AGENDA

MEDICAL AND PROFESSIONAL AFFAIRS COMMITTEE

Meeting Date: February 11th, 2016
Time: 9:00 AM
Location: 125 Worth Street, Room 532

BOARD OF DIRECTORS

CALL TO ORDER — **DR. CALAMIA**

ADOPTION OF MINUTES
January 14th 2016

CHIEF MEDICAL OFFICER REPORT — **DR. WILSON**

METROPLUS HEALTH PLAN — **DR. SAPERSTEIN**

INFORMATION ITEM:

1) OneCity Health — **DR. JENKINS**

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

MINUTES

MEDICAL AND PROFESSIONAL AFFAIRS/ INFROMATION TECHNOLOGY COMMITTEE BOARD OF DIRECTORS

Meeting Date: January 14th, 2016

ATTENDEES

COMMITTEE MEMBERS

Vincent Calamia, MD, Committee Chair
Lilliam Barrios-Paoli, Chair
Josephine Bolus, RN
Barbara A. Lowe, MS, RN
Ram Raju, MD President
Hillary Kunins, MD (representing Dr. Gary Belkin in a voting capacity)

HHC CENTRAL OFFICE STAFF:

Machelle Allen, MD, Deputy Chief Medical Officer, Office of Health Care Improvement
Chalice Averett, Director, Office of Internal Audit
PV Anantharam, Senior Vice President, Finance
Janette Baxter, Senior Director, Risk Management
Charles Borden, Senior Assistant Vice President, Quality
Nicholas Cagliuso, PhD, MPH, Assistant Vice President, Office of Emergency Management
Victor Cohen, Assistant Vice President, Corporate Pharmacy
Kenra Ford, Assistant Vice President Clinical Lab Operations/M&PA
Juliet Gaengan, Senior Director, Quality, Medical and Professional Affairs
Lucinda Glover, Senior Director, Medical and Professional Affairs
Sal Guido, Acting Chief Information Officer, Enterprise Information Technology System
Colicia Hercules, Chief of Staff to the Board Chair
Lauren Johnston, Senior Assistant Vice President, Office of Patient Centered Care
Michael Keil, Assistant Vice President, Enterprise Information Technology Services
Patricia Lockhart, Secretary to the Corporation
Ana Marengo, Senior Vice President, Communications & Marketing
Antonio Martin, Executive Vice President and Chief Operating Officer
Ian Michaels, Media Director, Communication and Marketing
Deirdre Newton, Senior Counsel, Legal Affairs
Salvatore Russo, Senior Vice President & General Counsel, Legal Affairs
Marisa Salamone Gleason, Assistant Vice President, Enterprise Information Technology System
Julie Shahroudi, Director, Primary Care Transformation, Medical and Professional Affairs
Jesse Singer, Senior Director, Medical and Professional Affairs
Eli Tarlow, Assistant Vice President, Enterprise Information Technology Services
Udai Tambar, Chief Transformational Officer, President Office
Madeline Tarvarez, Director, Office of Emergency Management, Medical and Professional Affairs
Diane E. Toppin, Senior Director Medical and Professional Affairs
Ross Wilson, MD, Senior Vice President/Corporate Chief Medical Officer, Medical& Professional Affairs

FACILITY STAFF:

Laura Evans, Bellevue Hospital Center
Bill Hicks, Executive Director, Bellevue Hospital Center
Nate Link, MD, Chief Medical Officer, Bellevue Hospital Center
John Maese, MD, Medical Director, Coney Island Hospital

John Maher, Associate Director, Bellevue Hospital Center
Anthony Rajkumar, Executive Director, Metropolitan Hospital Center
Arnold Saperstein, MD Executive Director, MetroPlus Health Plan

OTHERS PRESENT:
Moira Dolan, Senior Assistant Director, DC37
David Hoffman, Compliance Officer, PAGNY
Shaxlee Wheeler, Analyst, OMB
Alexander Shermansong, Consultant, Civic Consultant

MEDICAL AND PROFESSIONAL AFFAIRS COMMITTEE
Thursday, January 14, 2016

Dr. Vincent Calamia, Chair of the Committee, called the meeting to order at 9:00 AM. The minutes of the December 3, 2015 Medical & Professional Affairs/IT Committee meeting were adopted.

CHIEF MEDICAL OFFICER REPORT
Ross Wilson MD, Senior Vice President/Corporate Chief Medical Officer, reported on the following initiatives.

K2
Updated K2 reporting through 1/1/16 from NYC H+H emergency services.
Continued significant decreases overall, with a 60% system-wide decrease since the end of November and a greater than 70% decrease from early October. Woodhull continues to play a significant role in our overall count, with a dramatic drop off, to almost no cases, in the most recent week reported.

Behavioral Health
The Office of Behavioral Health is focusing on readiness for managed care and the start of HARP services as of January 1, 2016. The transformation efforts are focused on the following: Increasing ambulatory access in behavioral health, analyzation of high utilizer data to design interventions to reduce acute care utilization, readiness and implementation of HCBS services for HARP eligible patients, and integration of behavioral health and primary care services. These efforts are being coordinated with One City Health and DSRIP objectives. Transformation includes the work and involvement of Health Home and Ambulatory Care transformation.

The Office of Behavioral Health with Ambulatory Care, Women's Health and Pediatrics is developing the ability to screen for depression in pregnant women from prenatal through the postpartum aspects of delivery. This is part of the Mayor's Office city-wide initiative. NYC Health + Hospitals is one of the pilot systems to develop and implement the practice that will be spread across all city agencies.

The Office of Behavioral Health is coordinating a work group related to the management of violence. This will involve the Councils of Emergency Medicine and Psychiatry as well as other identified staff from facilities. The goal is to review the current state of resources, assessment and management of violence, review other best practices, and establish additional tools and interventions for the management of violence in HHC. A significant aspect of this work is the reduction in staff injuries. The OBH has initiated a "real-time" tracking mechanism to capture all staff injuries related to patient care in Behavioral Health. Information is reported to the Chief Medical Officer.

ACO
In December 2015 the ACO distributed $1.3 Million in 2014 shared savings payments to primary care physicians. Under a new incentive formula, 75% was awarded to PCPs according to their participation (FTE), with the remaining 25% based on patient satisfaction and hypertension control quality performance.

NYC Health + Hospitals has also dedicated nearly $300,000 of its shared savings to an ACO Team Fund that rewards the multidisciplinary teams that manage ACO patients. Under the stewardship of each local ACO Lead, funds will be dedicated to engagement, training, and/or workplace enhancements, as agreed up on by the team members.

The NYC Health + Hospitals' Board of Directors, sitting as the sole Member of the ACO, convened in January to elect ACO Directors for 2016. Community Healthcare Network, a large FQHC partner, has joined the ACO effective January 1st.

The Q4 2015 performance improvement project focused on reducing avoidable ED visits and inpatient admissions for a panel of 200 high-risk patients per hospital. Now that the performance period has concluded, the ACO is working with hospital teams to collect, analyze, and evaluate process and outcome data, and prepare for presentations to the NYC Health + Hospitals QA Committee.

The ACO partnered with Coney Island and Cumberland to host in-person focus groups with high-risk patients in December. The groups provided candid feedback about their experience at NYC Health + Hospitals and common barriers to care, which is being fed back to local leadership and the Office of Patient Centered Care. The ACO seeks to conduct additional focus groups at with remaining sites in 2016.

Flu
The flu season has not yet been declared by the state Health Commissioner, but ED visits with influenza like symptoms is starting to increase according to the DOHMH surveillance. There is a continuing campaign to increase vaccination rates for H+H staff, with currently more than 28,000 people having been vaccinated. Queens Hospital, Gouverneur, Cumberland, Seaview and Renaissance all have rates over 90%. Non-vaccinated will have to wear a mask as soon as the flu season is declared, consistent with the NY state regulation.

METROPLUS HEALTH PLAN, INC.
Arnold Saperstein, MD Executive Director, MetroPlus Health Plan Inc. Presented to the Committee. Dr. Saperstein informed the Committee that the total plan enrollment as of December 1, 2015 was 476,002. Breakdown of plan enrollment by line of business is as follows:

Medicaid	415,059
Child Health Plus	12,385
MetroPlus Gold	3,734
Partnership in Care (HIV/SNP)	4,534
Medicare	8,458
MLTC	938
QHP	22,265
SHOP	753
FIDA	179
HARP	7,697

The State's system currently has as its default choice that individuals not be automatically re-enrolled; they have to enter the State of Health system and make a selection for the new year. As a result, as of the date of this report, there is not sufficient information to determine the exact membership for January 1, 2016. Further, many individuals could be re-enrolled but because of some change in their income, unless they log into their account and verify their current income, they risk losing all their Advanced Payment Tax Credits which will raise their premiums substantially. As of the day of this writing, there are over 18,000 applicants who are currently in pending status due to the default set by the State; they will need to reverify and then pay their premiums before being activated.

In addition to our work for open enrollment, which continues through the end of January, we have conducted several efforts to retain our existing QHP members. We have done outreach through e-mail blasts, live phone calls and letters to both groups of individuals. Initial reports, through calls from our customer service line and people clicking from our e mail message to the State of Health web site, lead us to be hopeful that it has been a successful effort.

I would also like to provide an update on several efforts we are starting or will shortly start in the new year. I am happy to report that we have received approval from the New York State Department of Health to market our Exchange (QHP)

and Essential Plan (EP) products on Staten Island. We have already hired and trained a team of marketing staff who are working on the Island. Ads in the ferry terminal and on the ferry will start on January 4th and we will be placing ads in the Staten Island Advance around that date.

Next, as you may know, Governor Cuomo recently signed legislation to allow women who become pregnant to purchase insurance through the Exchange after the open enrollment period closes. Individuals who lose their job or move or have a baby are among those who have always been allowed to purchase insurance and now women who are pregnant have the same opportunity. We will be modifying our materials and training our marketing staff on this change.

We have begun marketing our products on Rikers Island to visitors to the Island. Currently every Friday marketing staff works with visitors who are interested in learning about health insurance options. We will be adjusting our presence over the next months based on our success.

In order to ensure better access to healthcare for our members assigned to NYC Health + Hospitals, we have been working closely with the division of Medical and Professional Affairs to redefine the auto-assignment algorithm. We are now able to obtain data listing providers with available panel capacity for each facility. This means that we are now able to avoid assigning new members to providers who are over-subscribed. This pilot has only been applied to Adult Medicine so far. We plan on expanding the new assignment algorithm to Pediatrics and Virology in the very near future.

INFORMATION ITEMS:

Nick Cagliuso, Assistant Vice President of Emergency management presented to the committee on the After Ebola: Three Ways We're Growing our Mission. NYC Health + Hospitals System-wide Special Pathogens* Program, Serving our patients; Region 2 Ebola and Special Pathogen Treatment Center; Serving our region; National Ebola Training and Education Center (NETEC); Serving our country; (*Highly infectious diseases).

There being no further business, the meeting was adjourned 10:30 AM.

CHIEF MEDICAL OFFICER REPORT

Medical & Professional Affairs Committee
February 11th, 2016

ACO

- The ACO reports to Medicare annually on 17 measures of clinical quality in the domains of care coordination/patient safety, preventive health, and at-risk populations. The 2015 process, which began in January and will conclude mid-March, draws upon data extracted from medical records through IT reports and manual chart review. The ACO is currently engaged in significant activity to coordinate IT exports as well as to train and support quality management teams.
- NYC Health + Hospitals committed nearly $300,000 of its 2014 shared savings to an ACO Team Fund dedicated to the multidisciplinary teams that manage ACO patients. Each team submitted a proposal for the use of their funds, which was reviewed and approved by local and central leadership. Over the next two months, our care teams will participate in engagement and staff appreciation events, population health training, and workplace enhancement activities across the enterprise.
- The Q4 2015 Board Quality Assurance Committee performance improvement project focused on reducing avoidable ED visits and inpatient admissions for a panel of 200 high-risk patients per hospital. Now that the performance period has concluded, the ACO is working with hospital teams to collect, analyze, and evaluate process and outcome data, and prepare for presentations highlighting their findings from one of the most in-depth reviews ever conducted of high risk 'super-utilizer' patients.

Behavioral Health

- The Office of Behavioral Health is focusing on readiness for managed care and the start of HARP services as of January 1, 2016. The transformation efforts are focused on the following: Increasing ambulatory access in behavioral health, analyzation of high utilizer data to design interventions to reduce acute care utilization, readiness and implementation of HCBS services for HARP eligible patients, and integration of behavioral health and primary care services. These efforts are being coordinated with One City Health and DSRIP objectives. Transformation includes the work and involvement of Health Home and Ambulatory Care transformation.

- Improved adult mental health access: Over the past 6 months, our adult mental health practices have made a concerted push to improve their scheduling practices, measure their appointment access data more effectively. Nearly all practices are now able to track their access metrics in an automated way. Appointment wait times also fell during this period as well.

- The Office of Behavioral Health along with Ambulatory Care, Women's Health and Pediatrics is working on implementation of a process to screen for depression in pregnant women from prenatal through the postpartum aspects of delivery. This is part of the Mayor's Office city-wide initiative. NYC Health + Hospitals is one of the pilot systems to develop and implement the practice that will be spread across all city agencies. Pilots are focused at Elmhurst, Queens, and Coney Island and scheduled for February.

Office of Ambulatory Care Transformation (OACT)

- **M&PA, in collaboration with ambulatory care leadership at each of our sites, has developed (for the first time) a centralized database on primary care staffing and team structures.** This was launched in Adult Medicine two months ago, and has already enabled a range of centralized analyses and outputs, including for example: a comprehensive analysis of panel size across primary care; a way to calculate and refresh our staffing shortage; a database Metroplus can use to steer new members to the providers with more availability; and a centralized way to calculate performance incentives for our affiliate contracts.

- **In the Collaborative Care for Depression Program, Quarter 4 2015 results demonstrated significant improvement.** The average percentage of patients of who showed clinically significant improvement in their depression increased from 17.7% in Q2/2015 to 44.7% in Q4/2015. The program also continues to maintain high screening rates: 90.7% of patients seen in adult medicine are screened for depression. This continuous improvement in patient care and outcomes can be attributed to strong collaboration and communication between OACT and facility teams, particularly around standardization of workflows across sites and utilization of data to drive high quality patient care.

- **249 staff across 15 of our 17 major primary care sites completed Team-Based Care Coordination Trainings facilitated by the Greater New York Hospital Association.** Care teams learned the fundamental, evidence-based concepts for building an effective care coordination process to achieve improved outcomes.

- **A consolidated Brooklyn call center for appointments is now live.** As of December, patients calling four of our Brooklyn facilities for appointments or general questions reach a single, 24/7, multi-language, multi-site scheduling in place, with calls answered within 30 seconds. This was implemented at little/no incremental cost, and without any of our new enterprise IT systems. The purpose was to serve as a proof of concept that our business processes can be streamlined and simplified in a way to achieve better scale and enable better call center services. Similar consolidation efforts are planned in other boroughs over the next 6 months.

DSRIP

OneCity Health continues to move forward with implementing its selected clinical projects as part of New York State's Delivery System Reform Incentive Payment (DSRIP) program and is on track to distribute funds to partner organizations, beginning with Community Based Organizations (CBOs), in February.

The details of our DSRIP planning is the subject of today's Board discussion; complete information is included in this meeting's information package.

IMSAL

Woodhull Operating Room Simulation to strengthen team work during an emergency (cardiac arrest prior to the commencement of surgery). Twenty-nine OR staff participated in the program. Using simulation methods including effective debriefing, and reinforcing prior Teamstepps training. Many issues were identified for attention from local leadership and staff.

This is consistent with the IMSAL approach of aligning the programs to the current practical needs of the particular facility or clinical area and delivering on those sites, as much as is possible.

Office of Population Health

- H+H received over $600,000 in funds from City Council to increase access to colorectal cancer screening. Sites will be utilizing these funds to increase access to colonoscopies for uninsured patients and to enhance patient education on the importance of screening.

- Health Leads program has screened over 10,000 families for social resource needs over the last 5 months. One of the most common resource needs was food-related and we are beginning to explore ways to streamline referrals to SNAP for our patients. A 6

month pre-post evaluation of the Health Leads program began in collaboration with researchers at NYU.

- Sites completed diabetes performance improvement projects over the last 3 months and H+H saw an improvement in diabetes control rates over this time period. Over the next few months, sites will be participating in hypertension performance improvement projects.

MetroPlus Health Plan, Inc.
Report to the
HHC Medical and Professional Affairs Committee
February 11, 2016

Total plan enrollment as of January 1, 2016 was 486,928. Breakdown of plan enrollment by line of business is as follows:

Medicaid	402,224
Child Health Plus	12,878
MetroPlus Gold	4,474
Partnership in Care (HIV/SNP)	4,498
Medicare	8,374
MLTC	974
QHP	15,796
SHOP	858
FIDA	187
HARP	7,563
Essential Plan	29,102

The January 1st Medicaid and Exchange (QHP) membership has changed significantly from the last report to this committee. All Medicaid Aliessa members and QHP members that have incomes between 138 and 200 percent of Federal Poverty level were transferred into the new product line, the Essential Plan (EP). Of the 29,102 EP members with an effective date of January 1, 2016, 50% represent transfers from Medicaid (14,743), 16% are transfers from QHP (4,898). The remainder are mostly new members.

The change in the total membership since the last report to this committee shows a growth of 10,000 members. The attached reconciliation report reveals an enrollment of 55,286 members (out of which 60% are new members to MetroPlus), and a disenrollment of 45,410 (out of which 53% were internal transfers to another MetroPlus product, and 47% were involuntarily disenrolled due to loss of eligibility, members moving out of the service area, etc).

Enrollment into the Essential Plan is ongoing year-round. Our staff has been working around the clock outreaching to thousands of members up for renewal and assisted those who had to verify their income eligibility via the NYSOH portal. The outreach efforts resulted in us reaching 89% of the target population. We received close to 18,000 payments over the last few weeks as a result of our outreach campaign.

It is important to note that the increase in the MetroPlus Gold membership from 2015 to 2016 (a total of 24% or 845 members) is comprised of increased enrollment of H+H employees, as well as enrollment from numerous NYC agencies including the Department of Social Services, NYPD and Department of Education staff.

When comparing the January 1, 2015 membership to that of January 1, 2016, we notice an overall increase of 5%. Individual line of business membership has fluctuated throughout the year as a result of new enrollment and various enrollment periods, introduction of new products, transfers of members among product lines, and evidently disenrollments.

We are continuing the aggressive marketing and retention campaigns we have embarked on in the recent months, and are also developing new initiatives and products to enhance growth this coming year.

In addition to focusing on membership, we have been working with multiple PPSs on the new Value Based Equity Infrastructure (EIP) and Equity Performance Programs (EPP) under DSRIP, as assigned by the Department of Health. The programs are still in the incipient set-up phase where each PPS is electing its deliverables. We will inform this committee as this project progresses.

We are also working with OneCity Health to identify a plan of action on how MetroPlus will help to administer the Patient Activation Measure (PAM) surveys within the H+H facilities.

A discussion between various associations and DOH took place earlier this week on the suite of managed care rate cuts in the Executive Budget. Most of the call was focused on the Medical Loss Ratio (MLR) proposal. Essentially, DOH looked at those mainstream plans in 2014 that had profits over 3.5% to come up with the proposed scoring of $62M in savings in the budget. It is their intention to apply the rate cuts through a minimum MLR or 89.5%, which they calculated as a 7% admin plus 3.5% profit/surplus allowance. DOH needs to hit the savings target, but they seem willing to work with the industry to come up with a reasonable implementation plan.

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

January-2016

		Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16
Total Members	Prior Month	472,101	473,028	470,462	470,570	471,786	472,804	477,052
	New Member	18,306	17,427	18,543	19,921	21,151	20,912	55,286
	Voluntary Disenroll	1,487	1,547	1,795	1,560	1,890	1,760	1,930
	Involuntary Disenroll	15,892	18,446	16,640	17,145	18,243	14,904	43,480
	Adjusted	-4	28	87	215	891	1,847	0
	Net Change	927	-2,566	108	1,216	1,018	4,248	9,876
	Current Month	473,028	470,462	470,570	471,786	472,804	477,052	486,928
Medicaid	Prior Month	416,201	417,717	416,330	417,077	416,955	416,090	416,694
	New Member	16,435	15,830	16,713	16,367	16,974	15,135	16,012
	Voluntary Disenroll	992	946	1,138	973	1,309	1,156	911
	Involuntary Disenroll	13,927	16,271	14,828	15,516	16,530	13,375	29,571
	Adjusted	-2	31	87	190	823	1,683	0
	Net Change	1,516	-1,387	747	-122	-865	604	-14,470
	Current Month	417,717	416,330	417,077	416,955	416,090	416,694	402,224
Child Health Plus	Prior Month	12,338	12,239	12,064	12,063	12,174	12,420	12,456
	New Member	562	554	750	867	862	707	1,284
	Voluntary Disenroll	261	386	376	380	350	385	668
	Involuntary Disenroll	400	343	375	376	266	286	194
	Adjusted	-1	-1	-9	4	3	71	0
	Net Change	-99	-175	-1	111	246	36	422
	Current Month	12,239	12,064	12,063	12,174	12,420	12,456	12,878
HHC	Prior Month	3,603	3,629	3,650	3,722	3,781	3,826	3,845
	New Member	109	64	92	74	76	38	654
	Voluntary Disenroll	0	0	0	0	0	0	0
	Involuntary Disenroll	83	43	20	15	31	19	25
	Adjusted	3	4	14	27	76	101	0
	Net Change	26	21	72	59	45	19	629
	Current Month	3,629	3,650	3,722	3,781	3,826	3,845	4,474

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

January-2016

		Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16
SNP	Prior Month	4,737	4,705	4,682	4,636	4,638	4,590	4,536
	New Member	56	63	52	67	48	34	49
	Voluntary Disenroll	33	24	40	24	41	36	26
	Involuntary Disenroll	55	62	58	41	55	52	61
	Adjusted	-1	-1	-1	1	-1	1	0
	Net Change	-32	-23	-46	2	-48	-54	-38
	Current Month	4,705	4,682	4,636	4,638	4,590	4,536	4,498
Medicare	Prior Month	8,440	8,458	8,462	8,443	8,410	8,422	8,455
	New Member	366	322	302	238	297	293	344
	Voluntary Disenroll	185	191	209	169	190	183	308
	Involuntary Disenroll	163	127	112	102	95	77	117
	Adjusted	0	0	-1	-1	-2	-3	0
	Net Change	18	4	-19	-33	12	33	-81
	Current Month	8,458	8,462	8,443	8,410	8,422	8,455	8,374
Managed Long Term Care	Prior Month	894	882	867	869	895	923	936
	New Member	50	53	63	55	56	53	60
	Voluntary Disenroll	16	0	32	14	0	0	17
	Involuntary Disenroll	46	68	29	15	28	40	5
	Adjusted	-1	-1	-1	-3	-1	-2	0
	Net Change	-12	-15	2	26	28	13	38
	Current Month	882	867	869	895	923	936	974
QHP	Prior Month	25,268	24,759	23,757	23,117	22,546	21,874	21,495
	New Member	673	480	539	478	461	544	7,580
	Voluntary Disenroll	0	0	0	0	0	0	0
	Involuntary Disenroll	1,182	1,482	1,179	1,049	1,133	923	13,279
	Adjusted	0	-2	0	-1	-5	-2	0
	Net Change	-509	-1,002	-640	-571	-672	-379	-5,699
	Current Month	24,759	23,757	23,117	22,546	21,874	21,495	15,796

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

January-2016

		Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16
SHOP	Prior Month	522	502	473	459	451	464	766
	New Member	15	15	14	12	32	317	134
	Voluntary Disenroll	0	0	0	0	0	0	0
	Involuntary Disenroll	35	44	28	20	19	15	42
	Adjusted	-2	-2	-2	-2	-2	-2	0
	Net Change	-20	-29	-14	-8	13	302	92
	Current Month	502	473	459	451	464	766	858
FIDA	Prior Month	98	137	177	184	181	181	181
	New Member	40	46	18	8	5	6	15
	Voluntary Disenroll	0	0	0	0	0	0	0
	Involuntary Disenroll	1	6	11	11	5	6	9
	Adjusted	0	0	0	0	0	0	0
	Net Change	39	40	7	-3	0	0	6
	Current Month	137	177	184	181	181	181	187
HARP	Prior Month	0	0	0	0	1,755	4,014	7,688
	New Member	0	0	0	1,755	2,340	3,785	52
	Voluntary Disenroll	0	0	0	0	0	0	0
	Involuntary Disenroll	0	0	0	0	81	111	177
	Adjusted	0	0	0	0	0	0	0
	Net Change	0	0	0	1,755	2,259	3,674	-125
	Current Month	0	0	0	1,755	4,014	7,688	7,563
Essential Plan	Prior Month	0	0	0	0	0	0	0
	New Member	0	0	0	0	0	0	29,102
	Voluntary Disenroll	0	0	0	0	0	0	0
	Involuntary Disenroll	0	0	0	0	0	0	0
	Adjusted	0	0	0	0	0	0	0
	Net Change	0	0	0	0	0	0	29,102
	Current Month	0	0	0	0	0	0	29,102

OneCity Health

DSRIP Planning + Implementation Update

NYC Health + Hospitals Board of Directors

Medical & Professional Affairs Committee

Christina Jenkins, MD

CEO, OneCity Health Services

February 11th, 2016

NYC HEALTH+ HOSPITALS | ONECITY HEALTH

Executive Summary

- Our DSRIP program efforts are aligned with NYC Health + Hospitals' ongoing transformation. We will use the program to enable sustainability through growth, improved access to primary care, and improved patient experience

- We are nearing the close of DSRIP Year 1 (DY1; April 1, 2015 – March 31, 2016) and are now implementing projects at site level

- We will need a contracting strategy that positions us to increase our value-based purchasing arrangements. Right now, we will contract with DSRIP partners on basis of resource needs and contribution to meeting project/process milestones

- To date, we have earned 100% of potential funding ($148M). Significant risk will be present through year 2020
  - Performance risk – mitigated by proper implementation planning
  - Reputational risk – mitigated only by transparency and engagement

DSRIP Program Requires Both Clinical + Organizational Transformation

NYS DOH Implementation Plan Framework

Organizational Component

Governance*	Population Health Management
Workforce*	Clinical Integration
Financial Sustainability*	Performance Reporting
Cultural Competency*	Practitioner Engagement
IT Systems & Processes	

Project Plan Component*

Integrated Delivery System	
Health Home At-Risk	Diabetes
ED Triage	Asthma
Project 11	Palliative Care
Primary Care + Behavioral Health	MHSA
Cardiovascular	HIV

Budget & Flow of Funds

Planning and strategy work occurs through OneCity Health governance structures, with HHC as *fiduciary*

An HHC DSRIP Advisory Committee advises on implementation of organizational efforts, as appropriate

Standardized project planning occurs through OneCity Health governance structures and cross-partner workgroups

An HHC DSRIP Advisory Committee advises on NYC H+H facility-level implementation of clinical programs

**Asterisk denotes section ties to DSRIP payment*

DSRIP Performance Payments by Risk Tier

- Over 40% of performance payments will be difficult to earn
  - Higher-risk payments are largely outcomes related, thus highly dependent on site level + care management performance (and perhaps other PPSs)
  - Outcomes-related payments are also riskier because of the impact of performance measurement year, which lags the DSRIP year

- Knowing relative risk and distribution of performance payments informs program and funds flow planning

OneCity Health Maximum Performance Payments by Risk Tier, by Payment Year**

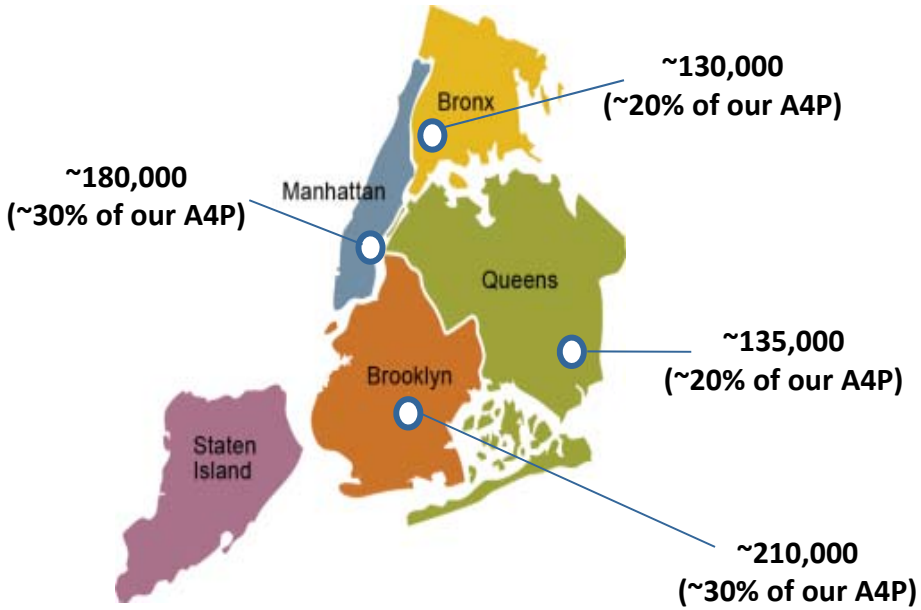
Relative Risk	5/15	2016	2017	2018	2019	2020	*Total*	Description
Low *received/state P4R*	$111	$31	$53	$50	$41	$30	***$315***	***Measures pulled by DOH in fulfillment of reporting requirements***
Medium *process milestones*	-	$37	$114	$138	$65	$5	***$359***	***Includes speed/scale commitments, org transformation efforts, and process and outcomes measures reported by CSO for P4R***
High *P4P*	-	$6	$31	$131	$177	$150	***$496***	***All pay-for-performance measures ($469) PLUS workforce targets through DY17***
Total	***$111***	***$74***	***$197***	***$319***	***$283***	***$185***	***$1,170***	

*** Derived from GYNHA DSRIP Payment Incentive Model, 4Q 2015*

OneCity Health and NYC PPS Attributed Populations (A4P)

OneCity Health PPS Attribution Estimate By Hub**
Attribution for Performance = 657K

NYC Health + Hospitals
Unique Patients Served, FY 2014: ~1.1 M



NYC Performing Provider Systems	Attribution for Performance
OneCity Health (HHC)	**657,070**
Advocate Community Partners	644,916
Community Care of Brooklyn (Maimonides)	448,420
Nassau-Queens PPS	417,162
Mt. Sinai PPS	364,804
Bronx Partners for Health Communities (St. Barnabas)	356,863
Bronx Health Access (Bronx Leb)	142,054
Brooklyn Bridges (NYU-Lutheran)	116,211
New York Presbyterian PPS	88,886
Staten Island PPS	76,295
New York Presbyterian Queens PPS	29,627

***Estimates derived from November 2014 NYS DOH attribution and do not include the uninsured, currently estimated at ~475K people citywide*

OneCity Health Network: ~1,100 Sites and ~12,000 Providers

Manhattan	
Inpatient/Hospital	3
Primary Care	69
Outpatient BH	78
Long-Term Care	26
Pharmacy	16
Social Services/CBOs	132

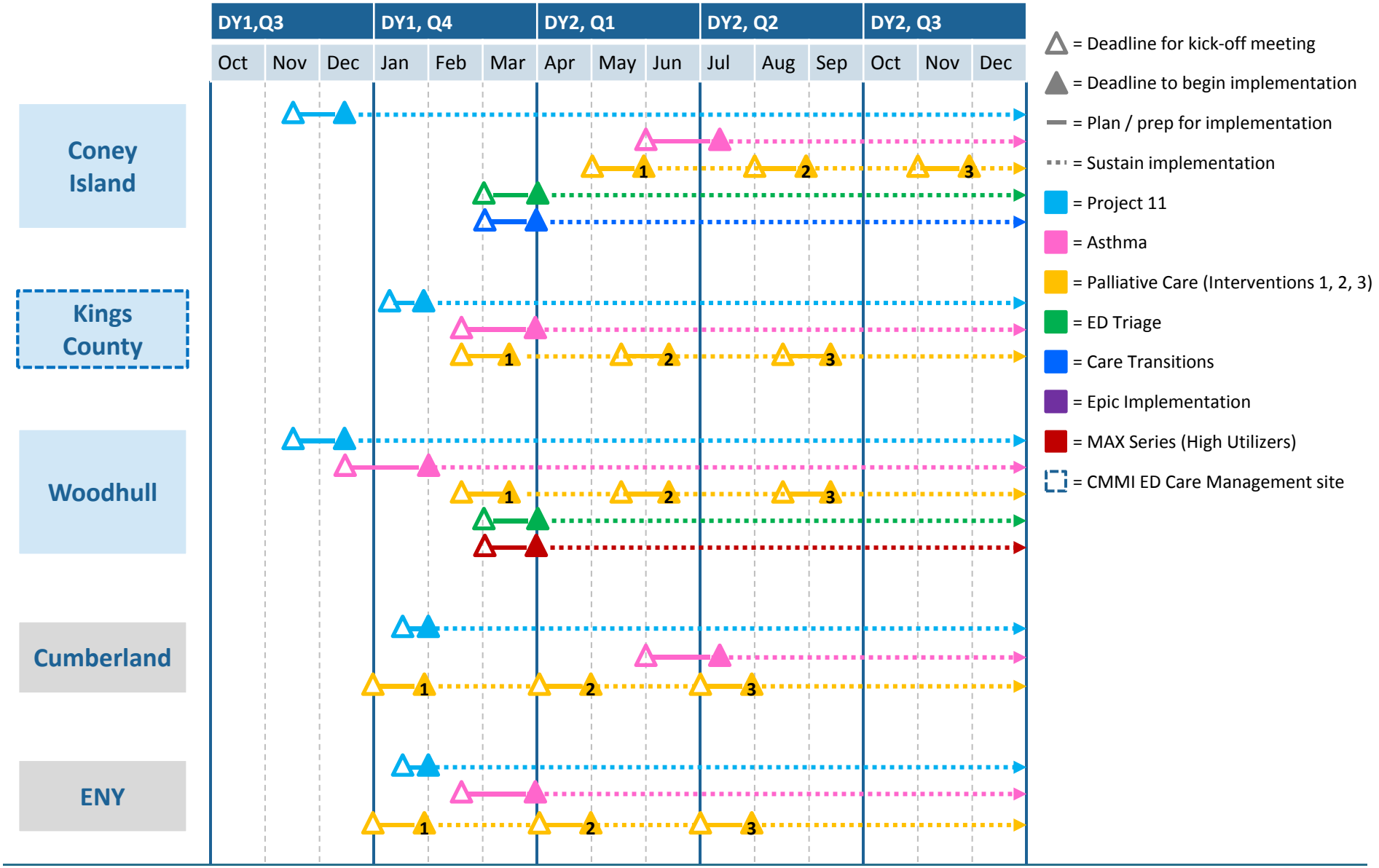
Bronx	
Inpatient/Hospital	3
Primary Care	36
Outpatient BH	50
Long-Term Care	39
Pharmacy	21
Social Services/CBOs	99

Brooklyn	
Inpatient/Hospital	4
Primary Care	51
Outpatient BH	58
Long-Term Care	36
Pharmacy	16
Social Services/CBOs	91

Queens	
Inpatient/Hospital	2
Primary Care	43
Outpatient BH	60
Long-Term Care	19
Pharmacy	16
Social Services/CBOs	61

Number of sites providing service, by borough, according to OneCity Health Partner Readiness Assessment Tool

Draft, Preliminary Rollout Example:
NYC Health + Hospitals – Brooklyn Hub



Implementation Example: Project 11

Project 11 requires us to administer the Patient Activation Measure (PAM®) survey tool to uninsured New Yorkers and Medicaid non- and low-utilizers assigned to OneCity Health and to link them to primary care

- First phase: Understand workflows and resource needs associated with PAM® survey administration
  - 10 NYC H+H sites
  - ~30 Community Based Organizations
  - Range of suitable NYC H+H frontline staff
  - Cautiously optimistic about meeting target of 11,000 PAMs® by March 31
- Second phase (April): Link New Yorkers to insurance/options and to primary care, develop sustainability and continuous improvement planning
  - Identify OneCity Health primary care capacity
  - Identify and train suitable staff in culturally competent navigation for insurance options, health coaching and motivational interviewing
  - Solve IT issues of PAM® score accessibility

OneCity Health Funds Flow + Contracting Approach

- Under DSRIP, funds flow from NYS DOH to fiduciary HHC according to how well OneCity Health has performed in meeting its DSRIP commitments
- Partner payment methodology is approved by the OneCity Health Executive Committee, which reports to HHC as fiduciary
- We have not yet distributed funds to partners and expect to do so in February, for CBOs participating in Project 11

Phase 1: Master Services Agreement

- **Timing**: Ongoing; ~80% executed to-date
- **Purpose**:
- Establishes general roles and responsibilities of partners
- Outlines general framework for distributing DSRIP payments
- Outlines governance process
- Provides basic legal terms governing relationships among the parties

Phase 2: Project-Specific Schedules

- **Timing**: Ongoing; began in December
- **Purpose**:
- Details specific obligations related to project implementation
- Identifies funding a partner is eligible to receive for implementing component(s) of a project
- Outlines data and reporting obligations

OneCity Health Workforce Planning

- As we transform the delivery system, we will need to understand and plan for any resultant workforce changes

- We have formed a consortium of four (4) NYC PPSs and engaged consulting firm BDO through an RFP process in order to complete some of the DSRIP workforce requirements

- We will commence training as needs are identified through DSRIP and other transformational planning. Some current or ongoing needs:
  - Community Health Worker (CHW) training for asthma home visits
  - Palliative care training for primary care providers
  - PCMH care team implementation
  - General DSRIP education

DSRIP Risks and Mitigation Strategies

Risk	Risk Description	Mitigation Strategies
Performance	Failure to meet performance commitments for either clinical or organizational transformation efforts	• Invest in performance of largest partner NYC H+H • Learn partner organizations' contribution to health + well-being and contract for that expertise • Given challenges with receiving promised DOH data at PPS level, execute alternate approaches to design and improve interventions through data/analytics
Reputational	Failure to manage the expectations of multiple stakeholder groups, whose expectations are high and varied	• Continue efforts to include, engage and educate stakeholders in planning and decision-making
Sustainability	Inability to sustain interventions proven to improve health and well-being	• Advocate for further payment reform • Urgent need to understand costs in order to prudently increase VBP arrangements • Pilot all interventions for which ongoing costs are not currently well-understood (e.g. Care Management)

Appendix

DSRIP Enables NYC Health + Hospital's "Vision 2020" Agenda

DSRIP Transformation Objectives

Improve access to quality, culturally competent primary and outpatient care via network of HHC and DSRIP partners

Implement and refine patient-centered care models to achieve primary and behavioral healthcare integration

Implement care management and care transition programs to reduce care fragmentation and unnecessary utilization

Establish strong community partner collaborations to engage patients, strengthen our continuum, and grow our network

Population-based data analytics and information-sharing platforms to connect points of care and enable evidence-based interventions

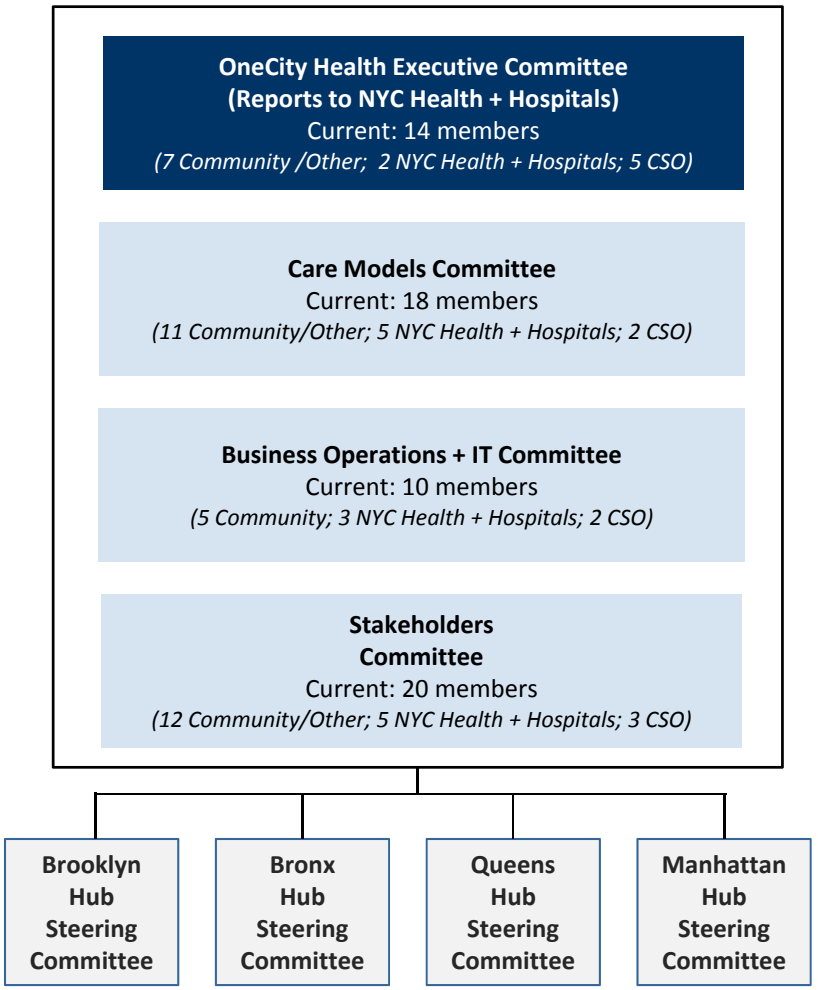
Leverage investments and earned performance payments to reduce cost of care and expand ability to accept full risk for patients under our care

Vision 2020

- **Patient satisfaction scores of 80% inpatient, 93% outpatient**
- **MetroPlus growth to 1 million members, with 80% connected to HHC PCP**
- **Average appointment wait time of 14 days for adult medicine, 5 days for pediatrics**
- **Financial sustainability**

OneCity Health Governance Committees Oversee Strategy, Program Implementation + Performance, and Funds Flow

Governance Structure



Committee Responsibilities

Executive Committee

- Provides strategic leadership and oversight for all DSRIP activities
- Approves proposals for funding allocations
- Evaluates performance of DSRIP projects and partners
- Ensures timely decisions

Care Models Committee

- Recommends DSRIP clinical processes, guidelines (and workflows) used across care continuum
- Plays key role in review/recommendation of tools developed by the CSO to monitor DSRIP project performance across all partners

Business Operations + IT Committee

- Reviews/recommends CSO-developed processes and protocols for adoption and use of IT technologies to be used by partners.
- Recommends budgets and the distribution of DSRIP funds

Stakeholders Committee

- Provides leadership in development and oversight of all stakeholder and patient engagement activities
- Recommends cultural competency and workforce planning efforts

Hub Steering Committees

- Provide local leadership of DSRIP activities and progress
- Reports back to PPS-wide committees on local issues and best practices
- Max 8-12 members

**OneCity Health Central and Hub-level PACs and Consumer Advisory Workgroups are not shown here

DSRIP Implementation Roles and Responsibilities

OneCity Health Centralized Services Organization ("CSO")

The CSO supports all OneCity Health partners and governance structures in design, implementation, and management of DSRIP transformation

OneCity Health PPS

HHC NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
nyc.gov/hhc

HHC has dual roles in the PPS – as fiduciary and as a partner organization

HHC is the largest partner in OneCity Health and its performance will determine overall PPS success

In its role as DSRIP partner, HHC must successfully implement programs to meet performance goals and earn payments

In order to succeed, HHC must rely on the OneCity Health partner network for certain skills and delivery system capacity

Coler | **Jacobi** | **Renaissance** | **…**

To succeed, each HHC facility must prepare to optimally manage transformation in midst of multiple priorities and limited resources

Care Models Design and Project Planning

(7 of 11 Projects Use This Process)

❑ Design the standard care model for entire PPS

- Defines roles, responsibilities, and relationships in performing a project
- Builds upon Clinical Leadership Team (CLT) and PAC input from Spring + Summer, 2015
- Identifies high-level training needs
- Recommended by Care Models Committee with final approval by Executive Committee

❑ Develop project launch strategy for entire PPS

- Guided by DSRIP commitments and outcomes targets, community needs, and site readiness
- Reflects a phased approach: some components of a project are implemented before others
- Uses larger-scale pilots: need to learn what works before attempting to scale across PPS
- Approach endorsed by Executive Committee, and as projects are implemented, progress will be reviewed through governance committees using common performance framework

❑ Prepare for local/site-level implementation

- Sites identified through launch strategy and for community sites, the publication of a Project Participation Opportunity
- Primary communication through site visit + site lead
- Local workflow design and identification of training + resource need
- Work supported by CSO with site-level lead (at NYC H+H, this is a facility implementation lead)

OneCity Health Partner + Consumer Engagement

Category	Engagement Activities To-Date
In-person, Small Group Partner Engagement	• 100+ partner site visits by hub teams to better understand partner capabilities, needs and interest in participating in a range of projects • Ad-hoc cross-partner workgroups, including CBOs, have informed project design (asthma, community primary care, Project 11), payment models, and implementation toolkits
In-person, Larger Group Partner Engagement	• Seven all-PPS or hub-specific PAC meetings since November 2014 to inform and build relationships; regular meetings throughout the next five years • Consumer Advisory Workgroups to begin in early February: comprise users of health and social services in each hub; will provide guidance on the social determinants of health, barriers to access and advise upon strategies and implementation plans • In addition to PAC, roughly 15 engagement sessions held for NYC H+H clinical councils, SUNY clinical and operational leadership, ad-hoc cross-partner clinical leadership teams since December 2014 • Ongoing meetings established with OneCity Health labor partners to improve engagement and participation
Other Regular Education and Engagement Channels	• Project Participation Opportunities (PPOs) distributed to OneCity Health network as transparent, supplemental method to identify full range of qualified partner organizations for each project • Webinars describing DSRIP clinical care models open to entire partner network • Website, **www.OneCityHealth.org** details our structure + planning efforts • Newsletters to subscribers comprising 50 near-weekly updates and engagement requests to nearly 1,000 newsletter recipients