce Medicaid spending:
 - “Service delivery model” is how providers organize and deliver care to patients
 - “Payment model” is how Medicare, Medicaid, or CHIP pay providers to incentivize efficient, high quality care
 - Innovation Category: Models that test approaches for specific types of providers to transform their financial & clinical models
 - Based the application on successful Pilot Program

Overview of CMS Health Care Innovation Awards Round Two Funding Opportunity

3

- \$900 million in funding available
- Awards to range from \$1 million to a maximum of \$30 million
- Grant funding provided over a period of three years (April 2014 – March 2017)
- Official grant funding announcement made by CMS on May 22, 2014
 - HHC was included in first round of announcements (there will be a second round after which contracting will ensue)
 - HHC will receive \$17,916,663 over three years

HHC's Pilot ED Care Management Program

4

- In 2008, there were pilot initiatives explored at Elmhurst, Bellevue, and Queens Hospitals
- Provides care and case management services to targeted patient population
- Uses interdisciplinary team to facilitate and coordinate care for patients who can be safely treated and released

HHC's Pilot ED Care Management Program

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- Target patients present with ambulatory care sensitive conditions (ACSCs) including:
 - Skin infections
 - Chronic Heart Failure (CHF) or Cardiomyopathy
 - Asthma/COPD
 - Hypertension
 - Diabetes
 - Pneumonia
- And patients who present in ED within 30 days of inpatient discharge

HHC's Pilot ED Care Management Program

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- Key care management activities:
 - Identify avoidable admissions
 - Team STEPPS communication model
 - Assess patients and determine needs
 - Connect patients into primary care services (Medical Home)
 - Educate and engage patients on maintaining their health, medication adherence and navigating health care system
 - Provide appropriate alternative options to hospitalization
 - Align with IHI Triple AIM and HHC Road Ahead

HHC's Pilot ED Care Management Program Expanded

7

- ED Care Management program rolled out across remaining 9 acute care facilities during 2012
- Program expansion supported with an HHC investment of \$15 million
 - ▣ Staffing model:
 - 0.5 FTE ED Physician Advisor
 - 1.0 FTE ED Care Manager
 - 1.0 FTE ED Case Manager

Overview of HHC's ED Care Management Program

- Between January 2012 and December 2013, HHC ED Care Management program provided services to a total of 26,698 cases
- Of the 26,698 cases, 12,909 cases had ambulatory care sensitive conditions (ACSCs)
- Some select outcomes:

Table 4: Evaluation of Pilot ED Care Management Results from 3 HHC Hospitals

	Woodhull Medical and Mental Health Center	Coney Island Hospital Center	Lincoln Medical and Mental Health Center
Intervention Period	<i>3 months</i>	<i>15 months</i>	<i>4 months</i>
% kept PCP appointment post intervention	Increased from 30.7% to 44.1%	Increased from 21.1% to 32.8%	Increased from 70.8% to 81.5%
% of ED visits within 7 days post intervention	Reduced from 21.2% to 8.3%	Reduced from 10.5% to 8%	Reduced from 20.8% to 12%
% of admission within 30 days post intervention	Reduced from 19% to 14.3%	Reduced from 9.1% to 5.6%	Reduced from 4.2% to 1.1%

HHC's Proposal to CMS: Build on Pilot

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- Initial application to CMS total \$28 million and include all HHC hospitals
- Funding to enhance pilot and to address gaps including:
 - ▣ Lack of medication management/adherence
 - ▣ Need for better linkages to home care
 - ▣ Need for better coordination with community provider
 - ▣ Need for improved and extended follow-up with patient at home
 - ▣ Need for more robust data collection/analysis
- Application included a proposed payment model

HHC's Proposal to CMS: Overview

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□ Aim:

- To respond to CMS' requirement of reduction in Medicaid spending by \$75 million
- To create an infrastructure that supports the sustainability and enhancement of the pilot across the acute care facilities

□ Goals

- Prevent unwarranted inpatient admissions/re-admissions
- Reduce unnecessary ED revisits of patients with ambulatory care sensitive conditions (ACSCs)

HHC's Proposal to CMS: Enriched Program

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- Expand capacity of pilot in each of the 11 participating hospitals to operate seven days per week, with on-site Care Management teams covering two shifts
- Enhance services by adding:
 - ▣ Full-time Physician Advisor Team Leader
 - ▣ Community Service Liaison Worker (CLW)
 - ▣ Clinical Pharmacist
 - ▣ On-site Home Care Intake Nurse
 - ▣ Social Workers and other clinical staff available to the ED will be involved when appropriate
 - ▣ Capacity for sophisticated analysis
 - ▣ Strong centralized leadership support

HHC's Proposal to CMS: Payment Model

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Applicants were charged with designing innovative payment models that would provide a sustainable source of funding after the agreement period is over.

- HHC's application highlighted its existing risk arrangements with MetroPlus and Healthfirst, which already allow savings from reduced healthcare expenditures to flow back to HHC.
- The State Department of Health committed to working with HHC to develop a new payment model for Medicaid Fee-For-Service, particularly focused on Emergency Medicaid.
- HHC secured letters of commitment from two commercial plans that currently pay on a fee for service basis to explore value-based reimbursement models.

Overall, the targeted reductions in avoidable admissions would result in a net decrease of \$75 million in Medicaid expenditures over the three years.

HHC's Proposal to CMS: Strong Evaluation

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- Independent organization identified and will be tasked with creating a sophisticated evaluation of the standardized program across 6 HHC sites
- A CMS coordinating center will assist with finalizing the selection of variables that “operationalize” improved healthcare and cost savings
- Evaluators will statistically compare the funded program with several similar groups to determine:
 - ▣ Did the enhanced program achieve clinical goals of improving healthcare?
 - ▣ Did it achieve financial goal of cost savings?
- HHC Evaluation tasks
 - ▣ Setting up internal systems to collect these data across all groups
 - ▣ Creating an evaluation plan
 - ▣ Ensuring that patients' rights are protected
 - ▣ Collecting valid data and double-checking
 - ▣ Statistical analyses by independent evaluator

CMS Asks to Scale Back Program

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- In April 2014, CMS recommended reducing the number of participating hospitals in the proposal from 11 to 6
- Criteria for selecting the 6 funded facilities based on pilot phase data:
 - Percentage of cases with potentially avoidable admissions
 - % of cases in which principal diagnosis is an AHRQ Ambulatory Care Sensitive Case Condition
 - Case with a prior admission within past 30 days
 - Cases with start of home care services
 - Percentage of cases in which patients returned to the ED within 7 days
 - Percentage of cases in which patients returned to the ED within 30 days
 - Percentage of cases that received post-discharge follow-up

Results of Applied Criteria

15

- Six HHC facilities chosen:
 - ▣ Bellevue – high performance on 3 of 4 metrics
 - ▣ Elmhurst– high performance on all metrics
 - ▣ Jacobi– high performance on all metrics
 - ▣ Kings County– high performance on 1 of 4 metrics, however highest volume
 - ▣ Lincoln– high performance on 1 of 4 metrics, however highest volume
 - ▣ Queens– high performance on 3 of 4 metrics
- Selections ensured:
 - ▣ Geographic coverage
 - ▣ Potential for reduction in ED use
 - ▣ Mix in baseline outcomes to provide the opportunity for health outcome improvement

Funded Program Budget

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Description	Total
Personnel – 2 Program Management FTE; 36 Clinical FTE	\$15,051,329
OTPS – Includes 2 Contracts (Evaluation; Community Health Worker Training)	\$394,070
Indirect Costs @ 16%	\$2,471,264
Grand Total	\$17,916,663

Next Steps

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- Sign contract with CMS
- Hire staff
- Sign contract with independent evaluator
- Attend CMS meetings