STRATEGIC PLANNING COMMITTEE MEETING
OF THE BOARD OF DIRECTORS

DECEMBER 9, 2014
10:00 A.M.
HHC BOARD ROOM
125 WORTH STREET

AGENDA

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

II. ADOPTION OF NOVEMBER 12, 2014 STRATEGIC PLANNING COMMITTEE MEETING MINUTES — **JOSEPHINE BOLUS, RN**

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

IV. INFORMATION ITEM

i. **PRESENTATION: FEDERAL AND STATE HEALTHCARE TRENDS AND CHALLENGES**
DENNIS WHALEN, PRESIDENT, HEALTHCARE ASSOCIATION OF NEW YORK STATE
VAL GREY, EXECUTIVE VICE PRESIDENT, HEALTHCARE ASSOCIATION OF NEW YORK STATE

V. OLD BUSINESS

VI. NEW BUSINESS

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

MINUTES

STRATEGIC PLANNING COMMITTEE MEETING OF THE BOARD OF DIRECTORS

NOVEMBER 12, 2014

The meeting of the Strategic Planning Committee of the Board of Directors was held on November 12, 2014 in HHC's Board Room located at 125 Worth Street with Josephine Bolus presiding as Chairperson.

ATTENDEES

COMMITTEE MEMBERS

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

OTHER ATTENDEES

J. DeGeorge, Analyst, New York State Comptroller
E. Colchamino, Department of Health and Mental Hygiene
M. Dolan, Senior Assistant Director, DC 37
C. Fiorentini, Analyst, New York City Independent Budget Office
S. Newmark, Mayor's Office
K. Raffaele, Analyst, Office of Management and Budget
J. Wessler, Guest

HHC STAFF

S. Abbott, Assistant Director, Corporate Planning and HIV Services
V. Austin, Senior Public Health Educator, Harlem Hospital Center
M. Belizaire, Assistant Director of Community Affairs, Office of Intergovernmental Relations
C. Barrow, Assistant Director, Lincoln Medical and Mental Health Center

S. Bender, Assistant Director, Metropolitan Hospital Center
E. Borges, Associate Director, Bellevue Hospital Center
L. Brown, Senior Vice President, Corporate Planning, Community Health and Intergovernmental Relations
T. Carlisle, Associate Executive Director, Corporate Planning Services
E. Casey, Assistant Director, Corporate Planning and HIV Services
D. Cates, Chief of Staff, Office of the Chairman
J. Daly, Project Administrator, Harlem Hospital Center
S. Davis, Director, Metropolitan Hospital Center
N. Duvilaire, MD, Chief of Family Medicine, Metropolitan Hospital
S. Fass, Senior Director, Corporate Planning Services
D. Green, Senior Assistant Vice President, Corporate Planning and HIV Services
L. Guttman, Assistant Vice President, Office of Intergovernmental Relations
T. Hamilton, Assistant Vice President, Corporate Planning Services
L. Johnston, Senior Assistant Vice President, Medical and Professional Affairs
J. Jurenko, Senior Assistant Vice President, Intergovernmental Relations
S. Kleinbart, Director of Planning, Coney Island Hospital
Z. Liu, Senior Management Consultant, Corporate Planning Services
P. Lockhart, Secretary to the Corporation, Office of the Chairman
A. Marengo, Senior Vice President, Communications and Marketing
R. Mark, Chief of Staff, President's Office
A. Martin, Executive Vice President and Chief Operating Officer, President's Office
H. Mason, Deputy Executive Director, Kings County Hospital Center
J. Omi, Senior Vice President, Organizational Innovation and Effectiveness
K. Park, Associate Executive Director, Finance, Queens Health Network
N. Peterson, Senior Associate Director, Woodhull Medical and Mental Health Center
S. Ritzel, Associate Director, Kings County Hospital Center
E. Russo, Director, Corporate Planning Services
S. Russo, Senior Vice President and General Counsel, Office of Legal Affairs
L. Sainbert, Assistant Director, Chairperson's Office
W. Saunders, Assistant Vice President, Office of Intergovernmental Relations
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
M. Winiarski, Assistant Director, Corporate Planning Services

CALL TO ORDER

The meeting of the Strategic Planning Committee was called to order at 10:12 a.m. by the Strategic Planning Committee Chairperson, Josephine Bolus, NP-BC. The minutes of the October 7, 2014 meeting of the Strategic Planning Committee were adopted.

SENIOR VICE PRESIDENT REMARKS

FEDERAL UPDATE

Ms. Brown began her report by stating that, in Washington D.C., the Republicans had gained a majority in the U.S. Senate with several seats still undecided. Senator Mitch McConnell (R-KY) is so far unopposed to be Majority Leader in January. She added that the lame duck session, which was scheduled to begin today (November 12, 2014), must resolve several issues including funding federal agencies and programs into next year, as well as the appropriation of the Administration's $6 billion request for supplemental funding to address the international and domestic Ebola crisis.

Ebola Preparedness

Ms. Brown reported that, to support domestic Ebola preparedness efforts by state and local governments and hospitals, the Administration had proposed several initiatives including:

1. Using the Public Health Emergency Preparedness Program, the Centers for Disease Control (CDC) would get $1.8 billion, of which $7.13 million would come to New York to support the accelerated planning and operational readiness for Ebola Virus Disease (EVD) preparedness and response within state and local public health systems. The CDC proposes to fund the current 62 Public Health Emergency Preparedness (PHEP) awardees in the US through formula funding, including, but not limited to, funding distributed through the PHEP grant for:
    - Preparedness planning for state and local EVD response
    - Conducting exercises, training and improvement plans
    - Assuring state/local compliance with active monitoring and direct active monitoring activities
    - Development of training courses, materials, videos
    - Assuring compliance with CDC's infection control guidance
    - Assuring Responder safety and health
    - Development of risk communication messages and public information
    - Coordination with the Ebola Treatment Centers (Nebraska, Atlanta, etc.)

2. The U.S. Department of Health and Human Services (HHS), excluding the CDC, would also receive $318 million of which, $2.5 million would be distributed to New York State, for direct support to no less than one Ebola Treatment Center in the state. An additional $4.89 million would be distributed to Hospital Preparedness Program (HPP) awardees in New York State.

3. Nationally, Ebola Treatment Centers would be established with no less than 55 well-equipped, highly-trained hospitals where patients can be transferred from Ebola screening centers in order to obtain definitive care.

4. A contingency fund of $1.5 billion would be created "to ensure that there are resources available to meet the evolving nature of the epidemic." This fund would be split equally amongst federal agencies such as CDC, and USAID.

Ms. Brown reported that the current thinking was that the lame duck session would adjourn on December 12, 2014; one day after the current Continuing Resolution to fund the federal government is set to expire.

Ms. Brown stated that, if the President were to issue an Executive Order regarding Immigration policy, it would be during the window between Congressional adjournment and the New Year. She added that, when the new Congress is convened in January, it would face the March 31st deadline for fixing the perennial Medicare physician reimbursement cut under the Sustainable Growth Rate formula as well as potential breach of the debt ceiling around the same time. There is the ever-present danger of the GME, IME and other hospital programs being cut to pay for other spending as there have been in the past. There is also a danger of a Republican Congress undertaking "entitlement reform" also known as block granting Medicaid or funding Medicaid on a per capita basis, and/or privatizing Medicare through a voucher system so that beneficiaries must buy their health insurance in the market place.

Ms. Brown reported that there were some promises being made by the new Republican leadership about making changes in some of the aspects of Obama Care. She commented however, that it was to be seen how successful that would be.

STATE UPDATE

Governor Cuomo Outlines Vision for Second Term

Ms. Brown reported that, on October 23, 2014, Governor Cuomo released, "Moving the *New* New York Forward," which is a 259-page document that highlighted the accomplishments of his first term and laid out an agenda for his second term.

Ms. Brown noted that Governor Cuomo devoted four pages to outline his successes in the area of healthcare, which included the approval of the Medicaid Redesign Team (MRT) Waiver, the implementation of the new Health Insurance Exchange, increasing recoveries for services inappropriately billed to Medicaid, legalizing Medical Marijuana, implementing initiatives to combat opioid abuse, increasing investments in Supportive Housing, the establishment of a Statewide Health Information Network (SHIN-NY), and the development of a plan to end the AIDS epidemic.

The document only included one new initiative, which was the State Health Innovation Plan (SHIP). The Plan, which the Governor describes as a "five-year strategic blueprint," is designed to "align the entire health care system, including private insurance, to further improve quality, keep costs low, and improve the health of all New Yorkers." Specifically, the Plan would focus on the following:

- Improving coordination and integration of care
- Improving transparency to allow patients and providers access to information they need to make informed healthcare decisions
- Transforming healthcare payment systems from models that are based on volume to models that pay based on value (defined as efficiently provided care with the best possible outcomes)
- Developing a healthcare continuum that links physicians and community-based resources

Ms. Brown reported that the State recently applied for a $100 million federal State Innovation Model (SIM) grant to implement that plan. In the grant application, the state indicates that the plan is expected to generate $4.4 billion in savings, of which $2.2 billion would be reinvested in the healthcare system. Ms. Brown added that the perspective of State Medicaid and the Health Department and Mental Health is that all efforts including DSRIP and managed behavioral health would all come together under SHIP.

Republicans Take Back Majority in New York State Senate

Ms. Brown reported that, in a turn of events few had expected, voters elected a clear majority of Republicans in the New York State Senate. She informed the Committee that for the past two years, the Senate had been controlled by a coalition of Republicans and the Independent Democratic Conference (IDC), a group of five Democrats led by Bronx Senator Jeff Klein. Going into Election Day, there was a great deal of speculation about which party the IDC would align. However, the Republicans held onto all 29 seats that they had previously occupied and picked up an additional three seats Upstate. This gives them a 32-vote majority in the 62 member Senate. In addition, Democrat Simcha Felder of Brooklyn is expected to continue to caucus with the Republicans.

CITY UPDATE

City Council Considers Ways to Boost Enrollment under ACA

Ms. Brown reported that last month, the City Council Health Committee heard testimony from City agencies and scores of community-based organizations on ways to increase enrollment during the second year of open enrollment under the Affordable Care Act. She informed the Committee that Mrs. Marlene Zurack, HHC's Chief Financial Officer and Senior Vice President, had described HHC's efforts to prepare for open enrollment and some of the challenges HHC faced. Mrs. Zurack was joined by colleagues from the New York City Human Resources Administration and the Department of Health and Mental Hygiene who testified on broader City efforts to boost enrollment and increase awareness in underserved communities. Many panelists and Council Members agreed that more outreach to immigrant communities was needed in New York City. Ms. Brown added that there was also consensus that the State needed to broaden their efforts to translate the New York State of Health website and relevant materials into multiple languages and expand partnerships with community-based organizations that have grass-roots level relationships in their communities. She added that HHC was looking forward to work with the Council and others to develop these initiatives.

Mr. Mark Page, Director, NYC Office of Management and Budget asked if the panoply of federal approaches that Ms. Brown outlined regarding the handling of Ebola and paying for it meshed with HHC's experience to date in terms of what HHC needed and what HHC would needed on an ongoing basis. Ms. Brown responded affirmatively to both questions. She added that there were many aspects of the funding that would accrue to NYS (and hopefully to New York City) for training and preparedness exercises and the cost of protective personal equipment (PPEs). She added that, on a longer term basis there was a panoply of other costs that the President proposal recognized for ongoing preparedness that have been separated out. In that context, New York State and other states would get funding as well. Ms. Brown added that, thirdly, the emphasis on the need for more hospitals to become well trained and prepared screening centers was also another aspect on an ongoing basis where NYC and HHC could benefit. Dr. Raju, HHC's President,

added that there were two issues. First, taking care of one Ebola patient is extremely expensive. The question is what would happen if there were more than four Ebola patients, which is a bigger issue. He added that Ms. Brown's team was working to ensure that HHC would be compensated for what was been spent thus far and what HHC has projected that it would need to spend. Secondly, in spite of the fact that there are other designated hospitals, none of these hospitals, as of November 12, was ready to take any patients which put a significant strain on HHC, specifically Bellevue Hospital. He emphasized that it took more than 100 staff to care for one patient. Ms. Brown commented that the question that was not asked was whether or not there was enough money. She added that there was not enough money based on HHC's experience.

Ms. Anna Kril inquired if HHC would be receiving reimbursement for the costs that have already been incurred. Dr. Raju responded that the City had prepared the total amount of cost that have been incurred; a large portion of which was attributable to HHC, with smaller portions relating to the work of New York City Department of Health and Mental Hygiene (NYCDOHMH), New York Police Department (NYPD), Emergency Medical Services (EMS) and the Fire Department of New York (FDNY). Dr. Raju commented that this was a large tab and that ongoing advocacy was needed to secure various levels of funding to be able to do this work.

Ms. Bolus, Committee Chairperson, asked if HHC missed a lot of revenue opportunities because people did not want to go to Bellevue Hospital. Ms. Brown responded that, while Bellevue's outpatient services were robust, there were some other residual impacts due to the transfer of intensive care patients to NYU. Ms. Brown added that, she had heard from her colleagues at Gouverneur Healthcare Services, that there was a level of hesitation and/or resistance on the part of Gouverneur patients to visit Bellevue Hospital for specialty services and for other treatment services that were not provided at Gouverneur. There will absolutely be some residual impact on revenue, which is accounted for in the total cost calculation.

Ms. Bolus asked if 29 nurses were used to care for one patient alone. Dr. Raju clarified that more than 100 staff members were involved in the care of one person, which included nurses, laboratory technicians, environmental workers and administrators. This was a very expensive proposition. He added that lost revenue was a major issue. He reiterated that revenue was lost because patients were redistributed to other institutions and also because of external forces as people were afraid to come in for a variety of reasons. Dr. Raju added that HHC's finance team had put together a cogent argument on the total impact on HHC. Dr. Raju commented that this comes on top of a Citizen's Budget Commission report which highlighted HHC's financial condition.

INFORMATION ITEM

DSRIP Community Needs Assessment Review and Preliminary Findings

Dona Green, Senior Assistant Vice President, Corporate Planning/HIV Services

Mrs. Brown invited Ms. Dona Green, Senior Assistant Vice President, Corporate Planning Services and her team to present on HHC's Delivery System Reform Incentive Payment (DSRIP) Community Needs Assessment. She explained that at the Board level there had been some discussions about the Community Needs Assessment within the context of the overall DSRIP program. Some of the Board Members requested a deeper dive in terms of the CNA findings. Mrs. Brown added that the beginning of Ms. Green's presentation would be a bit redundant for Board Members, but Ms. Green and her team had also drilled down into one borough, the Borough of Queens, to provide additional information and to connect the

findings of the CNA to subsequent discussions and decisions in terms of DSRIP projects. Ms. Green began her presentation by first introducing members of the Corporate Planning Team, Mr. Steven Fass, Senior Director and Ms. Sharon Abbott, Assistant Director, Corporate Planning Services. She stated that they represented an additional fifteen other individuals who did a lot of work to conduct the DSRIP Community Needs Assessment. Ms. Green stated that the purpose of her presentation was to provide the Committee with an orientation to the DSRIP Community Needs Assessment, and that her presentation would cover the following:

- Purpose of Community Needs Assessment (CNA)
- Methodology and data sources
- DSRIP guidelines and valuation
- Key findings in select Queens neighborhoods

Ms. Green described the purpose of the DSRIP CNA as the following:

- The DSRIP CNA builds on the recently completed health assessments tied to the New York State Prevention Agenda. The Prevention Agenda was developed by the New York State Department of Health (NYSDOH) in 2008 as a call-to-action to local health departments, provider organizations, community-based service providers, health plans and others to collaborate to improve the health of the population by preventing health problems before they occur or before they worsen. A primary aim of DSRIP is to promote community-level collaborations and reduce avoidable hospitalizations by 25% over 5 years.
- In order to choose the most effective projects, the Performing Provider Systems (PPSs) must understand the broad health status and health care system in the geographic region in which they are functioning.
- The CNA forms the basis and justification for system transformation, clinical improvement and population health improvement, which are consistent with NYSDOH's prevention agenda.

Ms. Green explained that the CNA included a compilation of primary and secondary research. The primary research comes in the form of interviews, focus groups and surveys and uses specific statistical methods and tools to collect, analyze and interpret that information. The secondary research also entails the collection, analysis, manipulation and interpretation of existing data sets, published articles and studies. All of this research helps to fill in some knowledge gaps. For instance, providers usually know whom they are serving, but through primary and secondary research, providers can begin to apply some disciplined concentration to the problem of finding/acquiring the knowledge that was untapped about the population, the majority of whom would be potential patients in a PPS targeted ecosystem.

Ms. Green stated that the CNA will help PPSs to answer, through primary and secondary research, the following questions:

- Whom aren't we reaching?
- What is the scale of concern with special populations?
- What are the big problems we have missed in the past?
- What aren't we doing that patients want/need?
- Where are the service gaps?
- Where are we over-resourced?

Ms. Green explained the service areas covered by the CNAs. She stated that the service area covered by the a CNA reflected the existing utilization patterns of the PPS and its existing partners, and the utilization patterns of the collective PPSs that may have collaborated on a particular CNA. The HHC PPS would

prioritize its efforts in neighborhoods that have high Medicaid and /or uninsured populations, and where the PPS would have a sufficient range of services and resources to improve population health. HHC worked in four boroughs in terms of the CNAs:

- In Queens: The HHC Queens Health Network (Queens Hospital Center, Elmhurst Hospital Center) had started early working with Medisys (Flushing Hospital and Jamaica Hospital). They determined that they would focus on all of the zip codes, excluding the Rockaways and Eastern Queens, but including some zip codes in East New York in Brooklyn.
- In Manhattan: The service areas cover north of 90th Street, extending into the South Bronx (due to public transportation patterns between the two boroughs), south of West 58th Street and East 40th Street. The service area excludes the Financial District.
- In the Bronx: Due to the collaboration of the many PPSs, they collectively represented all of the zip codes/neighborhoods within the borough.
- Brooklyn: Due to the collaboration of all of the PPSs, all zip codes/ all neighborhoods were covered within the borough.

Ms. Kril, Committee Member, asked, due to the fact that East New York was included as part of Queens, would East New York be covered/represented as part of the Brooklyn CNA. Ms. Green responded affirmatively. She explained that this was done for the PPSs that were represented in that area. She stated that Queens was very focused on Flushing and Jamaica. Collectively, these facilities serve a lot of patients who come from East New York so that they could not ignore that population. Mrs. Kril asked why the Financial District, which had experienced a dramatic increase in population, was excluded. Ms. Green clarified that the area of the Financial District that was excluded was the South Ferry area. She explained that the population in those neighborhoods did not use the services offered by HHC's D&TCs and hospitals. Ms. Green noted that the Lower East Side was covered. Ms. Brown clarified that what Ms. Kril was referring to was the Battery Park area. Mrs. Brown further explained that becoming a PPS, one assumes the responsibility for the health, health outcomes and health status of a particular geography. It starts with an assessment of whether all members of the PPS have existing service relationships within that geography. As such, the exclusion of certain parts of lower Manhattan was based on a deep dive into patient origin studies as to where do the people who live in those sets of zip codes get their care, and are they likely to charge that pattern or not. An analysis of data generally showed that people are receiving care in other health consortiums that comprise another set of Manhattan PPSs. Ms. Brown commented that Mrs. Kril's neighborhood was not left out without a study.

Mr. Rosen commented that the voluntary hospitals would also be interested in getting some of the funds that would ultimately flow through this program. He asked if the voluntary hospitals were also engaged in the same work as HHC was doing, and if they were meeting and working with HHC. Ms. Brown responded affirmatively. She stated that, with the exception of Manhattan, these CNAs were done in collaboration with voluntary hospitals and other organizations who would aspire to be selected by the state as PPSs. She added that there was a collective agreement that whether an entity was a voluntary hospital led PPS, public hospital led PPS, or a group of physicians led PPS, that they would join forces and resources together to conduct the CNAs. This is why all neighborhoods in Brooklyn and the Bronx and a large of Queens were selected. Ms. Green presented four borough maps to help the Committee to visualize the areas that were targeted for the CNAs.

Ms. Green reported that the CNAs were conducted in collaboration with other PPSs. The CNA partners are the following:

- In Brooklyn
    - AW Medical, Lutheran HealthCare, Maimonides Medical Center, SUNY Downstate Medical Center
- In Queens
    - Queens Health Network with Medisys Health Network
- In the Bronx
    - AW Medical, Saint Barnabas Hospital Health System/Bronx Partners for Healthy Communities (Montefiore)

Ms. Green stated that support to conduct the CNAs was provided by the New York Academy of Medicine (NYAM) and Tripp Umbach (a firm HHC worked with on a prior CNA). These organizations provided support in the following manner:

- The New York Academy of Medicine (NYAM)
    - In the boroughs of the Bronx and Brooklyn, NYAM collected and analyzed all primary and secondary data and produced first draft of the reports.
    - In Manhattan, NYAM conducted some key informant interviews
    - In the borough of Queens, NYAM collected and analyzed primary data

- Tripp Umbach
    - In Manhattan, Tripp Umbach conducted focus groups and performed analysis of the primary data

Ms. Green reported that the Office of Corporate Planning Services (CPS) collected and analyzed the secondary data for the boroughs of Queens and Manhattan. CPS also conducted the secondary data assessments for Medisys.

Ms. Abbott described the CNA's primary data collection process. She stated that, to collect primary data, NYAM and Tripp Umbach partnered with community-based and local organizations. Primary data collection included focus groups, key informant interviews, and a resident survey. Specific activities included the following:

- 20 focus groups were conducted per borough (78 in total and incentives were provided)
- 15 key informant interviews were conducted per borough
- Nearly 1,000 resident surveys were collected per borough (survey included 20 questions which focused on health care need, access etc.)
- Respondents (18 and older) were identified and recruited by local organizations and through street outreach
- Community representatives were trained to collect primary data specifically from non-English speaking populations. The survey was offered in multiple languages (including Spanish, French, Arabic, Bangla, Chinese, Haitian Creole, and Polish)

Ms. Kril asked if the samples per area were statistically significant. Ms. Abbott responded that they were not. She explained that the process would take up to two years in order to deliver a statistically powered CNA. The samples are not statistically valid and this information would be included in the CNA reports.

Ms. Abbott shared with the Committee the list of community-based organizations that participated in the CNA process. She noted that some had conducted both focus groups and resident surveys, while others conducted resident surveys. Ms. Abbott also shared with the Committee a list of institutions/organizations

that provided key informant interviews. She added that there were also six focus groups that were conducted with HHC Community Advisory Board members.

Ms. Abbott reported that the community-based organizations and key informants were identified by the PPSs' hospital partners, Central Office, HHC facilities and Ms. Brown. She added that there were a series of brainstorming activities that were held to share these recommendations with NYAM. Ms. Abbott stated that throughout the process, people wanted to be continuously engaged in HHC's planning and implementation activities. Ms. Brown added that many of the individuals who served as key informants would become members of HHC's PPS Advisory Committee (PAC).

Mr. Steven Fass, Senior Director, Corporate Planning Services, described the CNAs' secondary data collection process, which included the following:

- Demographics and Population Health Status
  - Examples of data sources:
    - US Census American Community Survey
    - NYC DOHMH Community Health Survey and EPIQUERY
    - Behavioral Risk Factor Surveillance Survey
    - NYS Prevention Agenda 2013-2017 Tracking Indicators
    - NYC/NYS Vital Statistics
    - NYS Perinatal Database
    - NYU Furman Center Data on Housing

Ms. Fass added that, in addition to the datasets that have been used in the past, in support of DSRIP, the State had made available a great deal of summarized information regarding the utilization of Medicaid beneficiaries, and the providers that bill Medicaid. Some of the healthcare and community resources data were gathered from sources including:

- NYC Department of City Planning
- Greater New York Hospital Association (GNYHA) Health Information Tool for Empowerment (HITE SITE)
- NYS Department of Health
- NYS Office of Mental Health
- NYS Department of Education
- NYS Department of Corrections (via Justiceatlas.com and Gothamist)
- Center for Health Workforce Studies
- National Alliance on Mental Illness (NAMI)

Ms. Green described the DSRIP CNA scoring process. Ms. Green explained that there were eight CNA sections of the DSRIP PPS Organizational Application

1. **Completion of the CNA**: Process and methods of completing the CNA including a listing of data sources (5%)
2. **Provider Infrastructure**: List of health care resources in the service area such as hospitals, ambulatory surgery centers, behavioral health resources, lab and radiology centers, dental services, specialty medical programs and medical providers (15%)
3. **Community Resources:** Housing providers, advocacy groups, transportation providers, faith-based organizations, community outreach organizations, youth development programs, etc. (10%)
4. **Community Demographics**: Information regarding the population who were institutionalized as well as those involved in the criminal justice system (15%)

5. **Community Population and Identified Health Challenges:** These are the types of metrics that will be tracked over the course the DSRIP program (15%)
6. **Provider and Community Resources Identified Gaps:** Information regarding service and/or bed excess or gaps at this time (Responding to this item will require further study) (15%)
7. **Stakeholder and Community Engagement**: Number of focus groups conducted and consumer interviews (5%)
8. **Summary of CNA Findings:** This is a new section from the original CNA guidance. It is best answered by the staff completing the project descriptions in collaboration with CPS. (20%) This will be done before December 16, 2014.

Mr. Rosen asked if the DSRIP application would be submitted to the state who in turn would give it to the federal government. Ms. Brown stated that the deadline for submitting the full DSRIP application was extended by one week. However, she added that HHC would be keeping the December 16th deadline for submitting its DSRIP application. She reminded the Committee that the CNA was only one part of the application.

Mr. Fass described the DSRIP CNA guidelines and requirements. He informed the Committee that the state had been very precise in what it expected to see. With the knowledge that the CNA would be scored, HHC and its partners followed the guidelines very carefully and interpreted every suggestion as a requirement. He stated that there were five main sections pf the report, which included:

1. Exhaustive inventory of health resources and community programs available to Medicaid beneficiaries and uninsured individuals
2. Community demographics, especially as it may affect effective delivery of care
3. Current health status of the community using official criteria
4. Identification of additional health challenges, such as behavioral and environmental risk factors
5. Comparison of existing community resources and health related needs, factoring in additional health service challenges

Mr. Fass informed the Committee that due to its size it would not be possible to present findings from the entire report because the full CNA report covered all of NYC except for Staten Island, all DSRIP disease priority areas, all DSRIP provider priority areas, and in great detail. To keep the presentation manageable in size, Mr. Fass stated that he would be presenting the highlights of the findings for three neighborhoods in Queens including Jamaica, Southwest Queens, and West Queens. He added that his presentation would focus on just two DSRIP priority areas, which are Behavioral Health/Mental Health and Asthma.

Mr. Fass first explained how the data was organized on the presentation slide focused on demographics (presentation slide #18). He stated that the columns of his presentation slides from left to right provided data for NYC, the Borough of Queens, Jamaica, Southwest Queens, and West Queens. Going down the rows in almost every category, it showed that West Queens stood out as being different from the other areas with:

- 51% Medicaid beneficiaries
- 27% uninsured residents
- 61% foreign born residents
- 30% of adults having less than a high school education

Mr. Fass stated that these are some of the factors that providers would need to take into consideration in determining how to improve population health, how best to deliver health care, and which community

services are needed. Ms. Kril asked, for the percentage of the foreign born was computed is the data would include country of origin. Ms. Brown responded affirmatively. Mr. Rosen asked if these were the categories that the state requested. Ms. Brown responded affirmatively.

Mr. Fass reported that the following three presentation slides/charts described the health of the population, which included:

- All Medicaid beneficiaries
- Medicaid beneficiaries with a behavioral health diagnosis
- Medicaid beneficiaries with an Asthma diagnosis

He stated that these slides were organized in a similar manner as the demographic slide with the exception that a column was added to include all of New York State as a comparison. He added that the rows showed three health indicators that will be analyzed throughout the duration of DSRIP, because not only do they describe population heath, these indicators will be reported to the state on a quarterly basis. The trend of these indicators show the state whether the HHC DSRIP projects are being successful, which will determine future payments, which are based on the success of the selected projects. Mr. Fass explained that were other indicators that the State would use, but these were especially important. The three indicators all reflect inappropriate care that would result when there is insufficient access to primary care, and patient management. They include:

- Potentially avoidable ED visits
- Potentially avoidable admissions
- Potentially avoidable re-admissions

Mr. Fass reported that all three Queens neighborhoods were performing well compared to the City and the State; going forward it was expected that improvements in the current performance of these neighborhoods would continue.

Ms. Kril asked if the state had established performance targets. Mr. Fass explained that the state's goal is to reduce the number of ED visits, avoidable admissions and re-admissions by 25%, using 2009 numbers as the base year. Ms. Kril asked if there were targets for NYC. Ms. Brown explained that at the end of the five years of the Waiver, the state would like to see, statewide, that these metrics were reduced by 25%. Ms. Brown stated that HHC will be reporting on these metrics (reduction of potentially avoidable ED visits, avoidable admissions and avoidable re-admissions). These metrics will become part of the bible of the performance reporting in order for HHC to get DSRIP payments. Ms. Brown explained that the state will come up with the periodicity and reporting format, which has to be consistent across all PPS' across the state. She stated that staff of HHC will share it with the Board. Ms. Bolus asked if the reporting format and information will be shared with Legislators. Ms. Brown stated that all DSRIP information including reporting format and PPSs' reports will be on the state's website, which would be accessible to everyone. The state is required to have full transparency.

Mr. Fass reported on the population health findings related to a behavioral diagnosis. He explained that the percent of Medicaid beneficiaries diagnosed with mental illness on the top row of the presentation slide (slide #20) was one indicator of how much need there is for Mental Health services in these Queens neighborhoods. The percent of Medicaid beneficiaries with a mental illness diagnosis is 17% statewide, nearly 20% citywide, compared to 11.5% in West Queens. The state will use other indicators to evaluate success of Behavioral Health related projects. These indicators will include:

- Percent of adults with major depression and treated with medication who remained on medication for greater than 12 weeks
- Percent of adults with schizophrenia and diabetes who diabetes was tested
- Percent (%) age 6+ with mental health disorder hospitalization who had outpatient visit within 30 days of discharge

Mr. Fass reported that, the three Queens neighborhoods were performing well compared to the city and the state for the most part with regard to these indicators. He added that, for the state designated indicators of population health, which focused on potentially inappropriate ED and inpatient care, the three Queens neighborhoods outperformed the statewide average.

Mr. Fass reported on the health of the population with regard to Asthma. The prevalence of Asthma was higher statewide than in Queens, and was more than one third greater than in West Queens. Ms. Kril asked for clarification on the term "potentially avoidable asthma." Ms. Brown explained that this referred to potentially avoidable asthma admissions and not about avoiding asthma. If you have asthma there are very specific regimens and medications. If a patient is in care, the provider should be using evidenced-based strategies to help the patient control asthma. The goal is that the patient would be able to avoid emergency room use and admission if the patient's asthma is being managed appropriately. Ms. Brown added that if a PPS should to address asthma, many of the strategies may not be direct clinic care but could include working with housing providers and schools to help patients manage asthma. Providers will have to go beyond the health care facility to improve population health.

Mr. Fass reported on some of the health service challenges for these neighborhoods. He added that these factors were identified by residents and experts in interviews and focus groups as affecting affect population health and that successful population health projects would need to take these challenges into account. These health services challenges for the target Queens's neighborhoods include the following:

- Difficulties meeting basic needs (e.g., housing, food) which leads to extended work hours and emotional stresses
- Work, children and education tend to be prioritized over health
- Lack of sufficient information on health and health services
- Minimal knowledge, interest, and engagement in prevention services
- Stigmatization of behavioral health treatment among foreign born/new immigrants
- Fear of medical bills, medical debt, and deportation

Mr. Fass reported on other health services challenges that were associated with health risk behaviors for NYC, Queens, Jamaica, Southwest Queens and West Queens. He stated that these additional challenges included risky patient behavior. For example, an indicator is the percent of the female population over age 40 that had a mammogram test within the past 2 years. For this indicator, the state and city are both at 74%, but in West Queens, it is less, at 60% of the population.

Mr. Fass reported on the findings from the primary data that was collected concerning Behavioral Health. He reported that:

- 23% of survey respondents reported that mental health issues were a main concern in their community
- 17% of survey respondents report personally facing depression or anxiety
- Depression was cited as relatively common in older adults, with implications for physical health and disease self-management

- CBO key informant reported that:
  "…And also one of the issues on the physical side that is connected with isolation is poor nutrition. A person oftentimes when they're alone has no incentive to cook or to eat. And we find that many of the [older adult] clients that [we see] are nutritionally compromised."
- Emergency department staff reported that caring for patients with alcohol issues was difficult and put a strain on ED resources
- Feedback from focus group:
  "We see a pretty large group of patients with alcohol related issues. And so those patients are very regular here and very difficult, despite trying to get interventions for them, whether it is psychiatric interventions or substance abuse interventions. It's extremely difficult to get them connected and to get them to stay in any kind of program. Once we admit a patient with intoxication, we treat and release, they go back and drink."

Mr. Fass reported on the environmental health risks for NYC, Queens, Jamaica, Southwest Queens and West Queens. The environmental factors include the incidence of homes with cockroaches, adults reporting second-hand smoke at home, homes with leaks and households rating neighborhood structures as good or excellent. These are factors that affect those with Asthma. The three Queens neighborhoods have lower asthma rates than the NYC average. Mr. Fass explained that there seems to be a relationship with some of these risk factors, specifically:

- Homes with cockroaches are less in Queens
- Mold in the home is less are less in Queens
- Homes with leaks is less are less in Queens
- Households are in better condition in Queens

While these factors were less of a concern in Queens, they are of greater concern in other boroughs.

Mr. Fass stated that, having outlined the Medicaid communities' health care and related needs, the analysis is followed by a comparison of current resources. This type of analysis is important to DSRIP project designers to identify questions for follow up regarding possible gaps in coverage. He highlighted presentation slide #26, which showed the number of Medicaid beneficiaries and uninsured in relation to the number of Safety Net physicians, which are those physician who serve a significant percent of Medicaid patients. He stated that the table on the left showed the relationship by neighborhood, and the Queens map showed the ratio by zip code. The CNA report includes similar looking tables and maps for each of the types of facilities and programs that provide care to all populations identified by the DSRIP Guide in all 4 boroughs. The chart shows that NYC as a whole has more physicians per 100,000 population than in Queens, at 331 vs. 168.

Mr. Fass stated that presentation slide #27 showed the number of Medicaid beneficiaries with a mental health disorder in relation to the number of psychiatrists. The finding is that NYC as a whole has more psychiatrists per 100,000 Mental Illness diagnosed beneficiaries than in Queens.

Mr. Fass explained that presentation slide #28 showed the number of primary care providers in relation to the number of Medicaid beneficiaries. The finding is that there is a greater number of physicians citywide than in Queens.

Mr. Fass reported on the number of Medicaid beneficiaries diagnosed with Asthma and High Medicaid Primary Care Physicians. The distribution of High Medicaid PCPs (excl. OB/GYN) per 100,000 Asthma diagnoses is the following:

- NYC: 2,412
- Queens: 2,047
- Jamaica: 1,830
- Southwest Queens 1,623
- West Queens: 2,398

Ms. Green informed the Committee that the CNA findings were to:

- Inform project selection by identifying population health concerns
- Identify neighborhoods and zip codes citywide with greatest healthcare needs
- Identify potential PPS Partners by showing gaps between existing provider and community resources and community need
- Shape project design by describing target populations and align with state health priorities

Ms. Green concluded her presentation by stating that the CNA supported HHC's PPS project selections. Selected HHC PPS Projects include:

<u>System Transformation (Domain 2) Projects</u>

- 2.a.i Integrated delivery system
- 2.a.iii Health Home at-risk intervention program
- 2.b.iii ED care triage for at-risk populations
- 2.b.iv Care transition intervention models to reduce 30 day readmissions
- 2.d.1 Project 11: Engage uninsured and Medicaid low- and non-users of care

The CNA findings that support the selected System Transformation projects include:

- Potentially avoidable admission rates and ER visits are high in all boroughs, but particularly in neighborhoods and zip codes with high Medicaid and uninsured populations
- Potentially avoidable admission rates for chronic diseases are 3% higher citywide than statewide
- Inadequate health services in the community contributes to inappropriate ER use (CNA interviews)
- The rate of mental health readmissions among Medicaid beneficiaries in 23.3% in NYC compared to 20.9% statewide

<u>Clinical Improvement and Population-wide Projects (Domain 3 and 4)</u>

- 3.a.i Integration of primary care and behavioral health
- 3.b.i Evidence-based strategies for Cardiovascular Disease Care management
- 3.d.ii Expansion of Asthma home-based self-management program
- 3.g.i Integrate Palliative care into PCMH model
- 4.a.iii Strengthen Mental health and substance abuse infrastructure
- 4.c.ii Increase early access to and retention in HIV care

Medisys projects that do not overlap with HHC

- 3.c.i Evidence-based strategies for Diabetes Care management
- 4.b.i Promote tobacco use cessation

The CNA findings that support these clinical improvement and population-wide projects include:

- Asthma prevalence is higher than statewide in most boroughs and parts of Queens
- Cardiovascular prevalence is 14% higher in NYC than statewide, and the gap is much greater in hot-spot neighborhoods

- 65% of all NYC Medicaid Beneficiaries with substance use diagnosis had an admission over a one year period, a 9% greater rate than statewide
- There are vast health disparities in HIV rates across the City. New HIV infection among the Black/African American population is four times higher than the white population. Many of the same populations that are struggling with HIV are now challenged by the increasing incidence and prevalence of Hepatitis C.

Ms. Kril stated that the presentation was incredibly helpful. Ms. Brown added that CPS had done enough to inform the DSRIP application. She added that the work is never done because over the next five years the PPS will need to continue to refine its implementation strategies in order to effect change; as such, the primary data collection work would continue. Dr. Raju thanked and recognized Ms. Green and her team for doing an excellent job.

Improving Access to Care for LGBT Patients

Mark Winiarski, PhD, Assistant Director of Planning, Corporate Planning Services
Stephen Davis, Director of Nursing Excellence and Utilization Management, Metropolitan Hospital
Dr. Nadia Duvilaire, Medical Director, Comprehensive LGBT Health Center, Metropolitan Hospital Center
Evelyn Borges, Associate Director, Office of Patient Experience/
Founder, LGBT Patient and Family Advisory Council, Bellevue Hospital Center
Vanessa Austin, Public Health Educator II, Harlem Hospital Center

Ms. Brown informed the Committee that the following presentation would be an update on HHC's work to improve access to health care services for LGBT patients. Ms. Brown invited Mark Winiarski, PhD, Assistant Director of Planning, Corporate Planning Services; Dr. Nadia Duvilaire, Medical Director at Metropolitan Hospital; Stephen Davis, Director of Nursing Excellence and Utilization Management, Metropolitan Hospital; Evelyn Borges, Associate Director, Office of Patient Experience/Founder, LGBT Patient and Family Advisory Council, Bellevue Hospital Center; and Vanessa Austin, Public Health Educator II, Harlem Hospital Center to conduct the presentation.

Dr. Winiarski began the presentation by providing some background information on HHC's efforts to improve access to care for LGBT patients. He stated that a 2008 Public Advocate report recommended that local hospitals should do more to improve access for this population. Dr. Winiarski described HHC's response as the following:

<u>In-house discussions</u>

- Explored whether La Clinica del Barrio can host an LGBT clinic
- Co-wrote grant applications with Transgender Legal Defense and Education Fund
- Mandatory training for all staff members
    - Contract with National LGBT Cancer Network to:
    - Produce a video
    - Develop curriculum
    - Conduct train-the-trainer sessions
- PeopleSoft training module available to staff
- Facilities conducted trainings and embarked on projects

Dr. Winiarski reported that an LGBT Advisory Committee was formed in 2014. This committee is comprised of 25 individuals who are interested in LGBT-related issues and quality care for all. Issues of concern were:

- Electronic Health Record
    - Questions regarding gender identity and sexual orientation
    - Neutral fields, e.g., "parents" instead of "mother" and "father"
- Wording in state-promulgated Patient Bill of Rights
- Translation of policies into many languages

Dr. Winiarski reported on HHC's effort to gain the Human Rights Campaign designation of "Leader in LGBT Health Care Equality." To gain this designation, a facility must meet the "Core Four" criteria, which include:

1. Managers and leaders must be trained
    - Two training sessions by Shane Snowdon, Director of HRC's Health & Aging Program
    - Attended by approximately 400 staff members
2. "Patients' Bill of Rights" must include the terms "sexual orientation" and "gender identity"
    a. Communicated to patients and employees
3. Visitation policy explicitly grants equal visitation to LGBT patients and visitors
    a. Communicated to patients and visitors
4. Employment policy includes the terms "sexual orientation" and "gender identity"
    a. HHC's corporate policy (0P 20-32) states:
    "*The Corporation's unequivocal policy is to provide equal opportunity to all…without regard to…gender (including 'gender identity'…)…sexual orientation."*

Dr. Winiarski reported that in 2014, a total of 10 HHC facilities had earned the designation as "Leader In LGBT Health Care Equality." These facilities include:

- HHC's acute care facilities
    - Bellevue Hospital Center
    - Metropolitan Hospital Center
    - Harlem Hospital Center
    - Woodhull Medical & Mental Health Center
    - Jacobi Medical Center
    - North Central Bronx Hospital
    - Coney Island Hospital
    - Lincoln Medical Center
    - Elmhurst Hospital Center

- HHC's Diagnostic &Treatment Center:
    - Cumberland D&TC

Dr. Winiarksi highlighted four key LGBT projects at select HHC facilities including Metropolitan Hospital Center, Bellevue Hospital Center and at Harlem Hospital Center.

<u>Metropolitan Hospital Center</u>

Mr. Stephen Davis, Director of Nursing Excellence and Utilization Management at Metropolitan Hospital Center, stated that, in addition to his role at Metropolitan Hospital, he is also a doctoral student at Yale University. He has focused his translational research on executive leadership and succession planning. Related to how healthcare executives effectively lead and manage organizations, the program requires

candidates to perform an ethical analysis. Given the increasing focus on LGBT health, he chose to evaluate the ethical issues surrounding access and resource utilization for the LGBT population in the context of the safety net. Metropolitan's executive leadership team approved his use of the hospital's work on LGBT health as a case study for this project and his paper was submitted in December 2013. In March, Dr. Nancy Berlinger, an adjunct faculty member at Yale and research scholar at the Hastings Center, contacted Mr. Davis to adapt his work for publication in the Hastings Center Special Report on LGBT Bioethics. In addition to showcasing Metropolitan Hospital as a leader in caring for the LGBT population from a safety net perspective, the article highlights the moral imperative public institutions have to allocate resources aimed at reducing LGBT health disparities. Additionally, significant attention is given to the resource challenges public institutions may face in comparison to private hospitals. Building on the recent release of this article and the others published in the special report, The Hastings Center and Montefiore are holding a symposium on LGBT health and Dr. Raju will be participating on the expert panel. Mr. Davis stated that he was thrilled that Metropolitan Hospital and HHC are part of this critical dialogue to address healthcare for an extremely vulnerable population that needs the safety net to provide inclusive and comprehensive care.

Dr. Nadia Duvilaire, Medical Director, Comprehensive LGBT Health Center LGBT at Metropolitan Hospital provided the Committee with information about the groundbreaking LGBT Clinic at Metropolitan Hospital. She stated the clinic was launched in April 2014 and a total of 25 sessions have been held so far. She added that they were proud to have achieved the 2014 HEI Leader in LGBT Healthcare Equality status and that the staff was committed to earning this status year after year by expanding LGBT services by:

- Renovating clinic space and holding clinic sessions Monday through Friday in addition to Saturdays
- Increasing visibility and patient base through formation of strategic partnerships with community-based organizations and other healthcare organizations
- Developing specialty transgender health care to address higher rates of health disparities experienced by transgender community
- Ensuring quality patient experience at the LGBT clinic and throughout Metropolitan Hospital by undertaking staff trainings in LGBT competency
- Embarking on the long-term goal of hosting researchers focusing on LGBT health care

Ms. Brown added that the renovations were being supported by City Council funding in excess of $2 million.

Bellevue Hospital Center

Ms. Evelyn Borges, Associate Director, Office of Patient Experience and Founder of the LGBT Patient and Family Advisory Council at Bellevue Hospital Center provided information to the Committee regarding Bellevue's LGBT Parent and Family Advisory Council. She stated that the Lesbian, Gay, Bisexual, & Transgender- Patient and Family Advisory Council (LGBT-PFAC) was comprised of patients, their families and staff. It is a multi-disciplinary and expansive advisory resource that strives to support the mission, vision, and goals of Bellevue Hospital Center. The LGBT-PFAC delivers the highest standard of comprehensive and compassionate health care. The PFAC aims to accomplish this goal by partnering with patients and families in identifying opportunities to effect changes for improving service and care to the LGBT community. The LGBT-PFAC is primarily concerned with ensuring dignity and respect for patients and their families by:

- Providing complete, unbiased information to LGBT patients and their families
- Sharing the decision-making process and responsibility with patients at the level they choose.
- Collaborating with patients and their families in creating the policies and programs for their well-being

Ms. Borges stated that, in addition to achieving the HEI designation, the Human Rights Campaign had also requested the Bellevue LGBT-PFAC brochure be used as a model for future Patient and Family Advisory Councils. Additionally, through the internal informational/educational awareness events, the Bellevue LGBT-PFAC has been able to establish relationships with various community groups including the LGBT Community Center and the Asian Pride Project. Ms. Borges described their next steps as including:

- The design and develop of a directory of providers who specialize in LGBT care
- Increasing the LGBT-PFAC membership
- Increasing community outreach

Harlem Hospital Center

Ms. Austin, Public Health Educator, Family Planning Program at Harlem Hospital Center and creator of the program she calls SAFE informed the Committee that Harlem Hospital was committed to attaining the Human Rights Campaign's "Leader in LGBT Healthcare Equality" designation and to demonstrate competency and improve the quality of its clinical care and customer services. She stated that a meeting was convened with the Harlem Hospital leadership of Nursing, Patient finance, Admitting, Guest Relations, Ambulatory Care, and Human Resources to ensure that Harlem Hospital's policies complied with the HEI designation criteria.

Ms. Austin reported that 10 Harlem Hospital staff participated in a cultural competency/empathy master training program. She stated that, over a period of eight weeks, they were able to train 148 staff from various departments. While completing this training, it was discovered that they needed to create a marketing "tag line "to promote LGBT patient-centered care. The tag line is Harlem Hospital Center is SAFE! ("SAFE" stands for **S**ervices and **A**dvocacy that **F**oster **E**mpowerment).

Ms. Austin explained that this tag line communicated Harlem Hospital's commitment to providing equity in LGBT healthcare. SAFE will be a symbol to LGBT Patients that HHC is a "safe" place where one can come and get the services they need. SAFE means when an LGBT person comes to an HHC facility, that individual will have advocates and allies to help them get what they need without trauma. She stated that to be empowered with equitable health care an individual needs a "safe" space and, HHC is SAFE!

Ms. Austin described Harlem Hospital's vision for the future as including the use of social media. She explained that Harlem Hospital can remove the barriers of information with platforms such as Google, Facebook, and Twitter. A successful marketing plan promoting LGBT patient-centered care including traditional brochures, posters, radio ads and print ads, adopted across the corporation is what is needed.
Ms. Austin concluded her presentation by stating, "How wonderful would it be to see HHC is SAFE on the side of a bus.

Dr. Raju stated that this was a good opportunity to talk about the Hastings Center. He stated that this was a human rights issue; and it is also about the right of freedom of expression. He stated that he was honored to have been invited to participate in the November 17th Hastings Symposium on LGBT Health. He added that HHC was leading the health care industry in this work. Ms. Brown stated that a presentation on HHC's LGBT work would be brought to the Council of CAB to further engage the CABs in this body of work. Ms. Brown stated that the goal for 2015 is for every HHC hospital and D&TC to become certified as a HEI leader. Ms. Brown thanked Mr. Winiarksi and the representatives from the facilities for their presentation and for leading this work at their respective facilities.

ADJOURNMENT

There being no further business, the meeting was adjourned at 11:40 AM.

Health and Hospitals Corporation
Strategic Planning Committee

Dennis Whalen
President

Val Grey
Executive Vice President

December 9, 2014

HANYS
Healthcare Association
of New York State

ELECTIONS

"All the News That's Fit to Print"

The New York Times

Late Edition

Today, a mix of clouds and sun, unseasonably mild, high 67. Tonight, becoming overcast, low 54. Tomorrow, rain, some heavy, a storm, high 61. Weather map, Page A20.

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G.O.P. TAKES SENATE

RIDING VOTER ANGER TO GAIN CONTROL OF CONGRESS

Party's First Step Was to Control Extremists

By JEREMY W. PETERS and CARL HULSE

WASHINGTON — It was late spring, and Republican leaders knew that if they wanted to win the Senate, they needed to crush the enemy: not Democrats, but the rebels within their own party.

And Chris McDaniel, a Senate candidate from Mississippi who had a history of making sexist and racially insensitive remarks, was a problem.

Candidates like Scott Brown, running for the Senate in New Hampshire, called the National Republican Senatorial Committee to complain that if Mr. McDaniel was not stopped, he could drag the whole party down. Strategists inside the committee's headquarters on Capitol Hill were envisioning nightmares of Democrats caricaturing all their candidates as "mini-McDaniels."

Races for the Senate Results as of midnight Eastern Standard Time.

Democratic Seats Fall in Seven States — Repudiation of President Obama

By JONATHAN WEISMAN and ASHLEY PARKER

Resurgent Republicans took control of the Senate on Tuesday night, expanded their hold on the House, and defended some of the most closely contested governors' races, in a repudiation of President Obama that will reorder the political map in his final years in office.

Propelled by economic dissatisfaction and anger toward the president, Republicans grabbed Democratic Senate seats in North Carolina, Colorado, Iowa, West Virginia, Arkansas, Montana and South Dakota to gain their first Senate majority since 2006. Senator Mitch McConnell of Kentucky, a shrewd Republican tactician, cruised to re-election and stood poised to achieve a goal he has pursued for years — Senate majority leader.

An election that started as trench warfare, state by state and district by district, crested of anxiety, leaving voters in a punishing mood, particularly for Democrats in Southern states and the Mountain West, where political polarization deepened.

The biggest surprises of the night came in North Carolina, where the Republican, Thom Tillis, came from behind to beat Senator Kay Hagan, and in Virginia. There, Senator Mark Warner, a former Democratic governor of the state, was thought to be one of the safest incumbents in his party, and instead found himself clinging to the narrowest of leads against a former Republican Party chairman, Ed Gillespie.

Those contests were measures of how difficult the terrain was for Democrats in an election where Republicans put together their strategy as a referendum on the competence of government, embodied by Mr. Obama.

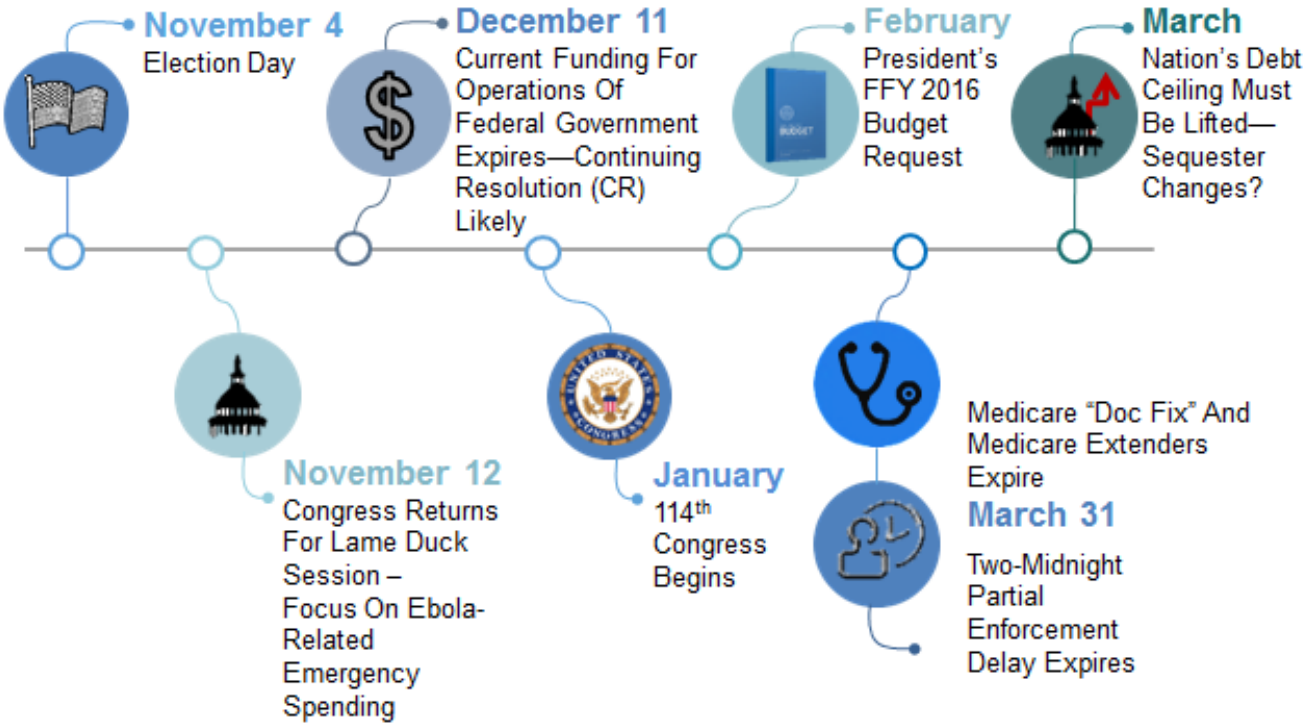
Governor sees more changes

By Matthew Hamilton
Updated 3:20 am, Wednesday, November 5, 2014

2 of 12 ◄ PREV NEXT ►

Republicans Gained Clear, but Thin, Majority in State Senate

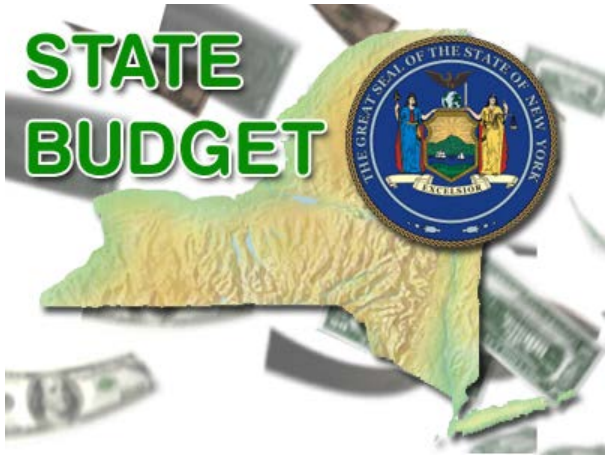
FEDERAL … LOOKING FORWARD …



Top Federal Issues

- Protecting Medicare and Medicaid payments
- Medicare Recovery Audit Contractors
- SES Risk Adjustment for Medicare Readmissions
- Disproportionate Share Hospital (DSH)
- 2-Midnight Rule Relief
- Extend Key Expiring Programs/Payments like MDH and LVH
- Improving Meaningful Use Program

MAJOR STATE ISSUES



State Policy Initiatives

NEW YORK state department of HEALTH

NYS Health Profiles

Find and Compare New York Health Care Providers

Health Data NY

nystate ofhealth
The Official Health Plan Marketplace

Redesigning
THE MEDICAID PROGRAM

APCD COUNCIL All-Payer Claims Database

KEY DSRIP ISSUES

Governance	The "bridge"	Timing
MMC role & VBP	Meaningful regulatory reform	Anti-trust
Intersection with other initiatives	End view	Government consistency & shared agenda
Adjustment	Coordination	Federal view

How Do The Pieces Fit Together?

MCO*

ROLE:
-Insurance Risk Management
-Payment Reform
-Hold PPS/Other Providers Accountable
-Data Analysis
-Member Communication
-Out of PPS Network Payments
-Manage Pharmacy Benefit
-Enrollment Assistance
-Utilization Management for Non-PPS Providers
-DISCO and Possibly FIDA/MLTCP Maintains Care Coordination

Other Providers

PPSs

ROLE:
-Be Held Accountable for Patient Outcomes and Overall Health Care Cost
-Accept/Distribute Payments
-Share Data
-Provider Performance Data to Plans/State
-Explore Ways to Improve Public Health
-Capable to Accept Bundled and Risk-Based Payments

HH #1

HH #2

Other PPS Providers

ROLE:
-Care Management for Health Home Eligibles
-Participation in Alternative Payment Systems

*Mainstream, MLTC, FIDA, HARP & DISCO

Source: NYS DOH

New York State Health Innovation Plan

SHIP

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Center for Medicare & Medicaid Innovation

State Innovation Models:
Round Two of Funding for Design and Test Assistance

- State entry into commercial market
- Mirror image of DSRIP for non-Medicaid
- Same goals for avoidable hospitalizations
- CMMI & DOH concept – actions will reduce healthcare spending in commercial market that can be re-invested via health plans for primary care
- Decision on grant expected soon
- DOH may pursue elements regardless
- No transition funding for hospital inpatient decline

New York State Health Innovation Plan

SHIP and Medicaid:
Different Constituencies, Different Funding – Same Goals

Medicaid
1. DSRIP
2. IAAF
3. VAP
4. Capital

Medicaid/ Safety Net Providers

Commercial/ Self Insured

Commercial/ Self Insured
1. DFS rate review
2. CMMI grant
3. NYSHIP

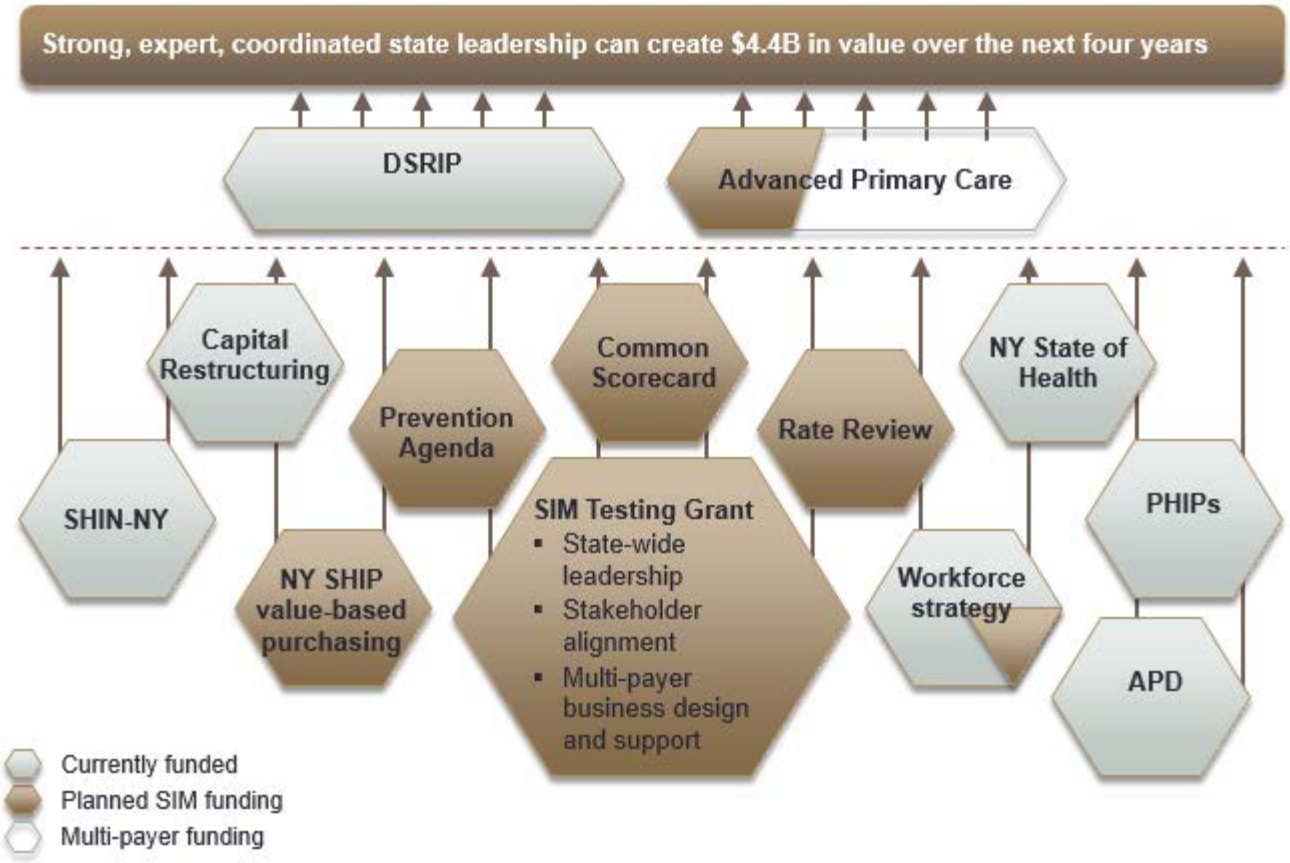
SHIP

Same Goals:

1. Reduce preventable hospitalizations by 25% in 5 years
2. Transform 80% of provider payment to value based (not fee-for-service)
3. Investment in HIT: APD & SHIN-NY
4. Population Health Improvement Projects to:
    1. Align with Prevention Agenda
    2. Promote an Advanced Primary Care Model
5. Evolve the health care workforce

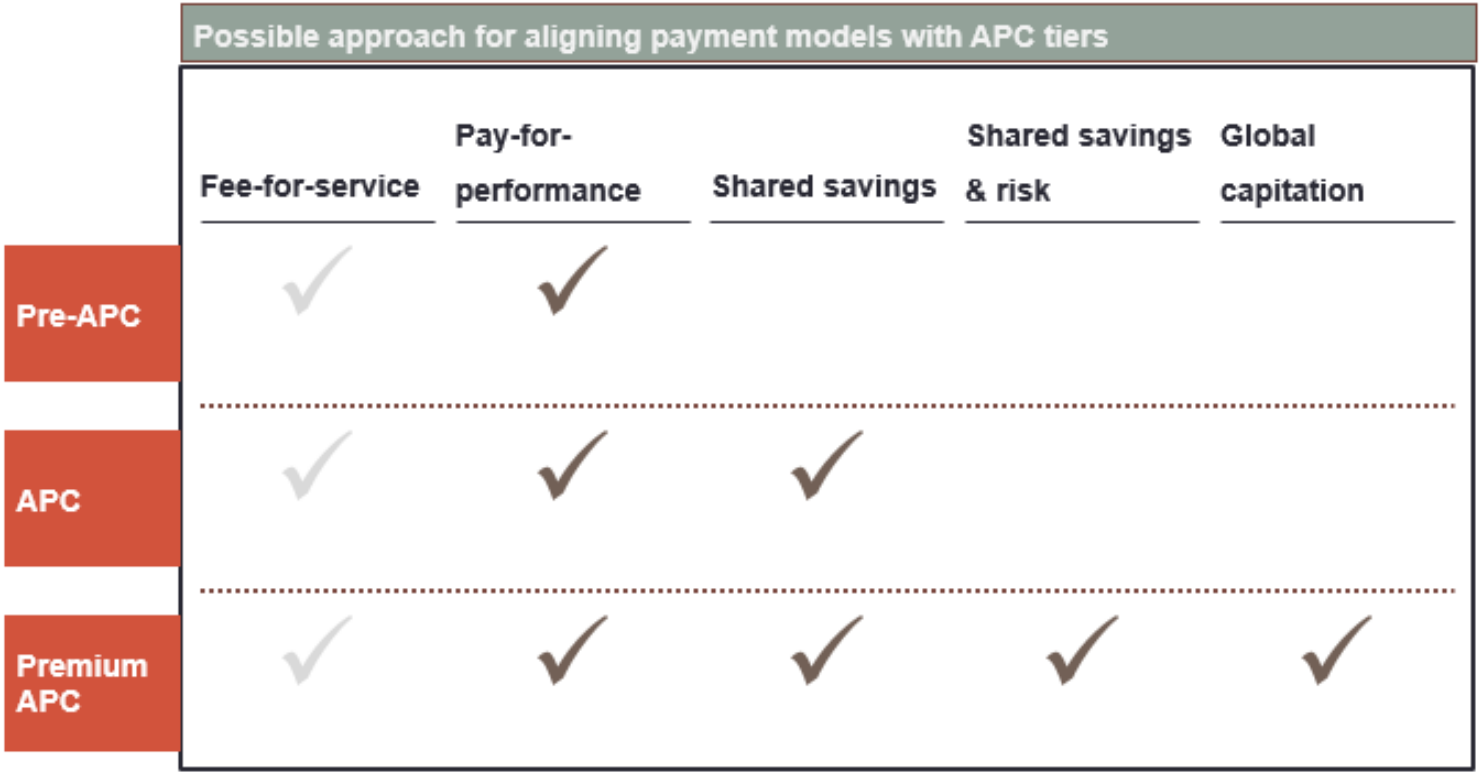
Source: New York State Department of Health

Figure 1: The SIM Testing Grant will spur innovation and catalyze change



Source: New York State Department of Health

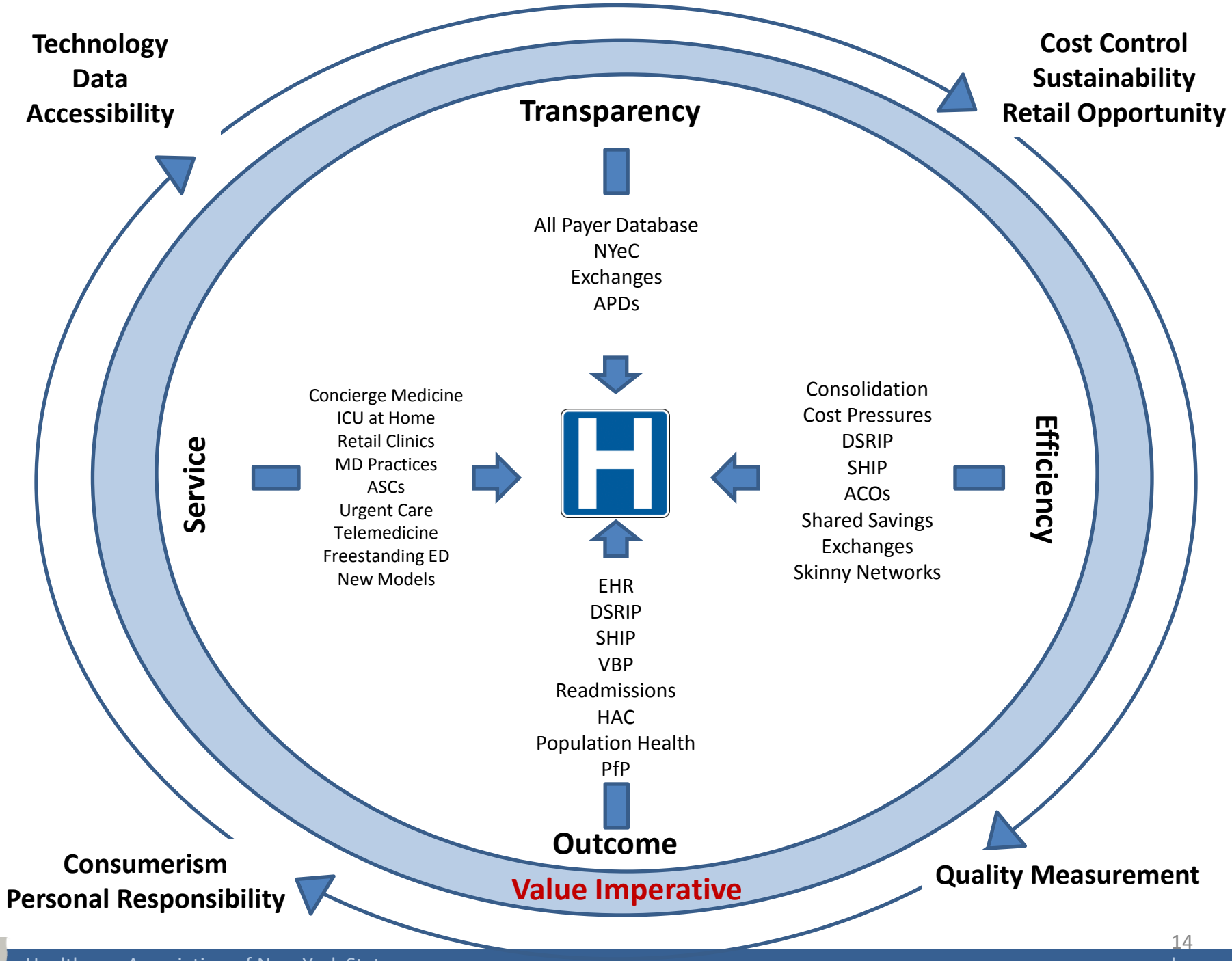
Figure 3: Value-based payment models by APC tier



Source: New York State Department of Health

KEY SHIP ISSUES

Commercial market intrusion	Need reinvestment & "bridge"	Governance
Meaningful regulatory reform	Value Based Purchasing	Ensure flexibility
Don't stifle innovation	Intersection with other initiatives	PHIP scope creep


Technology
Data
Accessibility
Cost Control
Sustainability
Retail Opportunity
Transparency
All Payer Database
NYeC
Exchanges
APDs
Service
Concierge Medicine
ICU at Home
Retail Clinics
MD Practices
ASCs
Urgent Care
Telemedicine
Freestanding ED
New Models
Consolidation
Cost Pressures
DSRIP
SHIP
ACOs
Shared Savings
Exchanges
Skinny Networks
Efficiency
EHR
DSRIP
SHIP
VBP
Readmissions
HAC
Population Health
PfP
Outcome
Consumerism
Personal Responsibility
Value Imperative
Quality Measurement

State, Federal, and Market Trends

- Downward pressure on costs
- Quality and cost measurement
- Transparency
- Payment reform:
  - Population health
  - Shifting risk
  - No single model

State, Federal, and Market Trends

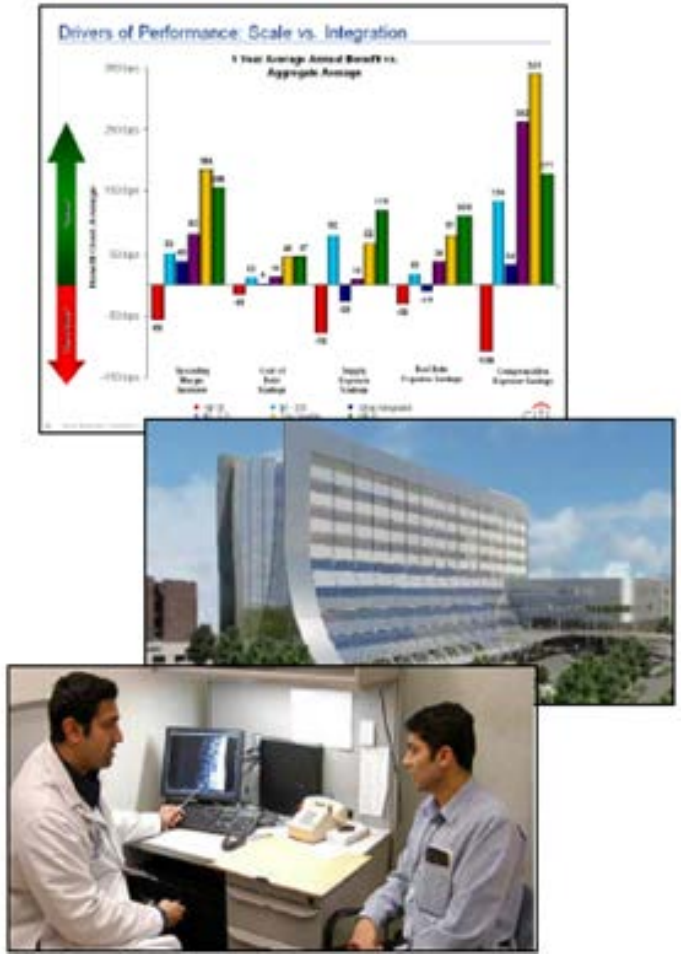
- Insurance exchange:
  - Price sensitive
  - High co-pays and deductibles
  - Employer behaviors
- Blurred lines
- Consolidations and partnerships

FUTURE SUCCESS FACTORS

The emerging success model requires:

- Scale and integration
- Market essentiality
- Leading quality and patient safety
- Aligned physicians
- Sophisticated IT with high adoption rates
- Highly efficient cost structures
- Post-acute linkages
- Progressive governance and leadership

Maintain Organizational Sustainability



Source: Michael R. Irwin, Managing Director, Citigroup, 11/2011

KEY REMINDERS

- Know when to jump . . . but be prepared
- Every market is unique
- Most important ingredient is intellectual capacity to manage
- “Build, buy, or partner?”
- Grand experiment; change is constant and dynamic
- Maintain organizational objectivity


CHANGE
SAME

THANK YOU!

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