

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

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

AGENDA

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

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

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

IV. INFORMATION ITEM

i. PRESENTATION: UPDATE ON THE MAYOR'S MANAGEMENT REPORT

DONA GREEN
SENIOR ASSISTANT VICE PRESIDENT, CORPORATE PLANNING SERVICES

V. OLD BUSINESS

VI. NEW BUSINESS

VII. ADJOURNMENT **JOSEPHINE BOLUS, RN**

MINUTES

STRATEGIC PLANNING COMMITTEE MEETING OF THE BOARD OF DIRECTORS

FEBRUARY 10, 2015

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

ATTENDEES

COMMITTEE MEMBERS

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

OTHER ATTENDEES

D. Daskalakis, MD, Assistant Commissioner, Bureau of HIV Prevention and Control,
NYC Department of Health and Mental Hygiene
J. Morne, Director, Office of Planning and Community Affairs, AIDS Institute
K. Raffaele, Analyst, Office of Management and Budget

HHC STAFF

S. Abbott, Assistant Director, Corporate Planning and HIV Services
P. Alberton, Senior Assistant Vice President, Operations
M. Belizaire, Assistant Director of Community Affairs, Office of Intergovernmental Relations
C. Barrow, Associate Director, Lincoln Medical and Mental Health Center
L. Brown, Senior Vice President, Corporate Planning, Community Health and
Intergovernmental Relations
T. Carlisle, Associate Executive Director, Corporate Planning Services

E. Casey, Assistant Director, Corporate Planning, HIV Services
D. Cates, Chief of Staff, Office of the Chairman
D. Green, Senior Assistant Vice President, Corporate Planning Services
L. Guttman, Assistant Vice President, Intergovernmental Relations
T. Hamilton, Assistant Vice President, Corporate Planning, HIV Services
L. Hansley, Director, Organizational Innovation, and Effectiveness
L. Isaac, PhD, MSc, Assistant Director of Data, Grants and Quality Improvement, Corporate Planning Services, HIV Services
S. James, Assistant Director, Harlem Hospital Center
J. Jurenko, Senior Assistant Vice President, Intergovernmental Relations
A. Marengo, Senior Vice President, Communications and Marketing
I. Michaels, Director, Media Relations, Communications and Marketing
P. Lockhart, Secretary to the Corporation, Office of the Chairman
R. Mark, Chief of Staff, President's Office
A. Martin, Executive Vice President and Chief Operating Officer, President's Office
H. Mason, Deputy Executive Director, Kings County Hospital Center
J. Omi, Senior Vice President, Organizational Innovation and Effectiveness
E. Orner, Director, External Communications, Communications and Marketing
K. Park, Associate Executive Director, Finance, Queens Health Network
S. Penn, Deputy Director, World Trade Center Environmental Health Center
N. Peterson, Senior Associate Director, Woodhull Medical and Mental Health Center
S. Ritzel, Associate Director, Kings County Hospital Center
S. Russo, Senior Vice President and General Counsel, Office of Legal Affairs
L. Sainbert, Assistant Director, Chairperson's Office
W. Saunders, Assistant Vice President, Office of Intergovernmental Relations
K. Whyte, Senior Director, Corporate Planning, Community Health and Intergovernmental Relations

CALL TO ORDER

Ms. Josephine Bolus, NP-BC, Chairperson of the Strategic Planning Committee, called the meeting of the Strategic Planning Committee to order at 10:40 A.M. The minutes of the January 13, 2015 meeting of the Committee were adopted.

SENIOR VICE PRESIDENT REMARKS**Federal Update**

Ms. Brown provided a report on President Obama's budget request, which was unveiled in early February. The House and the Senate Budget Committees will then craft their respective Congressional Budget Resolutions. Ms. Brown highlighted key issues that were of importance to HHC that were included in the President's budget request for federal fiscal year 2016. These issues included:

- Medicare and Medicaid provider cuts totaling \$431.3 billion over ten years
- \$7.7 billion in additional funding for Medicaid
- \$11.8 billion in new funding for the Children's Health Insurance Program through 2019
- 10% reduction in Indirect Medical Education (IME) funding
- \$2.7 billion in annual funding over three years (total funding of \$8.1 billion) for community health centers

Mrs. Bolus asked for clarification concerning the Medicare and Medicaid provider cuts and the additional \$7.7 billion in Medicaid funding. Ms. Brown explained that the \$431.3 billion reduction was being proposed for Medicare and Medicaid providers over ten years; and the \$7.7 billion would be additional funding provided to state Medicaid programs. These funds are to cover additional spending that states will incur as newly eligible individuals are enrolled in Medicaid as a result of the exchanges.

Ms. Brown informed the Committee that, last week, the Federal Government approved HHC's and its co-applicant, Gotham Health, FQHC's, application for Federally Qualified Health Center Look-A-Like (FQHC-LAL) designation. She added that, going forward, HHC would have to consistently monitor proposals in the federal budget concerning FQHCs in addition to monitoring the federal and state budget impacts on hospitals and HHC. Ms. Brown cautioned that there are some good and bad proposals in the President's budget concerning FQHCs. The President is seeking to add \$2.7 billion in funding for community health centers over the next three years as part of the continuation of the Affordable Care Act (ACA). Ms. Brown explained that the ACA provision that provided \$8 billion in funding for community health centers would expire this year. The President is seeking to keep that investment going. Ms. Brown commented that the funding proposal may not live through the budget process because a lot of the funding requests are at risk. The newly enjoyed Gotham Health FQHC LAL status comes with new risks including the funding for community health centers.

Ms. Brown reported on another significant key issue in the President's budget. She reminded the Committee that there had been talks since the enactment of the Affordable Care Act (ACA) concerning the threat of reduction in New York State's Medicaid Disproportionate Hospital Share (DSH) funding and ultimately to HHC. Ms. Brown highlighted the Medicaid reductions that had already been enacted through the ACA and subsequent legislation:

	FFY 2017	FFY 2018	FFY 2019	FFY 2020-2024
Estimated New York State Medicaid DSH Cut Percentage	16%	51%	51%	37%
HHC Losses-in millions including local match	(\$180.8)	(\$508.4)	(\$576.1)	(\$421.8)/ yearly

Ms. Brown explained that an initial source of funding of the ACA was to reduce DSH funding and to use those funds to pay for the cost of newly insured individuals. The assumption is that DSH funding would be used principally to support hospitals and states that provide a significant amount of care for uninsured individuals and would also address the significant underpayment around fee-for-service Medicaid. Moreover, the assumption is that the more people that are enrolled in insurance, the less need there would be for DSH funds. Ms. Brown added that, this assumption is known not to be true, principally in geographies like New York, Florida or Texas where the ACA does not fully include immigrants, particularly undocumented immigrants.

Ms. Brown reported that, in FFY 2017, New York State's Medicaid DSH funding is expected to be reduced by 16%, which would mean a cut of over \$180 million from HHC's total Medicaid DSH fund of \$1 billion. Additionally, in FFY 2018, the state is at risk of losing a little more than half of its Medicaid dollars and the impact to HHC would be at least half of its existing \$1 billion Medicaid DSH fund. What is significant about the President's new budget request is that he has added another year onto what has been the end of these DSH cuts. Ms. Brown explained that additional years had been added in past budgets. If the President's budget were to be implemented, the DSH cuts would go from 2017 to 2025. The additional year would be another \$421.8 million in potential cuts to HHC.

Ms. Brown reported that the President's budget also included some proposed reductions in Medicare payments for hospital outpatient based (HOPD) clinic services by \$29.5 billion nationally over 10 years. Ms. Brown informed the Committee that this was the first time that this item was included in the President's budget. The impact to HHC would be \$186.8 million over ten years.

Ms. Brown reported that the President's budget request included a proposal to reduce Medicare payments to post-acute care providers (e.g., inpatient rehabilitation facilities, home health agencies, and long term care hospitals and skilled nursing facilities) by a total of \$113.56 billion, which would result from a series of changes in policy concerning how and when post-acute care payments would be paid. The estimated impact for HHC over 10 years would be a \$20 million reduction in Medicare post-acute payments.

Ms. Brown reminded the Committee of the Inpatient Rehabilitation Facility (IRF) 75% Rule. She explained that with this rule, inpatient facilities would only be reimbursed if they are addressing a particular set of diagnoses. The current law only requires 60% of rehabilitation patients to fit into one of 13 diagnostic categories. The President's budget request proposes to raise the threshold to 75%. The 13 diagnostic categories are outlined below:

1. Stroke
2. Spinal cord injury
3. Congenital deformity
4. Amputation
5. Major multiple trauma

6. Fracture of femur (hip fracture)
7. Brain injury
8. Neurological disorders including:
 - Multiple sclerosis
 - Motor neuron diseases
 - Polyneuropathy
 - Muscular dystrophy
 - Parkinson's disease
9. Burns
10. Active polyarticular rheumatoid arthritis
11. Systemic vasculitis with joint inflammation
12. Severe or advanced osteoarthritis
13. Knee or hip joint replacement

Ms. Brown stated that, because this rule had been on the table for a long time, HHC's rehabilitation facilities, both acute and long term care, have been working to redesign their services and processes to fit into the 75% rule. If this rule is implemented, the impact to HHC would be nominal because HHC has already put in place the necessary services, assessments and screenings in preparation for the implementation of this new rule.

Ms. Brown reported on two perennial issues that were not included or addressed in the President's budget request:

- 340B Drug Program

Ms. Brown stated that under current law, pharmaceutical companies that participate in Medicaid must sell outpatient drugs to DSH hospitals, federally qualified community health centers and other safety net providers. HHC and other providers have advocated for that discount to be extended to drugs provided during inpatient stays. Ms. Brown stated that the 20% discount would save HHC an estimated \$30 million each year. There is an ongoing threat to eliminate or scale back the program. In June, HRSA plans to issue wide-ranging 340B program guidance on eligible patient definitions and other issues. Ms. Brown commented stated that Dr. Raju's wish has always been for the Board to be kept apprised of potential risks on the horizon. She added that the HRSA plan was one such big risk.

- The Two Midnight Rule

Ms. Brown reported that, in August 2013, the Centers for Medicare and Medicaid Services had finalized the Two Midnight Rule. Under the new rule, only hospital stays spanning two midnights would be considered inpatient for Medicare payment purposes. A stay of less than two midnights would be considered outpatient. She reminded the Committee that the rule was established in response to many cases of patients receiving observation services for less than 48 hours but getting a bill for inpatient care. She added that, because of the push back, the implementation was delayed until March 31, 2015. Legislation was introduced in both houses of Congress asking that CMS create a new payment methodology for short inpatient stays. Ms. Brown added that HHC had already put in place procedures to comply with the proposed rule, which has resulted in a decrease in HHC hospitals' revenues.

STATE UPDATE**New Leadership in State Assembly**

Ms. Brown reported that, last week, the Assembly had elected a new leader for the first time in 21 years. Assembly Member Carl Heastie, who has represented the Bronx since 2000, will serve as Speaker for the remainder of the 2015-2016 Legislative Session. Mr. Heastie's nomination is not only historic because he is the first African American leader of the Assembly, but also because of the change in the long term tenure of Mr. Sheldon Silver who was the Speaker of the Assembly for more than two decades. She added that HHC looked forward to working with Mr. Heastie as well as being guided by Mr. Robert Nolan, Board Member, who will provide for HHC's introduction.

Ms. Brown announced that Governor Cuomo had released his proposed 2015-2016 Executive Budget on January 21, 2015. Legislative Budget Hearings would be scheduled during the month of February as well as the Governor's 30 day amendments to his budget. Following the Budget Hearings in March, each house will pass their own Budget Proposal. One-House Budgets are introduced by the various Legislative Conference Committees. Those proposals are the starting point for budget negotiations. First, a consensus on the revenue forecast must be established which is preceded by budget negotiations. Ms. Brown informed the Committee that the Budget must be enacted by April 1, 2015.

Ms. Brown reported that, while there were dozens of specific budget issues that would impact HHC, she would only focus on a few key issues that were included in the Governor's Budget. Ms. Brown reported that the \$62 billion Medicaid funding would be increased by 3.6% moving the state's spend on Medicaid from \$58.752 billion to \$62.046 billion. Medicaid spending remains consistent with the Medicaid Redesign Team (MRT) goal of keeping spending in line with the medical component of the Consumer Price Index or CPI and the Governor has proposed to make permanent the Global Cap on Medicaid spending. His budget also includes provisions for the State Health Commissioner's so-called "superpowers"- now called the Savings Allocation Plan – which allow the Commissioner to take action without going back to the legislature if necessary to keep Medicaid spending within the Global Cap. The Budget also extends the Global Cap Shared Savings Provision which will allow providers, including HHC, to receive a portion of any funds that remain unspent within the Global Cap. The Budget has provisions to implement the Basic Health Plan, which will be available for certain low-income, legal immigrants who cannot qualify for Medicaid due to their immigration status. This includes immigrants who are currently covered on "state-only" Medicaid. Additionally, the Governor is proposing to expand Medicaid coverage for immigrants who are newly eligible as a result of the President's recent actions on immigration reform.

Ms. Brown reported that the Governor's budget includes language HHC needs to ensure that it would receive the more than \$1 billion in outstanding Upper Payment Limit (UPL) payments, which Ms. Marlene Zurack, Senior Vice President, Finance had mentioned so many times in the past. Ms. Brown stated that there is a need for a language change in state legislation concerning how HHC should get those dollars. Ms. Brown informed the Committee that the State Department of Health (SDOH) had agreed to insert that language, which was included in the Budget.

Ms. Brown reported that, importantly, the Governor's Budget proposes to extend the current methodology for distributing Charity Care funding for three years (through December 31, 2018). The Budget proposes to continue to gradually phase-in changes to increase the proportion of the funding to hospitals that provide

care to the uninsured, underinsured and Medicaid populations. HHC is still evaluating this part of the proposal.

Ms. Brown reported on the Capital Restructuring Financing Program. She stated that the Governor has proposed to add \$1.4 billion in new capital funding for healthcare providers to be split equally between upstate and Brooklyn, with \$700 million targeted to stabilize the health care delivery system in Central and East Brooklyn for a new hospital. Ms. Brown informed the Committee that HHC was concerned about the language concerning the establishment of a new hospital in Central Brooklyn because HHC believed that good public policy dictated the establishment of health care services in Central Brooklyn particularly those related to addressing the existing inequities in health care and the disparities in health status among the residents of Central Brooklyn and North Brooklyn. Building a new hospital would not be the best solution. There is also concern that the \$700 million would be allocated to a hospital that may not have the interest and/or the mission to serve all Brooklyn residents in Central and East Brooklyn including uninsured and low-income Medicaid patients. Ms. Brown added that providing \$700 million to create another hospital without addressing that issue would not address the real problem of the need for health care in Brooklyn. Ms. Brown informed the Committee that this issue would resurface in the future as HHC interacted with elected and others.

Ms. Brown reported that, along with the capital funding, the Governor's Budget included an additional \$290 million (\$580 million if a federal match is obtained) for the Vital Access Provider (VAP) Program to assist hospitals and health systems to adapt to the new DSRIP environment and to reduce avoidable hospital admissions by 25%.

Ms. Brown reported that the Governor also proposed a new Hospital Quality Pool of nearly \$100 million (including federal match) to incentivize and facilitate quality improvements in hospitals. In addition, the Budget would authorize the state and managed care plans to use value-based payment reimbursement methodologies to advance the DSRIP goal for 90% of Medicaid managed care plan payments to providers to be made using value-based purchasing methodologies.

Ms. Brown informed the Committee that the Governor's Budget would also advance other healthcare initiatives including employing a new health insurance surcharge to pay for the state's health insurance exchange (the New York State of Health). The Budget also included Public Health and Health Planning Council recommendations related to urgent care centers, limited service clinics, office-based surgery and regulatory reforms related to the certificate of Need (CON) process and other issues.

Ms. Brown reported that although Albany was focused on the Budget, there had been some activities on legislation that were of importance to HHC. Ms. Brown reported that the Nurse Staffing Ratios bill has been reintroduced in both houses but has not been acted on yet (A.1548 – Gottfried/S.782 – Hannon). There are a variety of bills making changes related to medical malpractice that have been reintroduced but there have not yet been any further activity. In addition, Senator Lanza has reintroduced two bills that would require HHC to build or financially support hospitals on Staten Island. Ms. Brown stated that although the legislation had not yet been reintroduced in the Assembly, it was expected that Assemblyman Cusick would submit them soon (S.3322, S.3326). Ms. Brown reassured the Committee that HHC would continue to monitor these bills as well as other emerging issues that could affect HHC.

Ms. Brown shared with the Committee an emerging issue. She reported that New York State was moving from Medicaid fee-for-service to managed care for Behavioral Health Services. Ms. Brown explained that

manage care premiums were insufficient and that current fee-for-service Medicaid reimbursement did not cover the costs for these services. Ms. Brown stated that HHC received only 77% of its costs for inpatient psych services; 73% of its costs for inpatient detox services; 29% of its costs for CPEP services; and 35% of its costs for outpatient mental health services. The total HHC underfunding is \$120 million.

Ms. Brown reported that HHC was not alone. All NYS hospitals' average costs far exceeded Medicaid rates: 79% of costs for psych inpatient services; 79% of costs for detox services; 34% of costs for CPEP services and 66% of costs for OP/MH services. Ms. Brown informed the HHC has been able to provide these critical services because in addition to fee-for-service Medicaid, HHC receives claims based and UPL payments. These two payments will be unavailable under managed care. The proposed managed care premiums for Behavioral Health are insufficient; and these payments have not been factored into the premium rate setting methodology. Therefore, there must be a premium fix. Ms. Brown stated that HHC would concentrate his advocacy efforts around this issue with the state.

Ms. Brown reported that there was a real effort on the part of the state to manage its Medicaid expenditures (\$62 billion of the state's budget). Ms. Brown explained that, when the Governor took office a few years ago, he had established a Global Cap as one mechanism to manage the spending trajectory of Medicaid. There are other mechanisms that the state is putting in place to manage that upward trend of health care spending. Ms. Brown commented that, if there is a Medicaid cut, HHC gets pneumonia while everybody else gets a cold. This is because HHC's payer mix relies not only on Medicaid, but also because HHC provides a vast amount of healthcare services in New York City to uninsured individuals.

Mr. Rosen, Board Member, commented that, if implemented, the DSH cuts would save the state a lot of money. Ms. Brown clarified that the state is concerned about the reduction of DSH funding. The state uses DSH dollars to fund not only HHC hospitals, but also the other voluntary hospitals. The reduction of DSH funding would create a hole for the state, which the state would have to figure out how to fill. The state's interest is to always optimize as much funding as they can from the Federal Government. Accordingly, the federal government's reduction or reinvestment of DSH funds means cuts to the state; and because of HHC's payer mix, this is a potential significant cut to HHC. Ms. Brown added that DSH cuts have been delayed to 2018. These cuts are being stacked up and getting bigger, which will create a bigger impact once implemented.

Mr. Rosen stated that the Republicans have stated that the President's budget would be dead on arrival; however, they seem to go with Continuing Resolutions. Ms. Brown commented that from the current majority's perspective, the President's proposed budget is dead on arrival. However, looking at prior years, many of the proposals that the President has included in his budget are proposals that were included in congressional budgets. Ms. Brown added that they will take all the bad cuts but may also take out the good things such as the continuation of the \$8.1 billion by cutting another \$2 billion for FQHCs, because they want to undo the Affordable Care Act (ACA). Ms. Brown noted that, unfortunately HHC's role in Washington, DC is to try to prevent bad things. HHC has rarely gotten the opportunity to support new, good things in recent years.

Dr. Raju referred back to the issue of managed care for Behavioral Health Services and stated that this change would have a double impact on HHC. He explained that HHC served a large number of mental health patients and does not have enough resources to take care of all the mental health needs of the City of New York. Even if a small portion of the cuts is implemented, HHC's ability to serve the mental needs of the City would be considerably diminished. Dr. Raju highlighted that this reduction of funds would have a

devastating effect on the mental health population of New York City. The second impact is on other providers, apart from healthcare providers, who have been providing mental health services as well. Considering that HHC cannot exit the mental health market, if these providers decide to leave because of these cuts, HHC will end up serving a larger mental health population. He informed the Committee that HHC will be working very hard with the City and will count on elected leaders,' community planning boards' as well as Community Advisory Boards' advocacy on this issue.

CITY UPDATE

Ms. Brown reported that, on February 3, 2015, Mayor de Blasio delivered his State of the City Address. The Mayor focused on greater opportunities including affordable housing, higher wages, and better benefits for New Yorkers. He also presented an initiative that will be led by the New York City Department of Health and Mental Hygiene to create six new neighborhood health clinics, or neighborhood hubs. The hub will provide services such as healthcare, human, social services, and other kind of resources that a particular neighborhood needs, which all will be housed in one building.

Ms. Brown reported that on, February 9, 2015, the Mayor released his Preliminary City Budget of \$77.7 billion, which is balanced in FY15 and FY16 and has \$750 million in reserves. Ms. Brown informed the Committee that the Mayor's Preliminary Budget also included funding for 45 new EMS tours and 149 new dispatchers. The Mayor's budget proposes to expand ACS training and prevention efforts; and would provide additional funding for homeless prevention and tenant legal services. The Mayor's budget also maintains funding provided to HHC in the November Plan for Ebola related costs and labor costs. Ms. Brown announced that New York City Council Speaker, Melissa Mark Viverito, will deliver her State of the City address on February 11, 2015. HHC is expected to provide testimony at the Council Health Committee's preliminary Budget Hearing on March 23, 2015.

Mr. Nolan asked Ms. Brown if the Mayor included funding in his budget for the neighborhood health clinics. Ms. Brown responded affirmatively.

INFORMATION ITEM

PRESENTATION: ENDING THE AIDS EPIDEMIC

Terry Hamilton, Assistant Vice President, Corporate Planning Services
Johanne E. Morne, Director of Planning and Community Affairs, AIDS Institute
Demetre Daskalakis, MD, Assistant Commissioner, Bureau of HIV Prevention and Control
New York City Department of Health and Mental Hygiene

Ms. Brown introduced Ms. Terry Hamilton, Assistant Vice President, Corporate Planning Services, and invited her to lead the presentation entitled "Ending the Epidemic of AIDS." Ms. Hamilton began the presentation by informing the Committee that Demetre Daskalakis, MD, Assistant Commissioner, New York City Department of Health and Mental Hygiene and Ms. Johanne E. Morne, Director of Planning and Community Affairs, NYS AIDS Institute would join her to present efforts on the global, state and local levels focused on ending the AIDS epidemic.

Ms. Hamilton informed the Committee that she was invited by UNAIDS to attend its Melbourne Conference, "Cities for Social Transformation on Ending AIDS 2014," the focus of which to target treatment scale-up in the cities most of affected to end AIDS. The rationale:

- Cities and urban areas especially affected by HIV (200 cities account for 35 million infected persons)
- No one left behind
- Resources follow need by leveraging public and private partnerships

Ms. Hamilton explained that focus of the UNAIDS Ending AIDS 2030 initiative. Twenty-five (25) high HIV incidence cities to lead the way by:

- Removing laws that hinder gender equality, human rights, and impose travel restrictions
- Reducing and preventing transmission - sexual, behavioral, and vertical transmission
- Eliminating stigma
- Strengthening care integration
- Closing the resource gap - more investment, engage young people and impacted communities

Ms. Hamilton shared with the Committee that vision zero efforts for 2030 have already begun with the goal of achieving: 90% of people who are living with HIV being diagnosed; 90% receiving care and having needed medications; and 90% virally suppressed so that their viral loads would be undetectable. Ms. Hamilton emphasized that vision zero meant zero new infections, zero discrimination and zero AIDS-related deaths. The overall goal is to prevent 28 million new infections and 21 million deaths by 2030 (21 million people is equivalent to three New York Cities).

Ms. Hamilton reported that New York State had already begun the process of ending the AIDS epidemic. It began several years ago by:

- Reshaping the approach to care by integrating HIV and other sexually transmitted infections (STIs)
- Focusing on developing diverse ways to end AIDS – need flexibility for a changing epidemic
- Continuing to strengthen extraordinary community engagement

Mrs. Bolus asked how it would be possible to end the epidemic in New York State with the constant flow of people coming into New York as soon as they become stigmatized in their own localities. Ms. Hamilton responded that it was the intention of the Governor and the community, after working very hard on this issue for quite some time, to really make New York a model of how it could be done. She added that inch-by-inch the community intended to make discrimination inhospitable in New York State and make that the model for the rest of the country.

Ms. Morne informed the Committee that she was honored to present in lieu of Mr. Dan O'Connell, Director of the Aids Institute, who was unable to attend the meeting. Ms. Morne stated that, in June 2014, Governor Cuomo had announced that he and others believed that they could end the AIDS epidemic in the State of New York. Among the key points that brought the Governor to that belief was the involvement, advocacy, passion of the community, and the partnerships between the government, public and private sectors. Ms. Morne added that the belief was further driven by the state's achievements in reducing HIV infections through injection drug use and through its successes with reducing mother to child transmissions.

Ms. Morne stated that ending the AIDS epidemic raised a lot of questions. There are over 30,000 diagnosed individuals who are living in New York State. Ending the epidemic does not mean ending lives but rather significantly reducing the number of additional lives from becoming affected by HIV. For those individuals who are diagnosed, the highest quality of care must be provided that is engaging and culturally competent,

effective at achieving viral suppression and that ensures that individuals have access to support services that address barriers to care. Ms. Morne stated that there were a lot of reasons why many people come from other states to New York. The intention is to work with those individuals and to ensure that they can gain access to quality health care.

Ms. Morne described New York State's goals for ending the AIDS epidemic as the following:

- Reduce from 3,000 to 750 new HIV infections per year by 2020
- Decrease the number of New Yorkers living with HIV for the first time
- Reduce by 50% the rate at which persons diagnosed with HIV progress to AIDS within two years

Ms. Morne reported that there was a downward trend in the number of newly diagnosed HIV cases in New York State for the years 2002 through 2012. She highlighted that, in 2002, there were 6,058 newly diagnosed cases in New York State compared to 3,316 in 2012. Ms. Morne stated that the goal was to continue to build on that downward trend.

Ms. Morne reported that when comparing the time to AIDS diagnosis for new HIV cases that were not concurrent HIV/AIDS diagnoses for 2002 to 2011, the 2002 diagnoses were over the 40% rate compared to below 10% in 2011. Ms. Morne explained that targeted prevention efforts to engage individuals to seek and accept HIV testing contributed significantly to that decrease in 2011. Ms. Morne added that one strategy that was instrumental was the implementation of the HIV Testing Law in which it became mandatory for individuals ages 13 to 64 to be tested. Mrs. Bolus asked why the implementation of the HIV Testing Law did not apply to individuals older than 64 years old. Ms. Hamilton responded that the age range was based on the CDC's prevention recommendation. HHC's operating policy is to extend screening above the age of 64. Ms. Morne added, while the mandatory offer is set for the purpose of identifying individuals between the ages of 13 and 64, it also covered the issue of risk. Therefore, for individuals who fall outside of these parameters if risk is identified, it is important to ensure that the offer is made so that people would have access.

Ms. Morne described the cascade of HIV care in New York State through the year 2012. Ms. Morne explained that there were 154,000 estimated HIV infected persons. There are more than 132,000 persons living with or diagnosed with HIV infection leaving a gap of 22,000 who are believed to be HIV positive, but remain undiagnosed. More than half (68,000) of infected individuals are virally suppressed. Ms. Morne stressed that there is a need to do better and to reduce the 51%. While more than half is great, it leads to the issue of opportunity in all health care systems to ensure viral suppression. Dr. Daskalakis commented that when people are in care in New York City and New York State, they do great. He highlighted that 79% of cases with any care are virally suppressed. The data indicates what the drive should be, which is to test more individuals, link them to care and keep them in care. Once they are in care, the care that is provided is fantastic. Ms. Morne added that the same result is true for individuals receiving their care in the correctional facilities.

Ms. Morne stated that the purpose of the "bending the curve" presentation slide is to ensure that everyone understand that the intention and goal of the ending of the epidemic initiative is to get to a place where HIV infections are less than HIV related deaths. Ms. Morne reported that, in October 2014, the Governor had announced the creation of a NYS Ending the Epidemic Task Force, which included 64 individuals from across the city and state including Ms. Terry Hamilton of HHC. Ms. Morne stated that Task Force met from October 2014 to January 2015 to develop recommendations that would support the Governor's Three Point Plan and to develop a blueprint. One of the main goals of the taskforce is to ensure transparency. The

taskforce was also charged with ensuring that there was opportunity for all community members to contribute, recognizing that regardless of whether one sits at the table, or from one's home or office, that they had a voice in the process of developing recommendations. On January 13, 2015, the NYS Ending the Epidemic Task Force completed its charge and finalized 44 committee recommendations that address HIV related prevention, care and supportive services. Committee recommendations were informed by 294 community recommendations and 17 statewide stakeholder meetings. The final Blueprint will contain 30 recommendations and 7 getting to zero recommendations.

Ms. Hamilton reported on the movement to patient-centered care then and now. Before 1980 and AIDS, we might have discussed what the provider would do for the patient. Now, HHC HIV care embodies the work of Ending AIDS. It builds on the patient as an actor on their own behalf to actively support the design and implementation of strategies to manage their health along with the healthcare team. The patient is the core of a multi-dimensional approach to healthcare using an interdisciplinary team (internal and external to HHC). This approach strengthens the ability to notice, understand and address social determinants of health and requires a common electronic health record (HER). This HIV work addresses the:

- Landscape of HIV prevention and care
- Triple AIM in HIV care
- Ending AIDS and DSRIP

Ms. Morne reported that within HHC, the targets for ending the AIDS epidemic are the following:

1. Diagnose the undiagnosed
 - Integrated HIV screening using 4th generation technology, allowing for acute HIV diagnosis
2. Link and retain diagnosed patients in care with maximal viral load suppression
 - Part of the ongoing QI work of HIV Services including participation in NY Links
3. Access to Pre-Exposure Prophylaxis (PrEP) for high-risk negatives to decrease possible transmission
 - Will include Post Exposure Prophylaxis (PEP)

Ms. Hamilton stated, as part of their commitment to ending the AIDS epidemic, some of the Performing Provider Systems (PPS) in New York City have agreed to work Domain 4 population health HIV related projects. HHC has identified the following six projects and is working on them along with a number of PPSs. The DSRIP Domain 4 HIV Projects are the following:

1. Integrate HIV screening – Improve linkage, transition counselors to Linkage Coordinators and work with CBOs and providers
2. PrEP - establish standard protocols
3. Peer Support - using model structure from NYLINKS special project of national significance
4. Consistent Messaging and Social Marketing - Consistent messaging to improve patient education, and social marketing with DOHMH to increase linkage and engagement in care
5. Virology FastTrack Plus – Improve patient screening for co-factors using a CDC supported EMR clinical alert/review system
6. Improve Cultural Competency – multi-layered integrated process, will include emphasis on building skills related to care for MSM and transgender populations and improving the ability of providers to effectively capture sexual history

Ms. Hamilton explained that cultural competency was particularly important because HHC had spent years focusing on that issue. She highlighted that the Lesbian, Gay, Bisexual, Transgender and Queer/Questioning (LGBTQ) community was one of the communities that is not yet well engaged in care. Ms. Hamilton referred to Metropolitan Hospital's LGBT clinic and stated that HHC has been working more aggressively with the

Human Rights Campaign to ensure that healthcare is more accessible, more appealing and its staff more understanding of the needs of the LGBT community.

Dr. Daskalakis reported on the NYC HIV/AIDS epidemic from 1981-2012. At the very beginning from 1981 to the mid-1990, there were an increasing number of new AIDS diagnoses and increasing deaths. Diagnosed individuals were getting sick, did not live long and were passing away. However, with the advent of antiretroviral therapy, the new AIDS diagnoses dropped dramatically as did AIDS deaths. Dr. Daskalakis reported that as the deaths have dropped off, more and more people were now living successfully with HIV. He explained that this success was a result of the great work that is being done at HHC and other facilities throughout the city. One of the important surveillance changes happened around 2000. The number of HIV diagnosed continues to go down as the new AIDS diagnoses and more and more people are living successfully with HIV. NYC and New York State are bending the curve now. The new end of the epidemic bending the curve means that there is a need to make changes, leverage resources and press down on the accelerator to make this curve bend faster.

Dr. Daskalakis described the NYC continuum of care for people with HIV in New York City. There are some significant drop-offs but there are still some people not diagnosed with HIV who have the condition. The City is currently working on a new series of surveys in five boroughs to have an accurate number of currently undiagnosed individuals. Dr. Daskalakis explained that the process is that, once diagnosed, a smaller number of individuals are linked to care and even fewer are retained in care. He added that, once people get into a clinic, the people that are linked and retained in care, 93% of them are on antiretroviral therapy and 82% are actually suppressed. If testing is increased, linkage to care will be increased and if linkage counselors can push retention higher and get more and more people into the high quality care in New York City, these individuals would be on antiretroviral therapy and their HIV would be suppressed. Dr. Daskalakis stressed that, not only will they be healthy, but also the curve will continue to bend down because by not having the HIV virus in their blood, HIV acquisition will be prevented. This process leads to the implementation of the 4th generation testing. By finding these people early on, not only can they be put on medication and become less infectious, they can also make a significant change in the story, as 50% of new diagnoses probably come from that early phase. Dr. Daskalakis added that even though numerically small, the impact can be massive.

Dr. Daskalakis reported on the other half of the continuum, which included HIV negative people who are potentially at risk for HIV. Testing, pre, and post exposure prophylaxis are available along with the technology to do primary care. At the end of the day, what is being done in primary care is HIV prevention. He stated that, from his personal clinical perspective, he can no longer distinguish between the individuals living with HIV from those who are at risk in terms of what the care delivery is since it has become identical. Dr. Daskalakis underscored that the opportunity for a primary care continuum for both people living with HIV and those potentially at risk is possible with all of the changes in health care delivery at HHC and other facilities.

Dr. Daskalakis described the New York City Department of Health and Mental Hygiene's (DOHMH's) emphasis and partnerships as described below:

DOHMH Emphasis

- NYC Testing Initiatives - the Bronx Knows, Brooklyn Knows, New York Knows – about 1.9 million tests
- Linked to Care - 75% of those diagnosed are linked to care
- Engagement in Care

- Viral Load Suppression
- PrEP and PEP detailing
- Care Continuum Dashboards

Partnerships with HHC

- HHC HIV Services Staff
 - Co-chair and participate on Steering Committees for The Bronx and Brooklyn Knows
- Care Coordination
- Patient Education and Social Marketing
- Provider and Staff Education
 - PrEP
 - Cultural Competency

Dr. Daskalakis stated that HHC was doing a fantastic job pushing that agenda of the continuum of care into the land of viral load suppression.

Dr. Daskalakis reported on efforts targeting men who have sex with men (MSM) and cultural competency issues. He stated that MSM information bulletins were created and disseminated throughout the city including HHC facilities to teach people how to make their practices friendlier for MSM. He informed the Committee that efforts were being made to expand that circle and making sure that people get the tools they need to make a friendlier environment.

Dr. Daskalakis added that one of the more important pushes in the city is to test more individuals. He referred to the BE HIV SURE subway campaign, which he described as being very purposefully not a stigma-based campaign. He emphasized that DOHMH's goal was not to tell the individual what to do and what not to do, but to provide the tools for the individual to know that he is contextually HIV sure for himself. DOHMH believes that it can teach its patients how to take control whether by testing, pre or pro exposure prophylaxis, or through HIV treatment to remain healthy. He informed the Committee that the field services unit would go out and identify people who were exposed to recently HIV diagnosed individuals to test them. Of those individuals, roughly 11% to 17% of those individuals test positive and are linked to care. Moreover, information is given to the HIV negative individuals to help them to stay negative. Another role of the field services unit is to find those individuals who have been lost from care. Also, DOHMH's own surveillance data are used to identify them and bring them back.

Dr. Daskalakis described ending of the epidemic (EoE) efforts to retain individuals in care and to promote the importance of viral load suppression. This body of work includes social media and the undertaking of the following programs:

- Care coordination
- Non-medical case management
- Housing support
- Food and nutrition services
- Harm reduction, recovery readiness and relapse reduction
- The Positive Life Workshop
- Care status reports
- Care continuum dashboards

Dr. Daskalakis reported on DOHMH's efforts to educate people about prevention and pre-exposure prophylaxis through the use of the following outreach strategies:

- MSM city health information bulletin
 - Ask about sexual behavior
- NYC condom availability program (37.5 million condoms distributed last year)
Note: National Condom Day is Valentine Day
- Trans health guide
- PrEP and PEP
 - Increasing awareness
 - Detailing (360 practices; 800 providers)
 - Implementation workshops

Dr. Daskalakis reported that the following actions must be undertaken in order to end the AIDS epidemic:

- Test individuals for HIV
- Provide pre-exposure prophylaxis for those who are at risk. Therefore, HIV negative is as important as HIV positive because someone who is at risk with an HIV negative test should also be connected to primary care. Negative or positive keep people engaged
- Empower health care and community partners to really make HIV testing a part of their mission. Just like getting a blood pressure, testing is now standard of care or a routine part of the visit
- Need to work with all of the resources to make sure that pre-exposure prophylaxis and care assistance does include resources for both drug access as well as supportive medical, social and behavioral services as well
- Interact with all the community-based organizations and others to really deal with the other hierarchy of needs including food access, harm reduction, mental health and substance abuse

Dr. Daskalakis concluded his presentation by stating that, ultimately, ending AIDS means linking and engaging patients in care.

Dr. Raju commented that when he graduated from medical school 40 years ago, HIV was one of the greatest challenges in medicine. However, in a short period of time, about 25 years ago, because of tremendous advances and the advocacy efforts, it would be very unusual for individuals to die from this disease as they once did. Dr. Raju emphasized that the advances made in dealing with the epidemic were due more to the commitment of educating the public than the clinicians and the research. Dr. Raju stated that he was very happy with the results until he went to Illinois and learned that diagnosed individuals living in Middle America were still being stigmatized and were still running into problems with being linked to care. Dr. Raju stressed that there is a need to figure out a national policy concerning the AIDS epidemic. It is hopeful that this advocacy will spread across the nation and that the great project of ending the AIDS epidemic will not be undermined with what happens in the other countries.

Mrs. Bolus commented that ending the epidemic agenda is time consuming. She asked how many staff members would be needed to implement the ending of the epidemic program.

Ms. Hamilton answered that ending the epidemic does require some additional resources. She informed the Committee that there had been some commitments made to the AIDS Institute in terms of expectations in its budget but the discussion still continues around what happens for direct care providers and what happens for direct prevention service providers. Ms. Hamilton admitted that it was unclear how to get these new resources including stable housing. However, she reminded the Committee that stable housing

remained a vital adjunct to being able to deliver the expected level of care impact, as patients will not be able to come to care.

Ms. Hamilton concluded her presentation by introducing the HIV staff members to the Committee. She introduced Ms. Eunice Casey, Assistant Director, and Lydia Isaac, PhD, MSc, Assistant Director of Data, Grants and Quality Improvement of Corporate Planning Services. Ms. Hamilton acknowledged them for their hard work, especially for their most recent work in collaboration with HHC facilities and other PPSs on DSRIP.

Mrs. Bolus thanked the team for their presentation.

ADJOURNMENT

There being no further business, the meeting was adjourned at 12:10 PM.

Mayor's Management Report

Presentation to the Strategic Planning Committee of the
Board of Directors

March 10, 2015

Corporate Planning Services

The Mayor's Management Report (MMR)

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- Serves as a public report card on City services affecting New Yorkers since 1997
- Mandated by the NYC City Council--reports are submitted twice a year to the NYC City Council for its review
- Final reports available online at

<http://www.nyc.gov/html/ops/html/data/mmr.shtml>

Report Specifics

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Reports	Time Frames	Submission Schedules
Preliminary Report	Covers the first 4 months of the current fiscal year (July – October)	Submitted no later than January 30 th of the current fiscal year to the City Council
Full Fiscal Year Report	Covers the full fiscal year (July-June)	Submitted no later than September 30 th of the subsequent fiscal year to the City Council

- Corporate Planning Services captures data from various central office divisions and enters data on the NYC Performance Management Application web site.

MMR Indicator Goals

4

HHC reports on 15 indicators which are categorized into the following four areas:

- Goal 1a: Improve access to outpatient services
- Goal 1b: Expand enrollment in insurance programs
- Goal 1c: Achieve/surpass local and national performance standards for specific health interventions and efficient delivery of health services
- Goal 1d: Reduce unnecessary emergency room visits and re-hospitalizations

Facilitating Improvement

5

- As a public report card, the use of the MMR is consistent with a management tool known as the **balanced scorecard**.
- In a balanced scorecard, a set of measures, aligned with the organization's goals and mission, provides the organization with a fast and yet comprehensive perspective on its performance.
- It also provides a feedback loop to enable improvement and the development of strategies to initiate change.

Alignment of MMR with HHC's Strategic Priorities

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

Strategic Priorities: DSRIP and its link to the MMR

7

- The Delivery System Reform Incentive Payment (DSRIP) Program is a healthcare reform initiative with the aim of:
 - ▣ Reducing unnecessary emergency room utilization
 - ▣ Reducing unnecessary hospitalizations for conditions treatable in primary care settings
 - ▣ Improving the healthcare experience through the coordination of healthcare providers across the continuum
 - ▣ Increase primary care access
- Many of the MMR indicators align with DSRIP goals

Alignment of MMR with DSRIP

Mayor's Management Report Indicators (MMR)	DSRIP Goals
<ul style="list-style-type: none"> • Total Uninsured patients served (Expand enrollment in insurance programs) • Prenatal care patients retained in care through delivery • MetroPlus Medicaid, Child Health Plus and Family Health Plus enrollees • Total Medicaid Managed Care, Child Health Plus and Family Health Plus enrollees • Mammography screening • Percent of two-year olds immunized 	Increase primary care access
<ul style="list-style-type: none"> • % ER revisits by adult asthma patients • % ER revisits by pediatric asthma patients • HIV patients retained in care 	Reduce unnecessary emergency room utilization
<ul style="list-style-type: none"> • Adult psychiatric patients 30 day readmission rate • HIV patients retained in care 	Reduce unnecessary hospitalizations
<ul style="list-style-type: none"> • General Care ALOS • Clinic cycle time (Adult, Pediatrics and Women's Health): Non-clinical patient time (minutes) • Mammography screening • Percent of two-year olds immunized 	Improve the healthcare experience
<ul style="list-style-type: none"> • Days in accounts receivable (net) 	N/A

Goal 1a:

Summary of Current Indicators

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Indicator Name	Owner	Data availability	Most Recent Data	Target	Desired Direction	Recent Direction	Comparables
Prenatal patients retained in care through delivery (%)	CPS	Quarterly & annually	88.8%	90%	Up	Up	None
HIV patients retained in care (%)	CPS	Annually	86.8%	90%	Up	Up	69.8% NYS 2009
Cycle Time Adult (Min)	M&PA	Quarterly & annually	45	60	Down	Change in formula	30 IHI Goal
Cycle Time Pediatrics (Min)	M&PA	Quarterly & annually	43	60	Down	Change in formula	30 IHI Goal
Cycle Time Women's Health (Min)	M&PA	Quarterly & annually	44	60	Down	Change in formula	30 IHI Goal

Goal 1b:

Summary of Current Indicators

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

Goal 1c:

Summary of Current Indicators

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

a NYS FQHC data CY 2013

b overall NYS ALOS 2011

c 2003 S&P data

Goal 1d:

Summary of Current Indicators

12

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

^a NYS OMH DSRIP metrics for fee for service patients 2012

Example- Preliminary Fiscal Year 2014-HHC MMR

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

Goal 1a: Improve access to outpatient services.

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

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

Example-Full Fiscal Year 2014

HHC MMR

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Goal 1a

Improve access to outpatient services.

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

★ Critical Indicator "NA" - means Not Available in this report ↓↑ shows desired direction

Behind the Curtain

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- CPS works with multiple (4) divisions to capture the data for the MMR
- A majority of the MMR indicators are reported monthly or quarterly on the Citywide Performance Report (data is available to the public)
- Any new indicator requires 3-5 years of prior data in order to establish the foundation for patterns and projections

Moving Forward

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- CPS will monitor the MMR metrics and work with senior leadership to ensure that the MMR will continue to be aligned with HHC's Guiding Principles and Strategic Priorities:

