STRATEGIC PLANNING COMMITTEE MEETING
OF THE BOARD OF DIRECTORS

MAY 12, 2015
10:30 A.M.
HHC BOARD ROOM
125 WORTH STREET

AGENDA

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

II. ADOPTION OF APRIL 14, 2015
STRATEGIC PLANNING COMMITTEE MEETING MINUTES — **JOSEPHINE BOLUS, RN**

III. SENIOR VICE PRESIDENT'S REPORT — **JOHN JURENKO**

IV. INFORMATION ITEM

i. **PRESENTATION: SUPPORTING STRATEGIC GOALS THROUGH ON-DEMAND TRAINING**
CARLOS SCHOLZ, SENIOR DIRECTOR, ORGANIZATIONAL INNOVATION & EFFECTIVENESS
NATHAN LINK, MD, MEDICAL DIRECTOR, BELLEVUE HOSPITAL CENTER
MARCY PRESSMAN, DEPUTY EXECUTIVE DIRECTOR, BELLEVUE HOSPITAL CENTER
LINDA LOMBARDI, CHIEF STRATEGY OFFICER, BELLEVUE HOSPITAL CENTER
KENNETH FELDMAN, AED AMBULATORY CARE, GOUVERNEUR HEALTHCARE SERVICES
MOLLY LOPEZ, ASSOCIATE DIRECTOR, WOMEN'S & CHILDREN'S HEALTH
GOUVERNEUR HEALTHCARE SERVICES
ROBERT MALONE, CHIEF FINANCIAL OFFICER, QUEENS HOSPITAL CENTER
HELEN SAPLA-COLL, AMBULATORY CARE NURSE, QUEENS HOSPITAL CENTER

V. OLD BUSINESS

VI. NEW BUSINESS

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

MINUTES

STRATEGIC PLANNING COMMITTEE MEETING
OF THE BOARD OF DIRECTORS

MAY 12, 2015

The meeting of the Strategic Planning Committee of the Board of Directors was held on April 14, 2015 in HHC's Board Room located at 125 Worth Street with Ms. Josephine Bolus, NP-BC, 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

C. Camarco, Marketing Director, DEK Consulting Services
J. DeGeorge, Analyst, New York State Comptroller
J. Lamontiz, Guest
E. Peterman, Registered Nurse, ECU, U.S. Army
K. Raffaele, Analyst, Office of Management and Budget
J. Wessler, Guest

HHC STAFF

C. Barrow, Associate Director, Lincoln Medical and Mental Health Center
M. Belizaire, Assistant Director of Community Affairs, Office of Intergovernmental Relations
L. Brown, Senior Vice President, Corporate Planning, Community Health and Intergovernmental Relations

D. Cates, Chief of Staff, Office of the Chairman
M. Cooper, Director of Community Affairs, Office of Intergovernmental Relations
E. Davis, Director, World Trade Center Environmental Health Center
C. Dunn, Senior Director, Communications and Marketing
J. Goldstein, Assistant Director, Corporate Planning Services
D. Green, Senior Assistant Vice President, Corporate Planning Services
L. Guttman, Assistant Vice President, Office of Intergovernmental Relations
C. Jacobs, Senior Vice President, Safety and Human Development
J. Jurenko, Senior Assistant Vice President, Office of Intergovernmental Relations
S. Kleinbart, Director of Planning, Coney Island Hospital
Z. Liu, Senior Management Consultant, Corporate Planning Services
P. Lockhart, Secretary to the Corporation, Office of the Chairman
A. Marengo, Senior Vice President, Communications and Marketing
R. Mark, Chief of Staff, Office of the President
A. Martin, Executive Vice President and Chief Operating Officer, Office of the President
I. Michaels, Director, Media Relations, Communications and Marketing
K. McGrath, Senior Director, Communications and Marketing
J. Omi, Senior Vice President, Organizational Innovation and Effectiveness
K. Park, Associate Executive Director, Finance, Queens Health Network
S. Penn, Deputy Director, World Trade Center Environmental Health Center
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, Office of the Chairman
W. Saunders, Assistant Vice President, Office of Intergovernmental Relations
D. Thompson, Associate Executive Director, Kings County Hospital Center
D. Thornhill, Associate Executive Director, Harlem Hospital Center
J. Wale, Senior Assistant Vice President, Behavioral Health
K. Whyte, Senior Director, Corporate Planning, Community Health and Intergovernmental Relations

CALL TO ORDER

The Strategic Planning Committee Chairperson, Ms. Josephine Bolus, NP-BC, called the meeting of the Strategic Planning Committee to order at 10:37 A.M. The minutes of the March 10, 2015 meeting of the Strategic Planning Committee were adopted.

SENIOR VICE PRESIDENT REMARKS

Federal Update

Sustainable Growth Rate (SGR – "Doc Fix"): House Passes Bill 392-37, Senate Action Needed

Ms. Brown reported that, on March 27, 2015, legislation concerning the SGR or "Doc Fix" had passed the House of Representatives by a wide margin of 392-37. Ms. Brown explained that the legislation, H.R.2, represented a bipartisan, negotiated agreement between House Speaker John Boehner and Minority Leader Nancy Pelosi and their respective leadership teams. She reminded the Committee that the latest SGR patch was set to expire on March 31, 3015, but that the deadline had been extended until mid-April to allow the Senate to pass legislation following their return from Easter Recess. Ms. Brown reported that the total cost of H.R.2 is estimated to be $214 billion over 10 years, which would add approximately $142 billion to the deficit. An estimated $72 billion of this funding would be generated from either revenue raising "pay for" policies or cuts to beneficiaries. Furthermore, the hospital community will not be on the defensive each year as it has been since 1997 to come up with "offsets" to finance what has been a yearly ritual of "fixing" the SGR.

Ms. Brown described the key provisions of the H.R.2 legislation as the following:

- The H.R. 2 bill proposes a transitional 0.5% Medicare payment update for physicians for five years and will freeze Medicare pay in fee-for-service over the next five years, while they move towards a value and performance-based system and away from a volume-based, fee-for-service system
- Starting in 2019, the bill proposes to replace the current pay-for-performance programs in fee-for service Medicare with a new "Merit-based Incentive Payment System" that will start with four percent of physicians' pay being at performance risk and increases to nine percent.
- Starting in 2019, the bill proposes to provide physicians who participate in two-sided risk alternative payment models, such as ACOs, with a five percent bonus.
- The bill proposes to extend the Children's Health Insurance Program (CHIP) for two years.
- The bill proposes to delay Medicaid Disproportionate Share Hospital (DSH) funding cuts until FY 2018. Current law has DSH cuts starting in FFY 2017 and extending through FFY 2024. The proposed House legislation would postpone the initiation of the DSH cuts until FFY 2018 and extend the DSH cuts through FFY 2025 with more aggressive reductions in funding over the last three years, than what is in current law.
- The bill proposes to extend the delay of the Medicare "Two-Midnight Rule" until September 30, 2015.
- The bill proposes to provide $7.2 billion in funding for Federally Qualified Health Centers (FQHCs).

Ms. Brown stated that, as a result of the advocacy of the hospital community, two possible cuts that were of great concern to HHC, which were reductions to Hospital Outpatient Department (HOPD) payments and cuts to Graduate Medical Education-Indirect Medical Education (GME/IME) had not been included in H.R.2. In prior "Doc Fix" proposals, there have been proposals to make HOPD payments site neutral, which would have cost HHC an estimated $19 to $23 million per year; and the proposed 10 percent reduction in IME payments which would have cost HHC $10 million per year. The House bill delays implementation of the Medicare Two-Midnight Rule until FFY 2016. Implementation of this rule would have cost HHC an estimated $23 to $38 million in Medicare revenue each year.

HHC ACO Coding Issue

Ms. Brown reported that a Centers for Medicare and Medicaid Services (CMS) rule, which was finalized in early 2014, had resulted in unintended consequences for HHC's six Elected Teaching Amendment (ETA) hospitals. The six ETA hospitals – Bellevue, Woodhull, Kings County, Queens, Jacobi and North Central Bronx – would no longer have many of the patients they serve counted toward their Accountable Care Organization (ACO) numbers due to a coding change. In addition, on April 1, 2015, this anomaly will result in these patients being automatically reassigned to other entities. Ms. Brown informed the Committee that HHC had requested that CMS correct this error in applying the Medicare Shared Savings Program (MSSP) beneficiary assignment methodology to these HHC hospitals. She explained that a change in the CMS hospital outpatient billing requirements had rendered the majority of eligible patients under HHC's care "invisible" to MSSP attribution. As such, an updated methodology is urgently needed, in order for ACOs that include ETA hospitals, to continue their participation in the MSSP. Ms. Brown explained that ETA hospitals receive a reasonable cost basis for direct medical and surgical services for their physicians in lieu of Medicare fee-for-service scheduled payments.

Ms. Brown informed the Committee that HHC had contacted CMS' Acting Administrator, Andy Slavitt, and Deputy Administrator, Sean Cavanaugh. HHC has also briefed the NYC Congressional Delegation. HHC has been notified that the "highest levels of management at CMS were reviewing the issue, which is now sitting in the General Counsel's Office for his consideration." Even with the Easter/Passover Recess, HHC continues to press the issue with HHS and CMS.

Ms. Brown added that HHC had established one of the best performing ACOs that treats a large number of vulnerable patients- principally "dual eligible" patients. Using CMS' metrics, HHC's ACO was among the highest performing Medicare Shared Savings Programs (MSSP) in 2013.

Ms. Brown explained that there was urgency concerning HHC's appeal since the New York State Department of Health and CMS had recently begun a Fully Integrated Dual Advantage (FIDA) demonstration program that would passively enroll Medicare-Medicaid beneficiaries into managed FIDA plans starting on April 1, 2015. She added that, once patients are enrolled in FIDA, they would no longer be eligible for ACO attribution. Ms. Brown informed the Committee that, two weeks ago, HHC was notified by NYS Department of Health that the 562 patients who had been manually extracted from the computer system would not be lost as a result of the April 1st deadline.

Reauthorization of James Zadroga 9/11 Health and Compensation Act

Ms. Brown reported that several activities had been launched in support of the reauthorization of the James Zadroga 9/11 Health and Compensation Act of 2010, which was set to expire during the current session of Congress. These activities include the following:

March 27, 2015

Senators Kirsten Gillibrand of New York and Kelly Ayotte of New Hampshire announced the passage of an amendment to the Senate budget to facilitate the renewal and extension of Zadroga by creating a deficit-neutral reserve fund, which would allow Congress to consider legislation that would continue to provide treatment and compensation for first responders and survivors of the September 11th terrorism attacks at the World Trade Center, the Pentagon and the Shanksville crash site. Passage of the budget amendment was a critical first step toward re-authorization.

March 30, 2015

The City Council's Committee on Civil Service and Labor convened a hearing in support of a re-authorization resolution as submitted by Council Member Margaret Chin. Two stakeholder panels presented: one for responders and the other for survivors, as well as a legislative panel with representatives from the offices of Congress members Jerrold Nadler and Carolyn Maloney. The survivor panel was comprised of members of HHC's Survivor Steering Committee, who were specifically acknowledged and thanked by the Civil Service and Labor Committee Chair, Daneek Miller, who stated that he had never heard the community's point of view on how gravely they had been affected.

On April 8, 2015

Dr. Joan Reibman, Medical Director, HHC WTC Environmental Health Center (WTC EHC), was asked to participate on a call with staffers of the Senate Health, Education, Labor and Pension (HELP) Committee to provide an overview of the WTC EHC Survivor Program alongside the medical directors for the Responder program and the Fire Department who summarized their respective programs for the staffers. By educating the HELP Committee, as fully as possible, it is anticipated that committee members would help to engender continued bipartisan support for re-authorization and become advocates for its passage.

Today, April 14, 2015

Representatives of HHC's WTC EHC's Survivor Program stood alongside Senator Gillibrand in a press conference as she and other legislators announced a Senate bill for re-authorization of Zadroga, which was anticipated to be quickly followed by introduction of a House bill by Representatives Peter King, Carolyn Maloney and Jerrold Nadler. An advocacy presence will be needed on Capitol Hill in the near future by the City, HHC, Fire Department and other WTC Health Program partners to ensure passage. HHC will rely as always on the leadership of the City in such endeavors.

The content of the bill being introduced remained the same as was originally approved in 2010 with the exception that the extended bill would support a permanent program without expiration and with budget-neutral funding sources. It will be exempt from sequestration and will increase funding for the Scientific and

Technical Advisory Committee to better administratively operate and to support scientific studies. It includes some minor technical corrections along with the establishment of administrative costs to oversee the program to be funded by the program itself instead of through the general NIOSH budget (National Institute of Occupational Safety and Health), which is the immediate federal overseer of the program.

Ms. Brown informed the Committee that the City has pledged its full support of the bill and that all recent communications regarding re-authorization from any source - be it legislators, union representatives or WTC program advocates of any kind – had mentioned the survivor population prominently and with parity to responders, which had not always been the case in the initial effort to pass a 9/11-related bill. This inclusion, along with what seems to be a more bipartisan approach than before, supports a cautious optimism that joint efforts to educate and advocate for the bill would result in passage of re-authorization of Zadroga within this calendar year but certainly before the closure of the current session of Congress.

Mr. Nolan, Board Member, asked if it would be more difficult for the bill to be reauthorized because the Republicans have taken control of the Senate. Ms. Brown responded that the James Zadroga 9/11 Health and Compensation Act is a nationwide program. She reminded the Committee that there were first responders who came from across the country to help following the 9/11 attack. There are people living in upstate New York who are suffering the consequences of having been exposed to some of the elements as a result of 9/11. Having constituents beyond New York City and New York State who have been impacted could help the bill. There will be a great deal of focus on the national program, not the New York City or New York State program to engender the support from Senate Republicans for the bill. Ms. Brown emphasized that this was the reason why Senator Gillibrand did not do this alone, but in collaboration with other Senate colleagues outside of New York.

Ms. Brown commented that the Republicans do not want this debate to be occurring as they are actively campaigning and to have the appearance that Republicans could be perceived as being unpatriotic and not supportive. There seems to be somewhat of a momentum on both sides of the aisle to try to get the reauthorization passed before January, when campaigning ramps up for the presidential election.

INFORMATION ITEM

Presentation: 2015-16 State Fiscal Year Budget Overview

Wendy Saunders, Assistant Vice President, Office of Intergovernmental Relations

Ms. Brown introduced Ms. Wendy Saunders, Assistant Vice President of the Office of Intergovernmental Relations and invited her to present an overview of the finalized 2015-2016 State Fiscal Year Budget.

Ms. Saunders began her presentation by stating that the budget was on time for the fifth year. She stated that, although the Assembly did not pass the final budget bill until almost 3:00am on April 1, 2015, all parties declared the budget to be "on-time." In addition, it was not only the fifth consecutive on-time budget, but also the fifth budget in a row to hold increases in State spending to 2% or less for a $142 billion budget. Ms. Saunders reported that the final budget would increase overall spending by 1.7% and included a significant $1.3 billion increase in education spending, along with several education reform initiatives, which proved to be quite controversial. She added that another package of controversial reforms that had been included in the final budget was a series of changes meant to strengthen ethics oversight. The final

budget also allocates a surplus of $5.4 billion that resulted from settlements with major financial institutions. She informed the Committee that the funded items included:

- $1.5 billion for Upstate Economic Development
- $1.3 billion for the Tappan Zee Bridge and to stabilize the State Thruway Authority
- $500 million for Broadband Access
- $400 million over four years for Health Care Capital Projects
- A variety of smaller initiatives

Ms. Saunders reported that, in terms of Medicaid spending, the final budget included $86.1 billion in Medicaid spending, a 3.6% increase over last year's Medicaid spending. Ms. Saunders stated that, while there was no inflationary increase or trend factor for Medicaid providers this year, the Legislature rejected the Governor's proposal to permanently eliminate the Medicaid inflation increase - known as the trend fact – but did extend the cut for two additional years through March 31, 2017. Furthermore, the Legislature rejected the Governor's proposal to make permanent the Global Cap on Medicaid spending, but allowed a one year extension (through March 31, 2017). The Global Cap will continue to include annual increases tied to the ten year rolling Consumer Price Index (CPI) with authority provided to the State Department of Health (SDOH) to take actions to reduce spending if it appears Medicaid spending will pierce the Global Cap.

Ms. Saunders informed the Committee that providers will continue to be eligible to receive "Global Cap Dividends" for any savings that would result if spending remained below the Global Cap. This initiative was first enacted as part of last year's budget. Dividend payments are based on a calendar year – and the first dividend has not yet been paid. She commented that it was hopeful that dividend payments would be made sometime soon and would be continued into the future as well.

Ms. Saunders reported on some key issues that had also been discussed in the previously held Finance Committee Meeting. The first of these issues was the HHC Upper Payment Limit (UPL). Ms. Saunders reported that the final budget included language to modify the way the State distributes the Upper Payment Limit or UPL for HHC. Ms. Saunders explained that these technical changes were necessary to meet new federal requirements. With this change, HHC will soon receive more than $1 billion in outstanding payments for services provided in 2011 through 2014.

The second issue is the voluntary hospitals' outpatient UPL. Ms. Saunders commented that, although HHC wouldn't typically be concerned about UPLs for voluntary hospitals, HHC was very pleased that the final budget created this new option. It is important to HHC because voluntary hospitals appear to have run out of "room" under the inpatient UPL, which would result in voluntary hospitals receiving payments using federal Disproportionate Share Hospital (DSH) funding instead. Such payments would reduce the DSH funding available for HHC. Ms. Saunders explained that, with the new budget provision, voluntary hospitals would receive up to $339 million annually in outpatient UPLs, which would ensure DSH funding would still remain available to HHC.

The third issue is Charity Care funding through the Indigent Care Pools. Ms. Saunders reported that the final budget would continue the methodology for distributing Charity Care funding for three years, including the gradual phase-in of changes enacted in 2012 to increase the proportion of the funding to hospitals that provide care to the uninsured, underinsured and Medicaid populations. These hospitals can also lose funding if caring for fewer uninsured, underinsured and Medicaid populations. Facility losses are capped at

10% in 2016, 12.5% in 2017, and 15% in 2018. Ms. Saunders stated that the final budget also continues to set aside one percent of funding for a financial assistance compliance pool.

Ms. Saunders reported that it was disappointing that the final budget did not provide the State Department of Health (SDOH) with the flexibility that SDOH was seeking to change the distribution methodology should the federal DSH cuts took effect as scheduled. As mentioned by Ms. Brown, Ms. Saunders emphasized that it now appeared that those cuts would be delayed again – until October 2018 – which would provide SDOH with some time to advocate for such change in a future State budget. Ms. Saunders added that, without this change, these cuts would take effect next October. Ms. Saunders added that, while delaying these cuts was beneficial to HHC right now, when implemented, these cuts would be detrimental to HHC as HHC would be hit hard with the first cut. Ms. Brown added that it is never too early to begin the conversations. Mr. Nolan asked if the problem was the Legislature, the Governor, or a combination of both. Ms. Saunders answered that the Legislature was not inclined to give flexibility to the Governor to make changes without coming back to them. She explained that the Governor's proposal was for SDOH to be able to make administrative changes without coming back to the State Legislature. Ms. Saunders explained that this proposal has not been implemented and that there has not been any change in current federal law.

Ms. Saunders continued her presentation and reported on the proposed new cuts that were included in the final budget. She reported that the Legislature had partially restored the Medicaid-Medicare Crossover cut that had been proposed by the Governor, which would limit Medicaid payments for co-insurance for certain low-income Medicare beneficiaries who are also eligible for Medicaid. Medicaid will continue to make payments for Part C co-insurance claims but would only pay Part B co-insurance if the total amount billed for the service is equal to or less than what would have been paid under Medicaid. The impact on HHC is still to be determined. The statewide impact is estimated to be $70 million.

Ms. Saunders reported that the Legislature rejected a proposal to limit billings to Medicaid Managed Care Plans for outpatient pharmaceuticals purchased under the 340-B program to the discounted 340-B invoice price. Providers participating in the 340-B program will continue to be able to bill Medicaid Managed Care Plans at an enhanced level.

Ms. Saunders informed the Committee that HHC was disappointed that the Legislature had also rejected the Governor's proposal to reduce an assessment or tax on inpatient obstetrical care. The Executive Budget included a 45% reduction in this tax, but since that proposal was not adopted, the tax will remain unchanged.

Ms. Saunders reported that the final budget does include good news in the form of the restoration of two prior rate cuts: 1) the penalty on potentially preventable negative outcomes (PPNOs), which included both potentially preventable readmissions and complications. This should increase reimbursement for HHC by approximately $4 million; and 2) the across-the-board rate reductions on inpatient obstetrical services. The benefit of eliminating this rate cut is still being determined.

Ms. Saunders reported on the capital funding proposal that was included in the final budget. She reported that the final budget allocates $1.4 billion in new capital funding in the following manner:

- $700 million for Central and East Brooklyn
- $300 million for Oneida County

- $355 million for rural communities
- $19.5 million revolving loan fund for the Primary Care Development Corporation (PCDC)

Ms. Saunders explained that these funds are discretionary and do not need to be competitively bid. She highlighted that the largest allocation of this new funding is for Central and East Brooklyn. The $700 million in grants will be available for hospitals, nursing homes, diagnostic & treatment centers, primary care providers and home care providers with the goal of replacing, as quoted in the budget, "inefficient and outdated facilities as part of a merger, consolidation, acquisition or other significant corporate restructuring activity intended to create a financially sustainable system of care."

Ms. Saunders reported that SDOH would reissue a $1.2 billion DSRIP-related Request for Applications from 2014. She commented that HHC was pleased to see that applicants were expected to engage the community and would be evaluated based on how community engagement shaped the project. She added that HHC was also pleased that a requirement was added to take into consideration the extent the project would benefit Medicaid enrollees and uninsured individuals. There is a new requirement that funds be awarded regionally in proportion to the applications received. HHC will need to resubmit its application, which was designed to support DSRIP-related projects. There is a prohibition on submitting projects for both this funding opportunity and the new $1.4 billion capital funding opportunity.

Hospitals

Ms. Saunders reported that HHC's biggest disappointment in the final budget concerned the Vital Access Provider (VAP) funding. Ms. Saunders explained that, although the final budget increased VAP funding by $245 million and targets it to providers in a manner similar to the Interim Access Assurance Funds (IAAF), HHC will not be eligible for this funding. At the last minute, language was added to the final budget that specifically excluded public hospitals operated by public benefit corporations, including HHC. HHC is working with the State to change this prohibition so that HHC could benefit from this funding. However, as it stands right now, HHC will no longer be eligible to receive that funding.

Ms. Saunders reported that HHC should benefit from the $91 million Quality Improvement Incentive Pool. She informed the Committee that this new program is designed to incentivize quality improvement in hospitals. She explained that, while initially, the funds are likely to be distributed proportionately to hospitals as non-competitive grants, eventually the program will be based on performance on various quality measures.

Ms. Saunders reported that HHC was pleased that the Excess Medical Malpractice Program will be extended with the same eligibility requirements until June 30, 2016. She added that the final budget did not include a policy proposed by the Governor, which would have required physicians to be cleared through the State Tax Department before they could participate in the program.

Lastly, Ms. Saunders reported that the final budget included a change that would alter the notice that SDOH must provide before implementing Medicaid rate changes for hospitals. She added that, while the Governor had originally proposed to eliminate this requirement altogether, the Legislature had instead agreed to reduce the timeframe from 60 to 30 days.

Long Term Care

Ms. Saunders reported on the Long Term Care related provisions of the final budget. Ms. Saunders stated that the final budget extends the nursing home reimbursable cash receipts assessment through March 31, 2017, along with a four year extension of Home Care Episodic Payments for certified home health agencies. Ms. Saunders added that the final budget also included a new provision that requires managed care plans to standardize billing codes for claims for home and community-based long term care and nursing home services starting on January 1, 2016. This universal coding is particularly important as patients are transitioning to manage care and there are varieties of different managed care plans using different kinds of billing codes and systems that are very difficult for providers to keep track of. This standardized billing code will be very helpful.

Ms. Saunders reported that the final budget includes a Hospital-Home Care-Physician Collaboration Program. This new voluntary program will allow hospitals, home care agencies, physicians, nursing homes, payers and other providers to design new initiatives to facilitate innovation to improve patient care access and management, health outcomes and cost effectiveness. SDOH can make rate adjustments and provide regulatory waivers to support projects related to care transitions, improving clinical pathways, increasing the use of tele health/telemedicine and physician house calls for home-bound patients.

Lastly, Ms. Saunders reported that a proposal to allow a new category of licensure for advanced home health aides was not included in the final budget.

Other Issues in the State Budget

Ms. Saunders reported that the final budget continues to provide $54.4 million for uncompensated care for diagnostic and treatment centers. This does not include a "reserve fund" to address any possible loss of federal funding due to new outcome requirements being proposed by the Centers for Medicare and Medicaid Services (CMS). However, SDOH is confident that it would get a one-year extension of the current waiver covering this funding.

Mrs. Bolus commented that her understanding regarding the conversion of HHC's diagnostic and treatment centers (D&TCs) into a Federally Qualified Health Center (FQHC) was to generate more revenue. She asked if that would still be the case. Ms. Brown responded affirmatively. Ms. Brown explained that this was a separate issue related to Indigent Care funds that the State provides. She added that this issue is still important to HHC as HHC would still receive approximately $18 million from that pool. Ms. Brown highlighted that HHC's Gotham strategy would generate an additional $30 million in reimbursements for being an FQHC-LAL entity.

Ms. Saunders reported that the final budget allows SDOH to implement the Basic Health Plan (BHP). She explained that the BHP will be available immediately for certain immigrants who receive state-only Medicaid pursuant to the Aliessa lawsuit. On January 1st, New Yorkers with incomes up to 200 percent of the federal poverty level who are eligible for coverage through the New York State of Health Exchange (the State's Health Insurance Exchange) will begin to obtain their coverage through the Basic Health Plan. HHC is pleased that this new program will maintain and/or expand coverage for low-income New Yorkers.

Ms. Saunders reported that the final budget includes a new statutory requirement for Performing Provider Systems (PPS) to establish and maintain Project Advisory Committees (PACs) to consider and advise the PPS on system operations, service delivery issues, elimination of disparities, measurement of project outcomes and goals, and development of plans and programs. Ms. Saunders explained that the PAC must be representative of the community served by the PPS and must include Medicaid consumers attributed to the PPS. Since HHC's PAC already includes consumers, this budget provide should not require any changes for HHC.

Ms. Saunders also reported that the Legislature had rejected the Governor's proposal to implement a new assessment on health plans to support the continued operations of the New York State of Health Exchange. Instead, the Exchange would be funded through existing Health Care Reform Act (HCRA) resources.

Items not included in State Budget

Ms. Saunders concluded her presentation by highlighting other budget proposals that were not included in the finalized budget:

- **Private equity pilot proposal:** The Assembly once again rejected the Governor's proposal to allow corporations to provide capital investment in health care facilities. This is the third time the Governor included a similar proposal.

- **Limited services "retail" health clinics and urgent care centers:** As with the private equity proposal, the Legislature also rejected changes to license limited service clinics and require full accreditation of urgent care providers.

- **Certificate of Need (CON) changes:** For the third year, the Legislature rejected changes to streamline the CON process. It is anticipated that this may be taken up later in the legislative session.

- **Audit of Resident Work Hours:** The final budget once again rejected the proposal to eliminate the requirements that hospitals report to SDOH on working hours for residents. SDOH will continue to be required to perform an annual audit of hospitals regarding compliance with state regulations related to working conditions and limits.

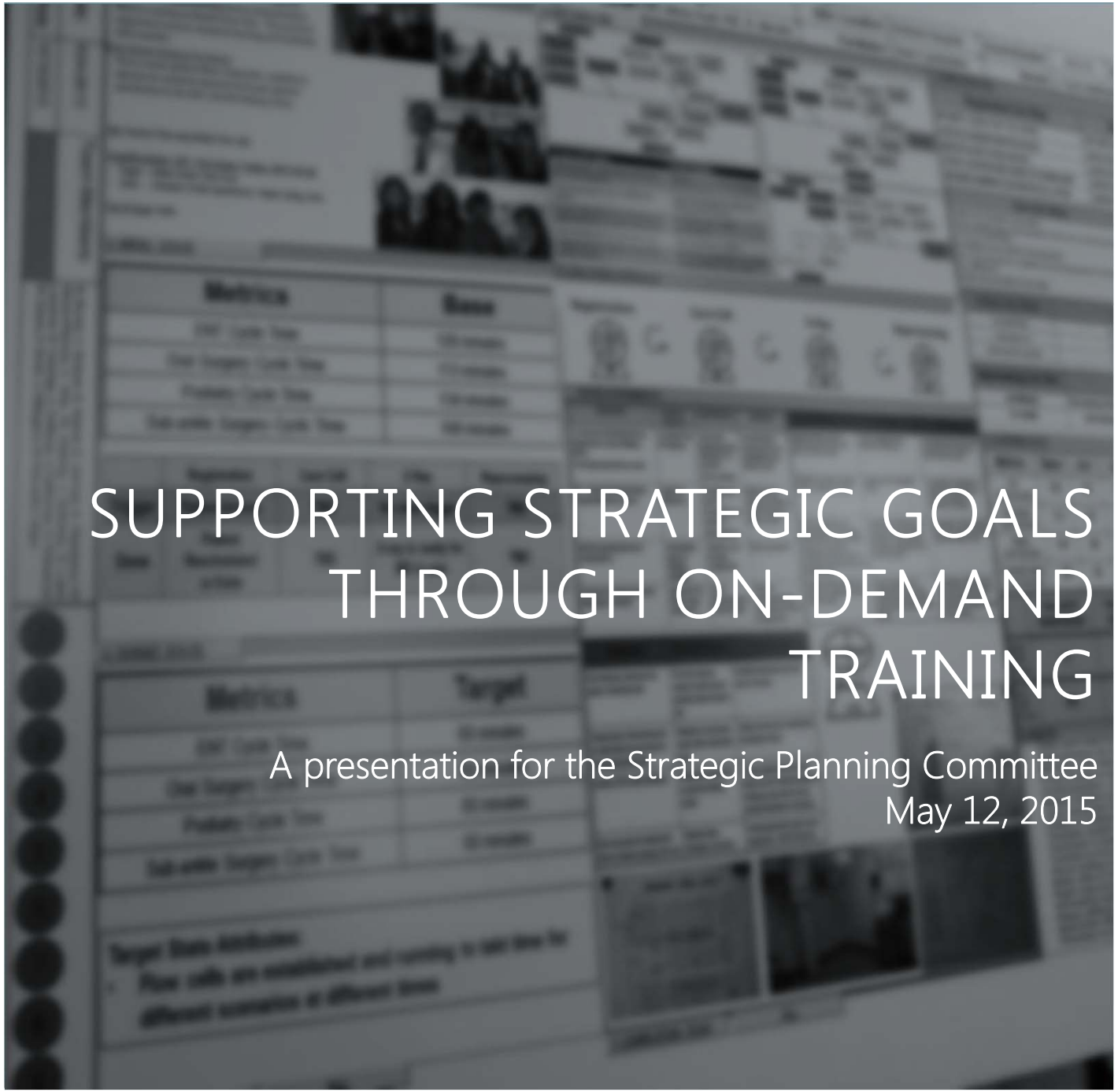
Mr. Rosen, Board Member commented that the State's Medicaid spending was more than half of the State's Budget. Ms. Saunders responded that it was more than half of the State's Budget including all funds. However, looking at State spending it is a little bit less, merely a third of the State-only funds. Mr. Rosen asked if the $142 billion was the total State Budget. Ms. Saunders answered that it included State only funds. It does not include all the federal funds.

Mr. Rosen asked about the provisions of the Governor's proposal on "limited services retail health clinics and urgent care centers" that was not included in the final budget. Ms. Saunders responded that it would have required licensure and the establishment of new standardized rules that providers would all have to meet in order to operate urgent care centers and limited service retail clinics. Mr. Rosen referred back to discussion concerning capital funding and asked if it was disclosed which hospitals in Brooklyn would receive the $700 million. Ms. Saunders responded that no specific hospital designation was made concerning those funds. She added that, originally it was just proposed for hospitals; however, the

Legislature added other providers such as, nursing homes, diagnostic and treatment centers, primary care and home care. Ms. Brown informed the Committee that HHC would be applying for this funding.

ADJOURNMENT

There being no further business, the meeting was adjourned at 11:26 AM.



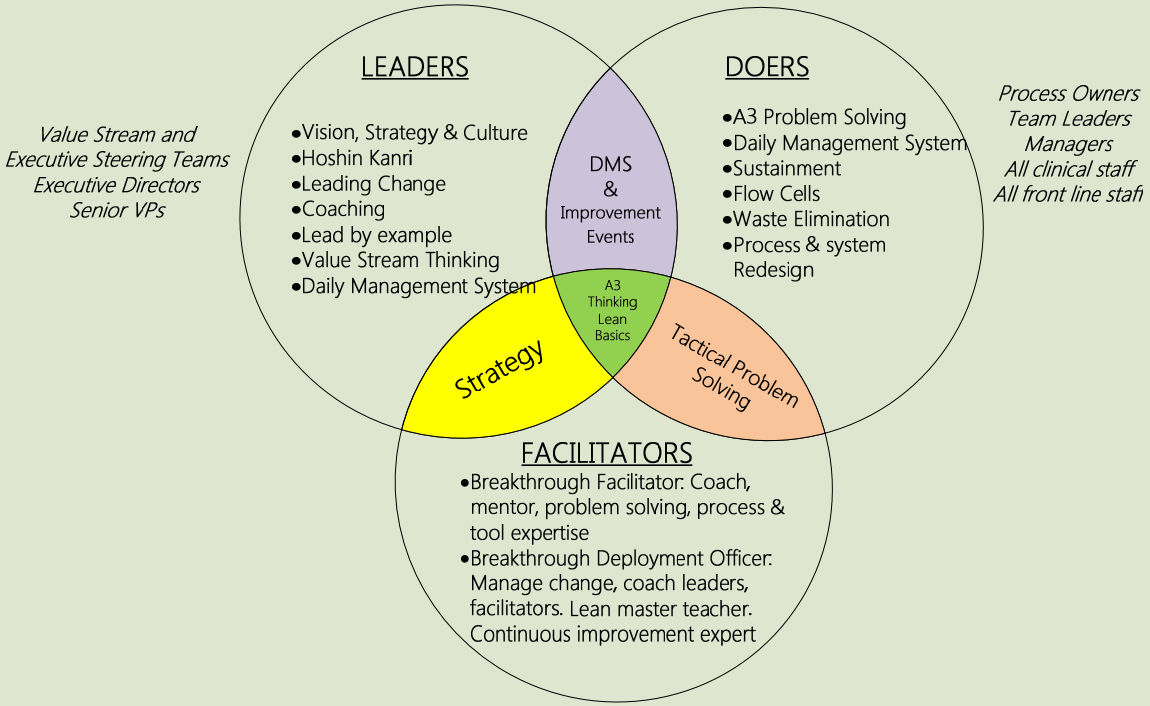
SUPPORTING STRATEGIC GOALS THROUGH ON-DEMAND TRAINING

A presentation for the Strategic Planning Committee
May 12, 2015

Breakthrough
Silver
Certification

Breakthrough
The HHC Enterprisewide Improvement System

TRAINING MODEL



Value Stream and Executive Steering Teams Executive Directors Senior VPs

Process Owners Team Leaders Managers All clinical staff All front line staff

LEVELS OF CERTIFICATION AND TRAINING

In Development

Opportunities for Improvement

- Idea generation and implementation

Lean Operating System

- Systemic engagement of everybody, every day

Coaching

- Support for and modeling behavior change for leaders, managers and supervisors

REASON FOR ACTION

- 2020 Vision
  - Improve the patient experience
  - Develop the workforce
  - Increase enrollment in MetroPlus
  - Grow market share
  - Improve financial viability
- Breakthrough is an essential tool for achieving the vision
  - HOW--Implement the Breakthrough operating system
    - Create internal expertise to adopt and lead Breakthrough
    - Create the structural elements for a system of bidirectional accountability and mutual respect that effectively supports continuous improvement
  - WHAT--Support specific corporate initiatives
    - Achieve and sustain primary care access goals
    - Support corporate-wide operational model for reducing ED length of stay
    - Integrate HARP planning into existing Breakthrough value stream activity
    - Implement the Daily Management System into critical value streams
    - Support integration and rollout of DSRIP goals

SILVER CERTIFICATION- CURRENT STATE

- Part of our Tiered Breakthrough Certification Level Program
- Provides basic flow cell skills and competencies:
  - Standard Work
  - 6S
  - Simple Flow
  - Pull Systems
  - Visual Management
- Previously, training includes 1 week of training, 1 week RIE "Blitz"
- From 2010 to 2013:
  - 13 sessions
  - 107 people trained
- Most of the students were dedicated or part time Breakthrough staff (Deployment Officers, Facilitators or Embedded Facilitator)

ASSUMPTIONS – CHANGE MANAGEMENT

- The effectiveness of training – how, when, what, to whom, can always improve
- Training effectiveness is enhanced:
  - When it is provided close to when and where it is needed
  - Adult learning principles, i.e., hands on, repeated instances, affects area of value to students, interactive
    - In the gemba (where the work is done)
    - Team-based
    - Opportunities to learn from fellow students
    - Okay not to be an expert on Day 1
- Pace and depth of change must escalate
  - Must spread from existing improvements (don't remake the wheel)
  - While still creating opportunities for organic learning and recognizing local differences

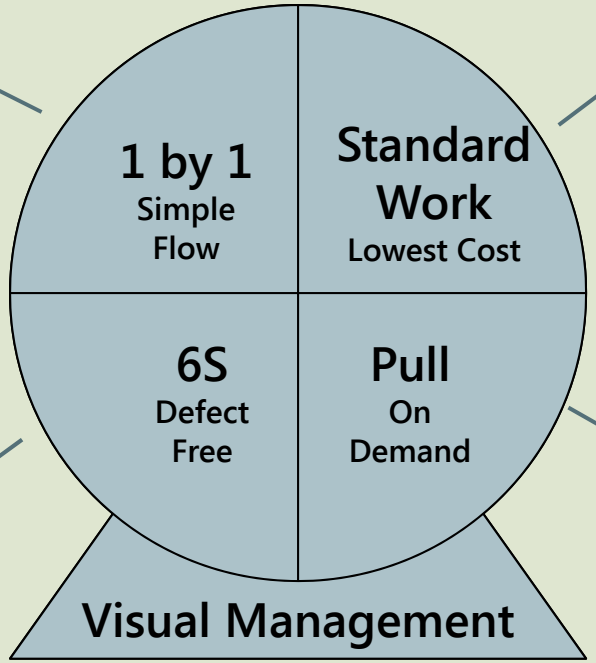
TARGET STATE

- Silver – Level III Breakthrough Certification – develops teams to conduct major improvement activities at facilities:
  - Format Change:
    - Group training, prep work and individualized coaching: 3 days
    - One week of multiple-team RIE blitz (reduced total training time by 2 days)
  - Multiple flow cells operationalized in the gemba by week end
  - Promotes area-wide standardization and best utilization of resources
  - Fully aligned to value streams critical to achievement of strategic goals
  - Provided on-demand, when and where needed
  - Students come from within the value stream or the facility where training is happening
  - Condensed schedule (from 10 to 7 days)
  - Significant customer and supplier input from students and Breakthrough staff from all facilities
  - Focus on quantitative results: students able to use and teach tools, subject focus enables or directly affects value stream outcomes
- Since then:
  - 8 Training sessions in one year
  - 67 people trained
  - Increasing pull from leadership groups, demand up 100%

RAPID EXPERIMENTS AND NEW MODEL IMPLEMENTED – 8 SESSIONS

Link to Strategic Initiative	Value Stream	Area	Facility
Access Patient Experience	Ambulatory Care	Adult Primary Care	Woodhull
			Queens
			Lincoln
		Women's Health	Gouverneur
Patient Experience	Perioperative Services	Central Sterile Services	Jacobi
			Bellevue
Patient Experience Financial Stability	Acute Care	Echo & Stress Labs	Bellevue
Patient Experience Financial Stability	Long Term Ventilation Patients	Unit 4 West	Carter

FLOW CELL OVERVIEW



Only handle information once
Only move the patient once
No batching

Reduce variation and errors:
--Optimal work sequence
--Produce at the pace of demand
--Resource to demand

Optimize the environment:
--Sort
--Set for flow
--Scrub
--Safety
--Standardize
--Sustain

Produce only when the next step in the process is ready
--No "pushing"
--Tight connections between steps

Make normal vs abnormal visible:
--Transparency in expectations and results
--Ongoing tracking and improvements

BELLEVUE HOSPITAL

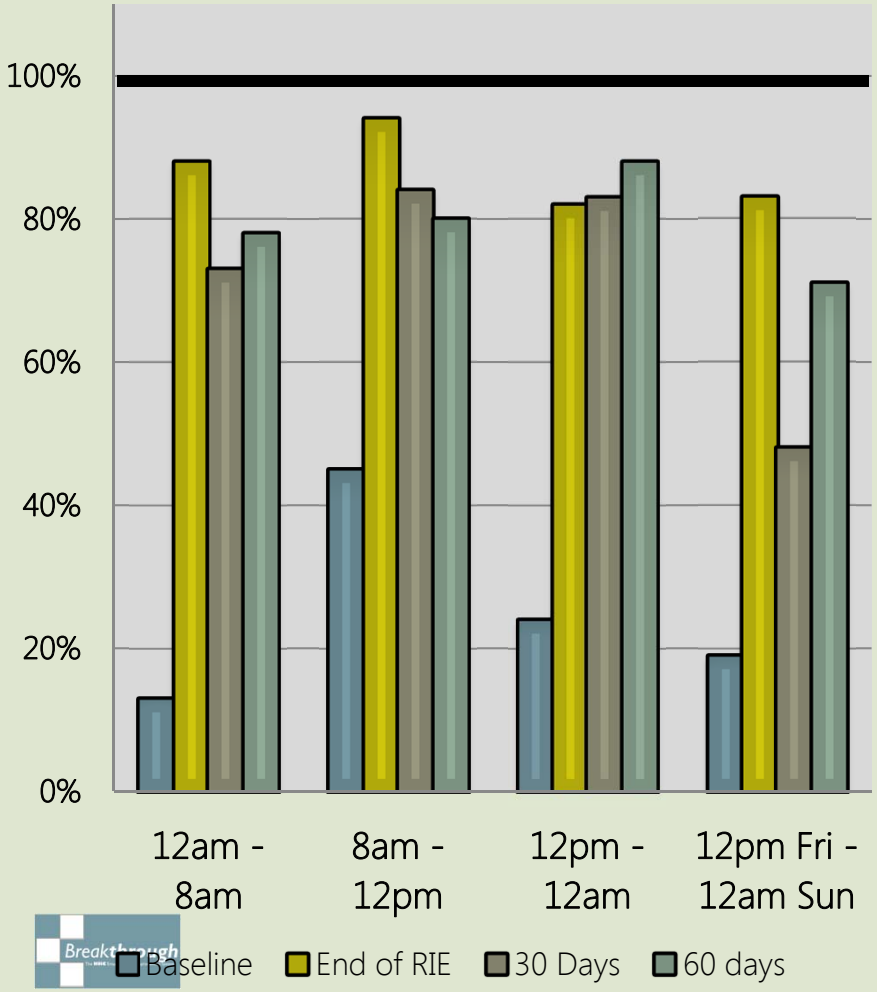
Acute Care Value Stream - Improvement in Echo and Stress Labs

BEFORE

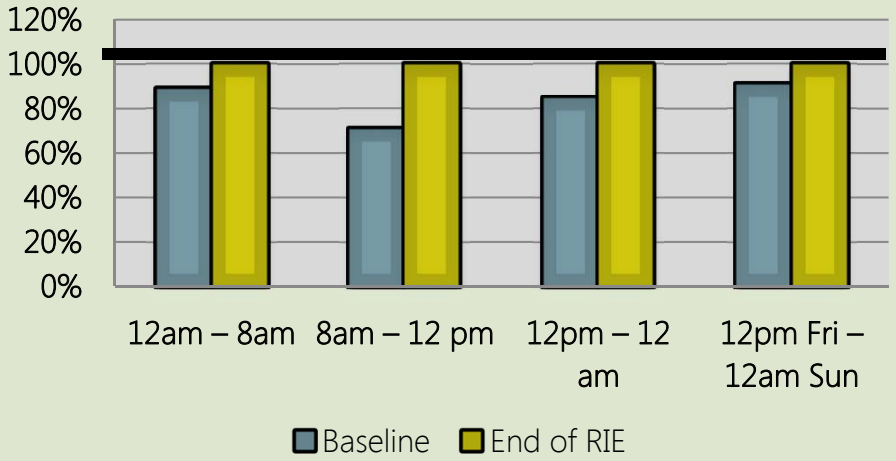
- Long wait times for inpatient patients to have echocardiogram tests done
- Incomplete orders in physicians' queues at day's end
- Outpatients scheduled in the morning, taking up time slots for pending inpatients
- 47% of physicians dissatisfied with turnaround time for echo
- 65% of physicians dissatisfied with turnaround time for stress
- Long response time is a significant contributor to length of inpatient stay

RESULTS

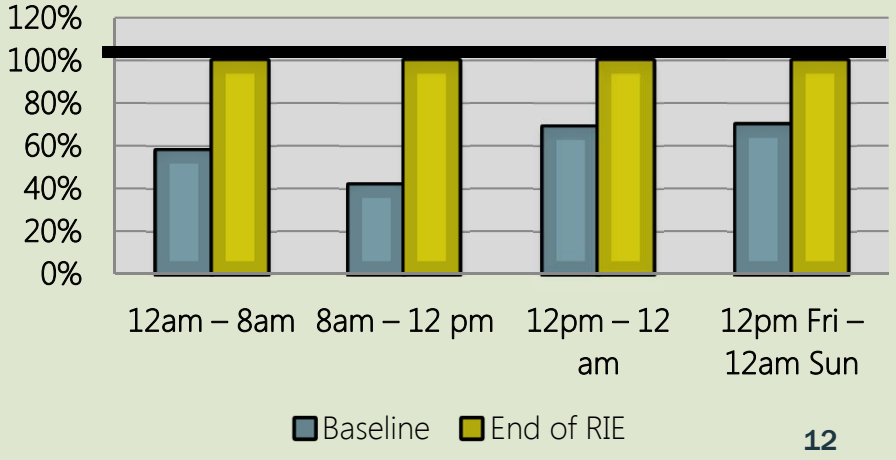
Echocardiogram on-time completion



Regular Stress on-time completion

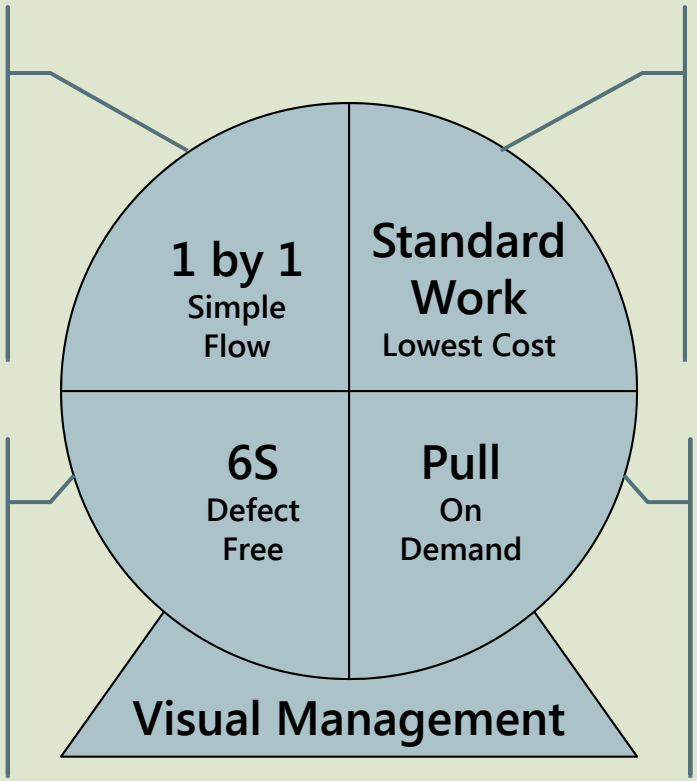


Nuclear Stress on-time completion



FLOW CELL DEVELOPMENT

- One by one flow, one-directional flow for inpatients
- Patients transported in the appropriate transport vehicle to eliminate congestion



- Standard Work for:
  - Head sonographer handoff of inpatient orders
  - PCB huddles and upkeep
  - PCT/Escort retrieving patients from unit
  - Clerk filing new inpatient files
  - Clerk determining mobility status of inpatient for transport

- Pre-packaged gowns with inventory levels
- Pre-packaged charts and optimized placement for clerical staff
- Organizing files alphabetically instead of by date
- Organized stress lab area

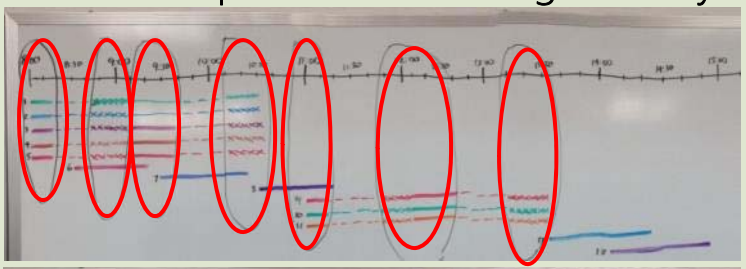
- Pull system to move patients and staff using green/red visual cards
- Move outpatients to the afternoon hours so pending inpatient orders can be processed in the morning

- Visual Process Control Board to see progress of work
- Visual management for placement and indication of patient status throughout the process and measuring target result time

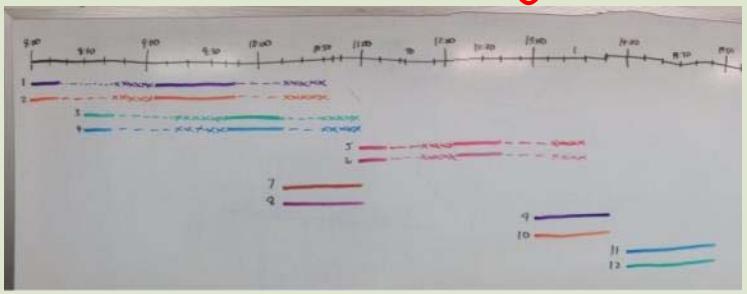
KEY CHANGES

Stress Lab patient flow throughout day

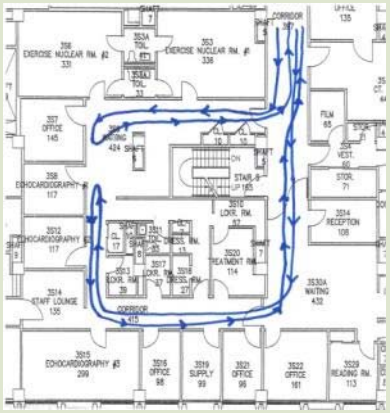
Before



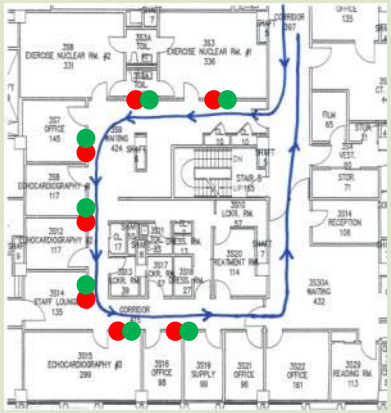
After



Before



After



Before...

On average
~ 6 mins/patient chart

After...

On average
~ 3 mins/patient chart

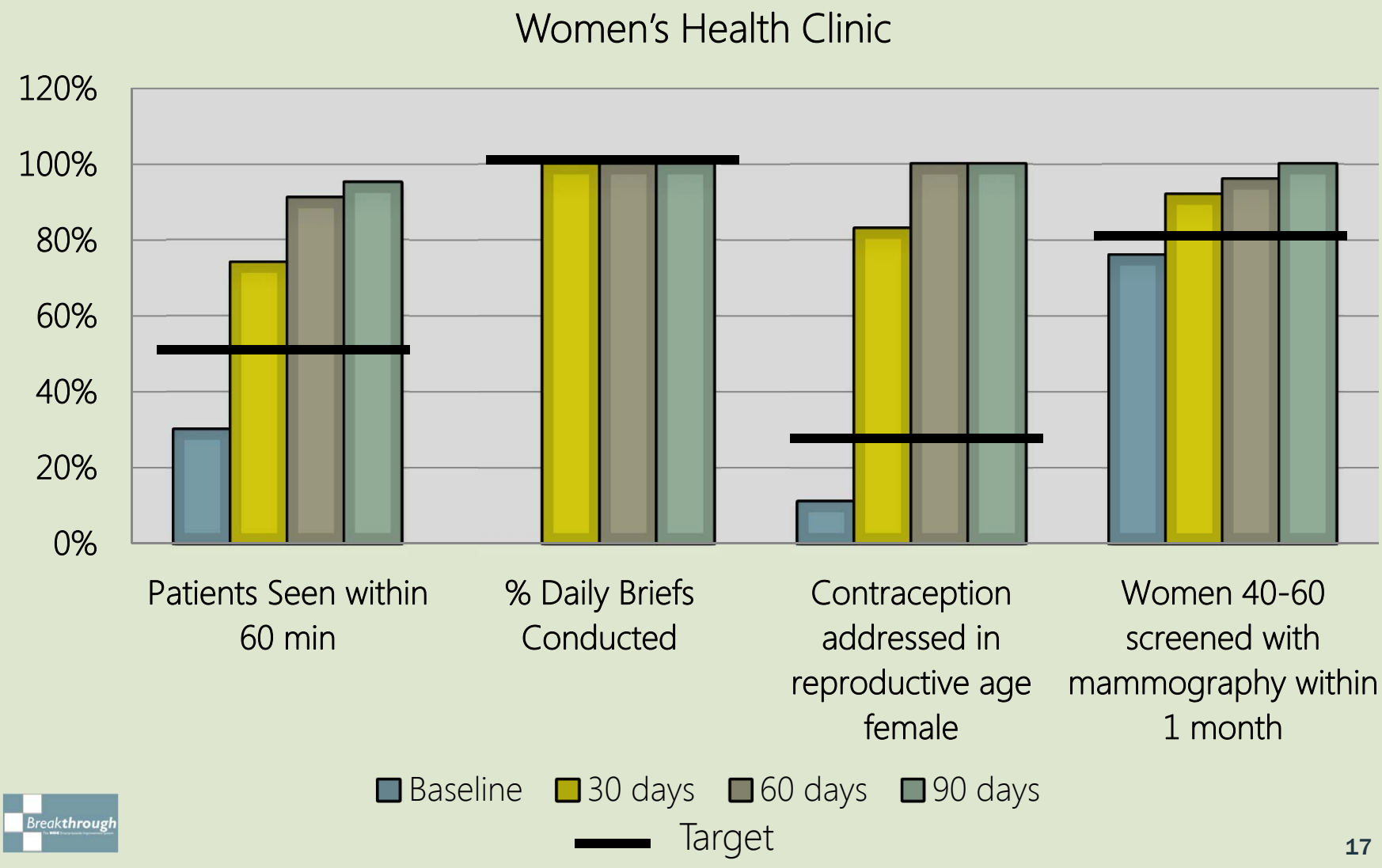
GOUVERNEUR HEALTH

Women's Health Clinic

BEFORE

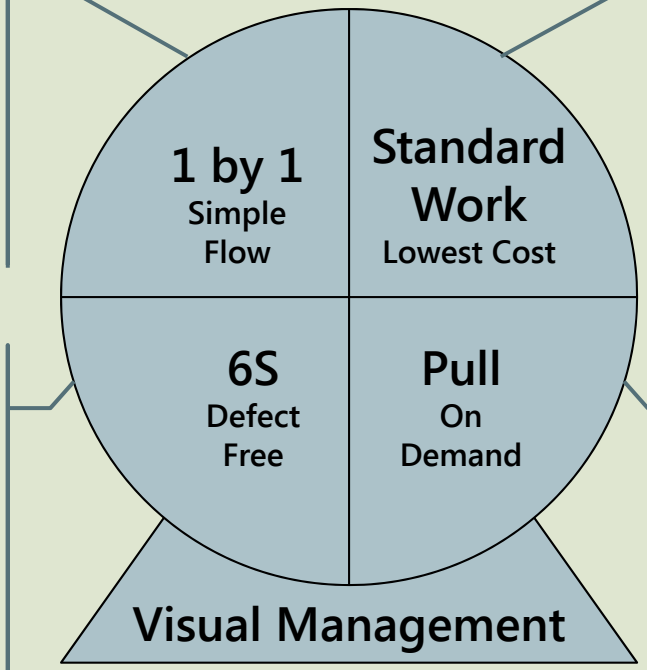
- Both patients and staff were often confused and frustrated by long waits, uneven work burdens, and a high degree of variation:
  - Excessive waiting
  - Rework – multiple staff asking for the same information
  - Each provider or support staff did similar tasks differently
  - Poor visibility re the status of any one staff person or patient
- No standardized clinical protocol for the well woman visit, potentially extending cycle time and duplicating effort, while not providing a fail-safe for preventive services

RESULTS


Women's Health Clinic
120%
100%
80%
60%
40%
20%
0%
Patients Seen within 60 min
% Daily Briefs Conducted
Contraception addressed in reproductive age female
Women 40-60 screened with mammography within 1 month
Baseline
30 days
60 days
90 days
Target

FLOW CELL DEVELOPMENT

- Geographic patient-centeredness in the clinic. Procedures done in the same exam room (pregnancy, HIV tests, etc)
- Clerical functions performed by the RNs minimized, more quality time spent with patients



- Team members' roles and functions defined to maximize staff productivity and reduce patient flow time
- Teams integrated to support department and patient centered flow
- Defined and Staffed teams by Demand

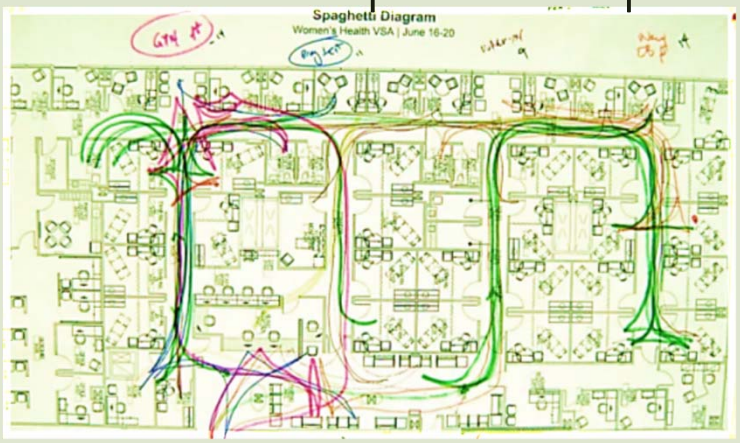
- Standards for room organization. All supplies and equipment are where needed and fully functioning (LARC, microscope, fetal monitor, scales, thermometer)
- Created procedure kits
- WOWs located where needed

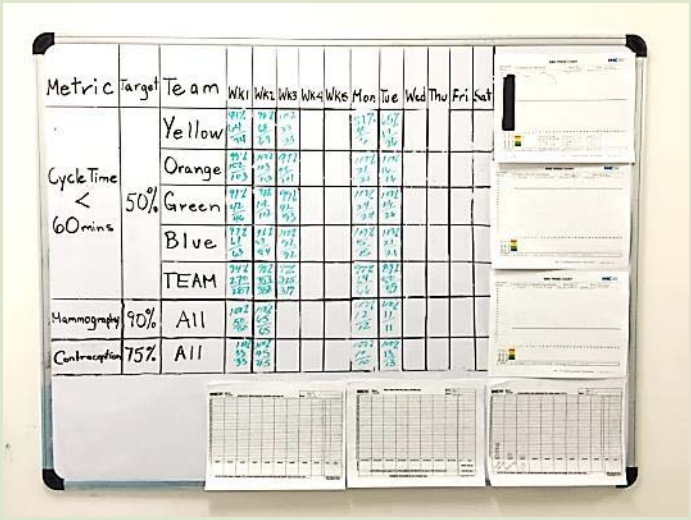
- Patients brought to one room, staff members swing rooms using color triggers
- Established supplies inventory standards, new par levels and replenishment system

- Created a Process Control Board to track metrics
- Daily morning briefs to discuss previous day and today's activity

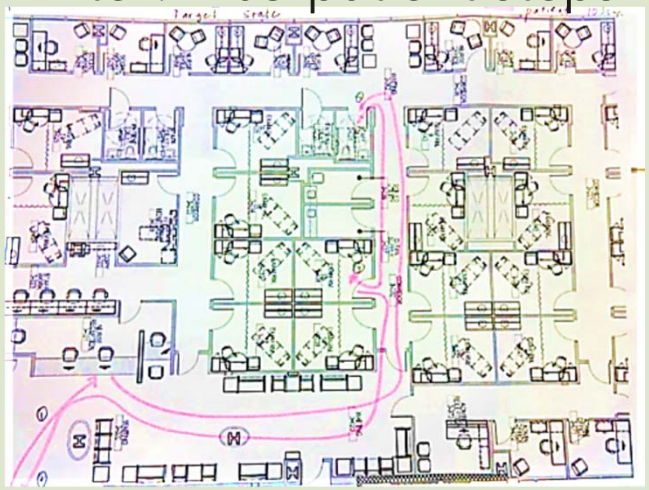
KEY CHANGES

Before: 176 patient steps





After: 103 patient steps



Supplies replenishment system

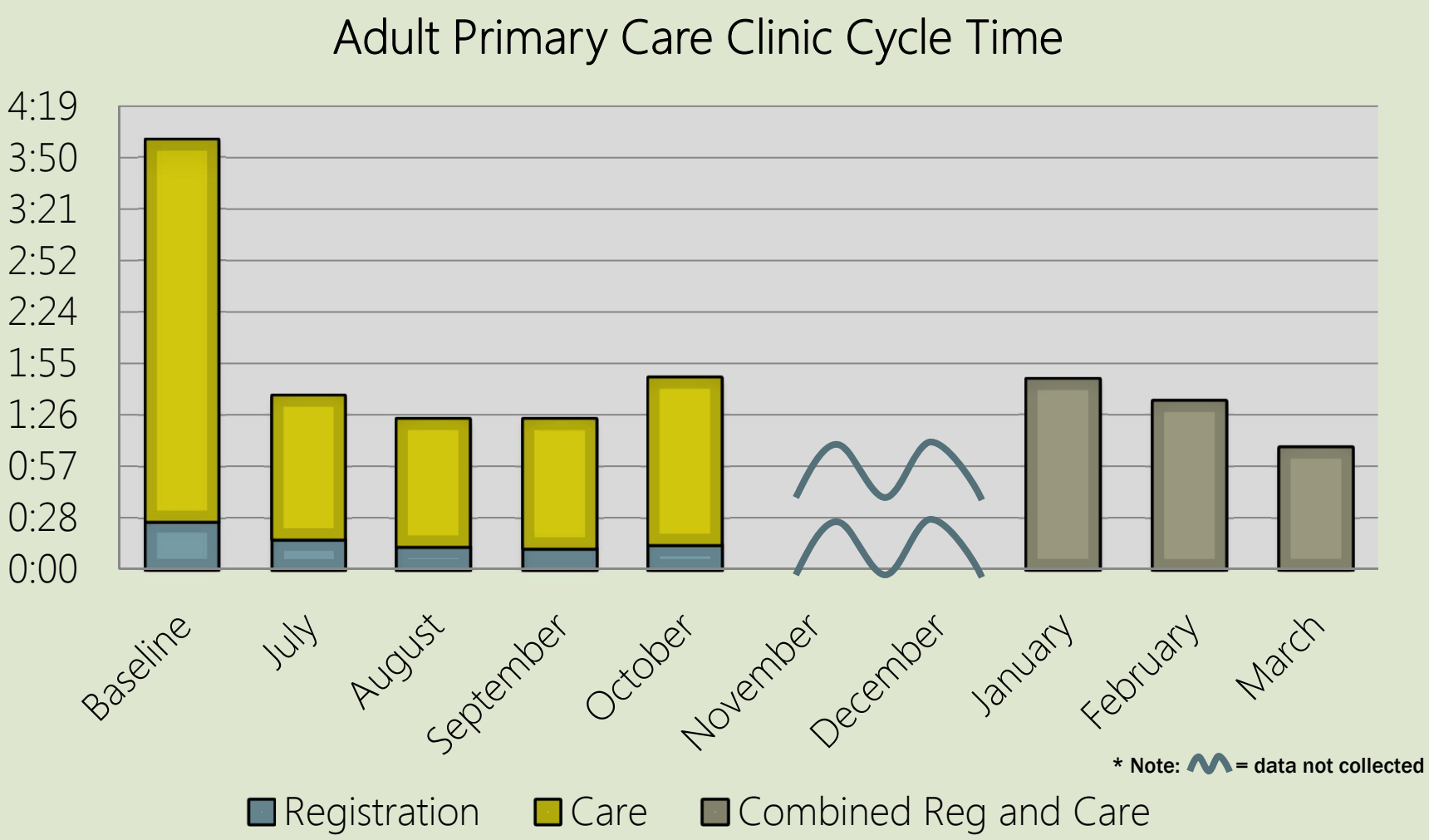
QUEENS HOSPITAL CENTER

Adult Primary Care Clinic

BEFORE

- No visual management guiding the process
- There are no pull systems for treatment process. Staff "pushed" patients from one process to the next regardless of readiness
- Dwell time of registration was extensive, the process was cumbersome and siloed
- Care was interrupted each time a new room was needed
- Staff had to leave exam rooms throughout the day to get basic supplies due to inefficient stocking of supplies in each treatment room, creating multiple interruptions and adding to total flow time
- Patient was moved multiple times to the waiting room between treatment phases
- Space was not optimized for flow

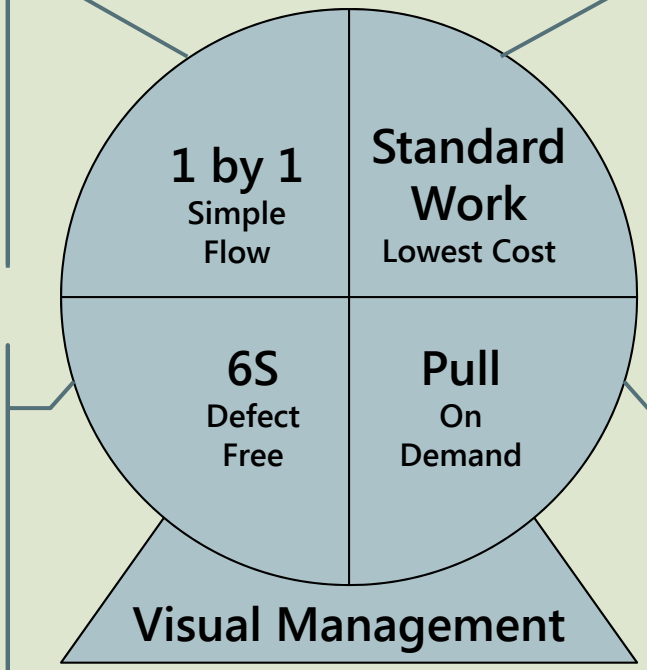
RESULTS


Adult Primary Care Clinic Cycle Time
4:19
3:50
3:21
2:52
2:24
1:55
1:26
0:57
0:28
0:00
Baseline
July
August
September
October
November
December
January
February
March
* Note: = data not collected
Registration
Care
Combined Reg and Care

FLOW CELL DEVELOPMENT

- Cell concepts introduced in Green Team in which providers use swing room to provide care

- 6S a "Model" Treatment room and 2 "model" RN room with everything labeled with pictures of what it should look like. Later introduced to the rest of the clinic
- End of shift replenishment system



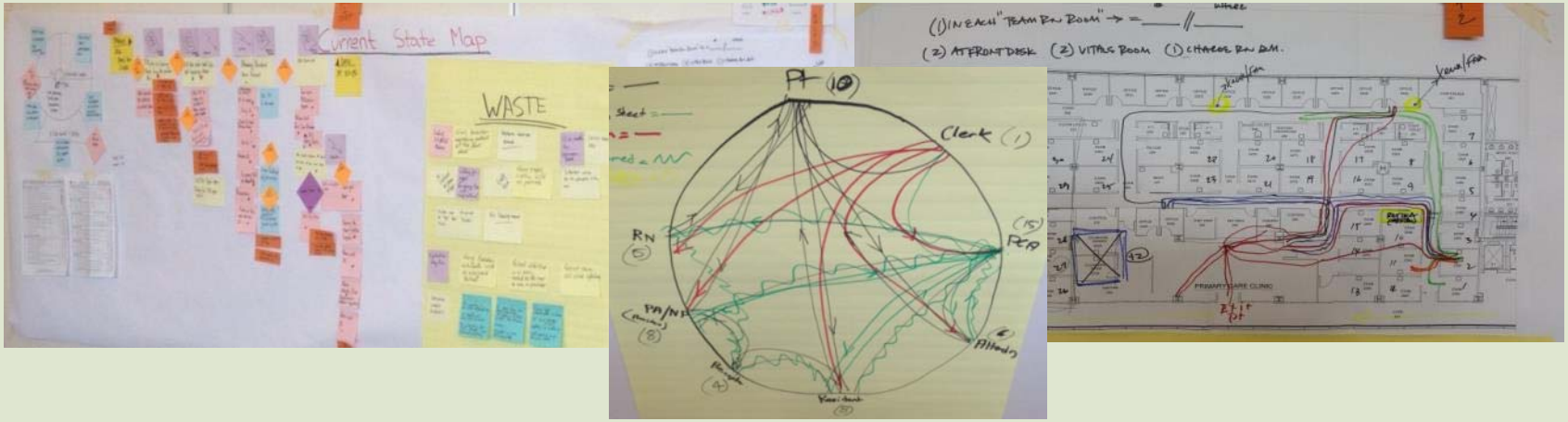
- Cross-trained all registration staff
- Standardized work was created for each discipline and posted where the work is being done (pilot: green Team)

- Room flag system to improve flow

- Process Control Board to understand and manage flow
- Soarian chart "ready" trigger included in the standard work and flag system installed in the model treatment rooms

KEY CHANGES

Before…



After…

Patient Centered Approach:

-Patient in the middle
-Purple represents care
-Pink represents equipment
-Green represents all Disciplines involved
-Blue represents pull systems in place

NEXT STEPS

- Bring more students to Silver earlier in their development
- Ensure that all value streams include flow cell development and have opportunities for Silver
- Use Silver as a tool to achieve enterprisewide project outcomes more quickly
- Create prescribed models to deliver flow improvement for different value streams
- Ensure Silver improvements are sustained through DMS
- Apply learning to Gold and Platinum courses