NYC HEALTH+ HOSPITALS

STRATEGIC PLANNING COMMITTEE
OF THE BOARD OF DIRECTORS

September 8, 2016
1:00 PM
Boardroom
125 Worth Street, Room 532

AGENDA

I. Call to Order   Gordon J. Campbell

II. Adoption of June 8, 2016
    Strategic Planning Committee Meeting Minutes   Gordon J. Campbell

III. Action Item

    a. FY'16 IRS Mandated Community Health Needs Assessment
      Implementation Plans

        Adopting, in the name of the New York City Health and Hospitals
        Corporation ("NYC Health + Hospitals") Board of Directors, the
        twelve Implementation Strategies prepared for each of NYC Health
        + Hospitals' eleven acute care hospitals and for the Henry J. Carter
        Specialty Hospital and Rehabilitation Center ("HJC") as
        supplemental documents to the Community Health Needs
        Assessments ("CHNA"), which were approved by the Board of
        Directors in June 2016.

        Steven Fass, Assistant Vice President, Corporate Planning Services
    Christopher Philippou, Assistant Director, Corporate Planning Services

IV. Information Item

    a. Overview of Transformation
        Ross Wilson, MD, Chief Transformation Officer & Senior Vice President/
            CEO of Health + Hospitals Accountable Care Organization

    b. NYC Health + Hospitals' System Scorecard FY'16 Second Quarter Report
        Ross Wilson, MD, Chief Transformation Officer & Senior Vice President/
            CEO of Health + Hospitals Accountable Care Organization

    c.   Metroplus Updates

              Arnold Saperstein, MD, President & Chief Executive Officer of Metroplus

    d.   NYC Health + Hospitals' Facility Level Scorecard Template

                 Richard Gannotta, Senior Vice President of Hospitals

V. Old Business

VI. New Business

VII. Adjournment   Gordon J. Campbell

STRATEGIC PLANNING COMMITTEE MEETING
OF THE BOARD OF DIRECTORS

JUNE 8, 2016

The meeting of the Strategic Planning Committee of the Board of Directors was held on June 8, 2016 in NYC Health + Hospitals' Boardroom, which is located at 125 Worth Street with Mr. Gordon Campbell, presiding as Chairperson.

ATTENDEES

COMMITTEE MEMBERS

Gordon Campbell, Chairperson of the Committee
Ram Raju, M.D.
Lilliam Barrios-Paoli, Ph.D., Chairman of the Board
Robert F. Nolan
Mark Page
Bernard Rosen

OTHER ATTENDEES

A. Shermansong, Civic Consulting
J. Wessler, Guest

NYC HEALTH + HOSPITALS' STAFF

M. Belizaire, Assistant Director of Community Affairs, Office of Intergovernmental
    Relations and Planning
C. Barrow, Senior Associate Director, Lincoln Medical and Mental Health Center
D. Benjamin, Restructuring Project Management Officer, Presidents Office
M. Beverly, Assistant Vice President, Finance
S. Bussey, Chief, Ambulatory Care, President's Office
T. Carlisle, Associate Executive Director, Corporate Planning Services
R. Carter, Director, Patient Experience
E. Casey, Director, Corporate Planning, HIV Services
M. Cooper, Director, Office of Intergovernmental Relations and Planning
O. Deshchenko, Director, President's Office

A. Divittis, Senior Associate Director, NYC Health + Hospitals/Woodhull

R. Dixon, Associate Director, NYC Health + Hospitals/Harlem

S. Fass, Assistant Vice President, Corporate Planning Services

L. Guttman, Assistant Vice President, Office of Intergovernmental Relations and Planning

T. Hamilton, Assistant Vice President, Corporate Planning and HIV Services

C. Hercules, Chief of Staff, Office of the Chairman of the Board of Directors

J. Jurenko, Senior Assistant Vice President, Office of Intergovernmental Relations and Planning

S. Kleinbart, Director of Planning, NYC Health + Hospitals/Coney Island

F. Leich, Senior Director, Office of the President

Z. Liu, Senior Management Consultant, Corporate Planning Services

L. Lombardi, Chief Strategy Officer, NYC Health + Hospitals/Bellevue

P. Lockhart, Secretary to the Corporation, Office of the Chairman of the Board of Directors

A. Marengo, Senior Vice President, Communications and Marketing

R. Mark, Chief of Staff, Office of the President

A. Martin, Executive Vice President and Chief Operating Officer, Office of the President

W. Mejias-Gonzalez, Senior Associate Executive Director, NYC Health + Hospitals/Queens

A. Moran, Chief Executive Officer, NYC Health + Hospitals/Metropolitan

S. Newmark, Senior Corporate Health Project Advisor, Office of the President

A. Ormsby, Senior Director, Communications and Marketing

C. Philippou, Assistant Director, Corporate Planning Services

M. Ramirez, Director, Communications and Marketing

S. Ritzel, Associate Director, NYC Health + Hospitals/Kings County

R. Rowell, Director of Community Affairs, Office of Intergovernmental Relations and Planning

E. Russo, Senior Director, NYC Health + Hospitals/Coney Island

S. Russo, Senior Vice President, Office of Legal Affairs

U. Tambar, Assistant Vice President, Transformation

K. Whyte, Senior Director, Intergovernmental Relations and Planning

R. Wilson, M.D., Senior Vice President, Corporate Chief Medical Officer, Medical and Professional Affairs

A. Young, Director of Community Affairs, Office of Intergovernmental Relations and Planning

CALL TO ORDER

Mr. Gordon Campbell Chairman of the Strategic Planning Committee, called the June 8th meeting of the Strategic Planning Committee (SPC) to order at 10:05 A.M. The minutes of the March 30, 2016 SPC meeting were adopted.

ACTION ITEM

FY'16 IRS Mandated Community Health Needs Assessment Update Report
Steven Fass, Assistant Vice President, Corporate Planning Services
Christopher Philippou, Assistant Director, Corporate Planning Services

Mr. Jurenko, Vice President, Intergovernmental Relations and Planning introduced Steven Fass, Assistant Vice President and Christopher Philippou, Assistant Director of Corporate Planning Services. He informed the Committee that they will give an update of the FY'16 IRS Mandated Community Health Needs Assessment. Mr. Jurenko explained that the Affordable Care Act (ACA) added requirements that 501© (3) tax-exempt hospitals nationwide must conduct a Community Health Needs Assessment (CHNA). The goal is to improve community health by identifying opportunities to improve health care delivery or address other community needs. He informed the Committee that the initial Community Needs Assessment Report was done in 2013. As part of the process, CHNA reports must be adopted by a governing body of the facility; made widely available to the public and upon demand; and completed or updated at least every three years. In addition, hospitals are also required to develop implementation strategies to address high priority needs identified in the CHNA. Implementation strategies must be adopted by an authorized body of the facility no later than November 15. Mr. Jurenko noted that the ACA also added an excise tax of $50,000 on any hospital organization that fails to meet these requirements.

Mr. Fass reported that there were five required components of the CHNA Report as listed below:

- A definition of the community served. For most hospitals we used the zip codes where 75% of patients reside and described the demographics and population health of those zip codes.
    - HJ Carter LTAC patients come from all over the City. We also made an adjustment for Bellevue who also draws from a wide area.
- A list of the most significant health needs of the community in rank order. Ranking the needs is a new requirement and was not done in the 2013 CHNA report.
- Detailed process and methodology
- A list of all community benefit organizations and city agencies
- An evaluation of programs included in the 2013 CHNA report

Mr. Fass reported on the Process and Methods to Identify and Prioritize Community Health Needs as the following:

- Each hospital created a specific CHNA report, the methodology was developed by a work group of hospital planners and consistently implemented.
- From a review of internal, state, and federal documents, the work group created a list of over 40 potential health needs.
- This was narrowed down to 13 after receiving input from other hospital staff and testing it with hospital users.
- To rank the health needs, 4 sources were blended together, weighted equally: CAB members; hospital users; hospital leadership; and the prevalence of the condition.

- A total of 1700 Hospital user surveys were collected, translated into 8 languages (Bambara – Bali; Bengali, simplified Chinese, French Haitian Creole, Polish, Russian, and Spanish).
- Using this methodology, the community needs were often very tightly grouped and occasionally in a tie; however one of the new requirements in 2016 is that they must be ranked.
  - Lastly, the final rankings were reviewed by hospital leadership and staff.
  - Those needs ranked highest meets the IRS definition of, "significant community health need". The IRS requires that these require an action plan, which is to be posted in November.

Mr. Philippou reported on CHNA's findings: Significant Community Health Needs which is presented below:

- Hypertension/high blood pressure and diabetes are significant community health needs at all hospitals
- Obesity and heart disease are significant at the majority of hospitals.
- HIV/AIDS was identified as a significant community health need at 5 hospitals in 2013, but by none in 2015, reflecting progress in reducing HIV/AIDS diagnoses and deaths in NYC.

Significant health need and its rank (1=greatest need; 13=lowest need)	Not a significant health need and its rank (1= greatest need; 13 = lowest need)

Need	Bellevue	Carter	Coney Island	Elmhurst	Harlem	Jacobi	Kings County	Lincoln	Met	NCB	Queens	Woodhull
Hypertension	1	1 (tie)	4	2	1	1	2	1	2	2 (tie)	2	1
Diabetes	5	1 (tie)	1	1	2 (tie)	3	1	3	1	2 (tie)	1	3 (tie)
Obesity	2 (tie)	4 (tie)	6	4 (tie)	9	4	6	6	3	4	5	3 (tie)
Heart Disease	2 (tie)	3	2 (tie)	4 (tie)	8	5 (tie)	4	4 (tie)	5	6	10 (tie)	5
Mental Illness	4	6 (tie)	8 (tie)	4 (tie)	6	5 (tie)	3	10 (tie)	9	5	3 (tie)	6
Substance Use	6	9	10	7	5	9	7 (tie)	2	7	9	6 (tie)	2
Asthma	8	6 (tie)	8 (tie)	12	2 (tie)	2	9	4 (tie)	4	1	13	7 (tie)
Cancer	7	10	2 (tie)	3	11	8	5	9	8	7	8 (tie)	11
Smoking	11	6 (tie)	5	8	4	7	12	7	12	8	3 (tie)	10
Violence	10	12 (tie)	11	9	10	10	10	8	6	10	6 (tie)	7 (tie)
HIV/AIDS	9	11	13	10	7	11	7 (tie)	10 (tie)	10	11	12	7 (tie)
Dementia	12	4 (tie)	7	11	12 (tie)	12	13	12	11	12	10 (tie)	12 (tie)
Perinatal	13	12 (tie)	12	13	12 (tie)	13	11	13	13	13	8 (tie)	12 tie)

Mr. Philippou reported that the top significant health needs identified in the system's acute care facilities' service area in the 2016 CHNA persist from 2013. These include:

- Hypertension and Diabetes, both identified as significant needs in all 12 acute care facilities;
- Obesity and Heart Disease identified in the majority of facilities;
- Mental Illness identified in half of our acute care facilities;
- Asthma and other respiratory issues identified in 5 facilities.

Mr. Philippou explained that the significant needs (identified in blue highlighted cells) are the highest ranked needs after the needs identification and ranking processes from each acute care facility's

perspective. In addition, the needs are sorted by system-wide ranking of the collective needs of our communities (with 1 as greatest need, ascending to 13 as lowest need). Mr. Philippou informed the Committee that the final list of significant needs is the prioritized list of needs based on the synthesis of community input, facility leader input and public health data. He cautioned, however that it does not make any statement that the other identified needs in the grid or other needs that do not appear on this grid are not important. Contrary to this, all of the identified needs, as well as many social determinants of health and risk factors to the identified chronic conditions have a need for programming and resources in our communities. This list recognizes the *top* concerns from the perspective of the acute care facility community served and leadership. Mr. Philippou stressed that, while the CHNA 2016 and 2013 processes are not comparable, for reasons which are listed below, it is important to note that HIV/AIDS, which was identified as a significant need in 5 acute care facilities in 2013 was not identified in any in 2016. He noted that this is partly due to a real world decline in HIV diagnosis rate in the communities that we serve. He added that the methodology differences, as per differing IRS requirements, otherwise drive many of the shifts in the significant needs that are identified in each respective year. Collectively, these changes led to a more coordinated and systematic 2016 CHNA process. Key methodological changes include:

- Identifying need through community input varied in methodology
- Use of a standardized list of identified needs in 2016;
- Needs in 2016 are prioritized with community input as compared to their identification by facility leadership in 2013;
- The number of needs considered significant in each acute care facility is standardized in 2016.

Mr. Philippou noted that, with respect to the December 2014 DSRIP Community Needs Assessment, conducted for OneCity Health, these needs assessment findings are also not directly comparable. He added that the approach for the DSRIP needs assessment was more comprehensive and included community input of health and health-related subject matter experts and focused groups of vulnerable populations, as well as gap analysis of needs and resources in the neighborhoods that we serve. He highlighted, however, that the needs identified in the 2016 CHNA align with the projects currently being implemented by OneCity Health, as well as system-wide clinical initiatives coordinated by Medical and Professional Affairs.

Dr. Raju inquired about those health needs that did not make the list as the top Community Health Needs Assessment. He asked if this is due to NYC Health + Hospitals' robust programs in those areas or because the need is no longer prevalent as before in those areas. Mr. Jurenko answered that it is because NYC Health + Hospitals is providing good care in those areas. In addition, because of all the work that is being done on behalf of the City and the tremendous amount of resources that are spent on this, the community health needs have dropped down. Mr. Fass commented that half of the findings are based on perception of users in the community or the CAB members and this perception is based on what they read on the paper and provided information. Mr. Mark Page, Board Member, asked whether we are driving off a dearth of care in a given community for a particular health need or are looking at the healthcare that the community requires. Also, a dearth question is what happens if there are a bunch of other hospitals in that community. Is there a dearth that needs to be filled by NYC Health + Hospitals? Is it a shortage of care being provided by NYC Health + Hospitals in that community or is it something else? In other words, Mr. Page would like to know what is being measured. Is it a shortfall, an HHC facility shortfall or is it just that a lot of people have asthma in this community and are being treated beautifully, but they show up here because asthma is important.

Mr. Steve Bussey, Senior Vice President, Ambulatory Care noted that the listed inpatient results would have been totally different for outpatient facilities. He commented that he was surprised to see that HIV/AIDS was so low particularly in some communities, but would not see much of it at the inpatient sites. Ross Wilson, MD, Senior Vice President, Corporate Chief Medical Officer, interjected

that the goals are mixed. He explained that one goal is how prevalent is the disease and, therefore the health care need in that community; and another could be what are the demands that people want from that facility. For chronic illnesses, he noted, however, that the demands are going to be high whether the services are good or not as people are still going to need care. Dr. Wilson added that he is a little perplexed by these results, particularly as most of these conditions are ambulatory care conditions and that only the hospitals were surveyed. Dr. Wilson recommended that the D&TC's be surveyed as well and that the DOHMH maps are added into it. He explained that DOHMH have various significant maps and would like to see how these needs line-up. Sympathetically, Dr. Wilson added that we have been told to do this assessment within a set of rules and will end up with a product that may not drive to what needs to be done. Dr. Wilson reiterated that the questions are real and what we are trying to do is to balance what is a requirement with its associated rules versus what we need to drive that care plan. Mr. Page commented that all these questions are extremely important and while it requires a lot of thoughts and resources to put the report together, it would be nice if it drops out a useful answer. The question is that how can this be done and still hit the boxes on what the Feds are requiring of us.

Mr. Philipou answered that it is important to note that there are a lot of other needs that are not even identified. He noted that social determinants are being considered here. He admitted that a lot of needs that were identified by CAB members and users are not on this grid. He reminded the Committee that the IRS mandate is for the hospitals to first identify a standardized list of needs for all the communities NYC Health + Hospitals serve and then to prioritize that list. Mr. Philippou admitted that the communities face more than these 13 needs; at least 30 to 40 different types of needs. However, the purpose of this process is to highlight the most significant, the most important, or the needs that are mostly targeted by NYC Health + Hospitals' acute care facilities. Mr. Philippou informed the Committee that outpatient clinics were also surveyed; but given the magnitude and the weight of the people that are thinking from an acute care prospective, it is directly correlated to have acute care facilities think of these conditions. However, another needs assessment from the prospective of Gotham is in the work and will have different viewpoints. Mr. Philippou summed that, firstly, there was a need to meet the need of IRS to identify the needs. This is an evolving process and Gotham would have a different prospective. The point is that these are the most significant needs in these communities.

Mr. Campbell interjected that, while we need to adhere to IRS rules, there is a need to look at if these perceptions are close to reality. Mr. Page asked about how the priority is being identified. His understanding is that you need to identify where we actually have issues or shortages that need to be addressed. Mr. Philippou answered that the report is a less comprehensive report. It was not a gap analysis report where needs and resources are aligned. He reiterated that CHNA is trying to get all those different perceptions together to identify significant needs. Mr. Philippou stated that we cannot conclusively say that these are the only needs of the community and because something was not flagged as a significant need that it is not prevalent in the community. He informed the Committee that the 2013 CHNA report resulted in 90 different needs identified. He also added that due to a constraint in resources, it is not possible to have 50 different new programs to identify every need that comes around. Mr. Jurenko reiterated that the IRS mandate calls for those needs to be prioritized. Mr. Jurenko shared with the Committee that a broader approach was used to survey hospitals users, inpatients and outpatients, and Community Advisory Board members. In addition, DOHMH's community health needs assessments as well as other data sources were looked at in trying to balance the findings of the community residents, hospital users and CAB members versus NYC Health + Hospitals leadership; all of which were blended together to create that list which is prioritized as per IRS' request. Mr. Jurenko informed the Committee that identifying the community needs is the first phase of the assessment and that the next phase will be on the implementation side. The question is whether this is something unique to us or is community-wide. Looking at the asthma scores, for example, the data was analyzed to see: how it ranks with other health needs; what does it mean for

Lincoln, the downtown Bronx and Harlem where the data score is prevalent; and does that comport with what the community residents and leadership is telling us and made some adjustments as necessary.

Dr. Raju commented that the first part of the report is very useful. However, while it is a mandated process, the results can be used to our advantage. He added that the Gotham needs assessment will be very useful because, as clinics are being expanded in the future, we need to figure out what services are needed in those clinics depending on the community needs. Dr. Raju stated that since the identified need is a community need, perhaps there are other providers providing the same services. Therefore, is there a gap to be filled? He noted that this gap is: 1) NYC Health + Hospitals' mission, and 2) market share. He explained that if we provide those services, more people will come and use NYC Health + Hospitals' services. Dr. Raju noted that we are given an opportunity to go to the next level. Dr. Raju added that even with the inpatient services, NYC Health + Hospitals need to take a close look of the percentage of the five major needs identified (Hypertension, Diabetes, Obesity, Heart Disease and Mental Illness) from the total inpatient service. Whether it is measured by FTEs or toward the amount of money, how much are the most spent on those five ones and how much are the most spent outside the five ones. Dr. Raju noted that as a traditional health care delivery system, we continue to perpetuate those services even though there may not be enough need for it as it was 5, 10 or 20 years ago. He added that, as we are taking advantage of this opportunity to transform the organization and redesign the care, there is a need to look at the market share, otherwise, we will be selling the same product. Dr. Raju stated that uniqueness is what is going to drive this organization. Therefore, the planning department should take it over and keep advising us on how to do that. The days are gone when cheap rent and location were the only factors taken into consideration in opening a clinic. Dr. Raju stressed that in the future the clinics will be based on where it is, what is the market share, who is next to us and what is the competition in the area? Mr. Jurenko agreed with Dr. Raju that this first step of the CHNA report should be expanded.

Mr. Fass reported that the implementation strategy is due on November 15, 2016. He stated that this second part of the CHNA report is a description of how the hospital plans to address the high priority community needs identified in the community health needs assessment. The implementation strategy must include:

- The anticipated impact of these actions and a plan to evaluate the impact;
- Identified programs and resources the hospital plans to commit to address each high priority health need; and
- Description of any planned collaborations with hospitals or other organizations.
- The implementation strategy must be adopted by a governing body of the facility.
- This implementation strategy must also be posted on NYC Health + Hospitals' website.

Mr. Jurenko read the resolution as follows:

> "Adopting in the name of the New York City Health and Hospitals Corporation ("NYC Health + Hospitals") Board of Directors the twelve Community Health Needs Assessments ("CHNA") prepared for each of NYC Health + Hospitals' eleven acute care hospitals and for the Henry J. Carter Specialty Hospital and Rehabilitation Center ("HJC").

The resolution was moved and adopted by unanimous vote.

INFORMATION ITEMS

NYC Health + Hospitals' System Scorecard FY'16 First Quarter Report
Udai Tambar, Chief Transformation Officer

Mr. Campbell introduced Mr. Udai Tambar, Chief Transformation Officer, and invited him to present the first quarter of the System's Scorecard as presented below:

SYSTEM SCORECARD 2016 Q1

		LEAD	TARGET Q1	ACTUAL Q1		PRIOR QUARTER	PRIOR YEAR	TARGET 2020
Anticipate & meet patient needs								
1	Out-patient satisfaction (overall mean)	COO	80%	78%	Y	78%	77%	93%
2	In-patient satisfaction (rate-the-hospital top box score)	COO	62%	59%	R	59%	60%	80%
Engage our workforce where each of us is supported & personally accountable								
3	Staff completing leadership programs	COO	242	385	G	536	239	1,200
4	Employee engagement (5 point scale)	COO	4.1	3.5	Y	3.5	NA	4.1
Provide high quality safe care in a culturally sensitive, coordinated way								
5	Hospital-acquired infections (CLABSI SIR)	CMO	1.00	1.04	R	0.86	0.95	0.50
6	DSRIP on track	OneCity CEO	90%	100%	G	100%	NA	90%
Expand access to serve more patients (market share)								
7	Access to appts (new adult patient TNAA days)	CMO	14	20	Y	22	26	14
8	Unique patients (thousand)	COO	1,200	1,226	G	1,238	1,218	2,000
9	MetroPlus members (thousand)	M+ CEO	490	493	G	482	470	675
10	Patient revenue (proportion of expense)	COO	62%	55%	R	58%	59%	70%
Increase efficiency by investing in technology & capital (organizational reform)								
11	EMR budget variance	CIO	0%	0%	G	0%	0%	0%
12	EMR implementation on track (milestones)	CIO	100%	90%	Y	90%	90%	100%
13	Contractors performance at service level	COO	100%	91%	Y	91%	NA	100%
14	FEMA projects on track	COO	100%	100%	G	92%	NA	100%
		LEAD	TARGET	ACTUAL		PRIOR QUARTER	PRIOR YEAR	TARGET 2020

Note: Calendar year.
CLABSI data not finalized for 5 months after the reporting period; considered to be most accurate after CMS reporting deadline for the quarter.

G	on target
Y	trending toward target
R	off target

Mr. Tambar

Mr. Campbell reminded the Committee that the Scorecard is a work in progress and that their ideas and suggestions are welcomed.

Mr. Tambar stated that the scorecard's data for the first quarter is up to August 31st. He recapped that the scorecard is comprised of five main categories that are aligned with Dr. Raju's vision 2020 as listed below:
1. Patient Experience
2. Employee Engagement
3. Quality

4. Access (Market Share)
5. Efficient Support (Organizational Reform)

Mr. Tambar described the meaning of the traffic lights in this context as the following:
- Green: above the quarter's target
- Yellow: below target but trending in the right direction
             (Trending in the right direction: either above the quarter's target or the prior year's target)
- Red: below the target and below both the prior quarter and the prior year's target

Mr. Tambar informed the Committee that Ms. Raven Carter, Director, will be reporting on the Patient Experience section of the Scorecard. He also brought the Committee's attention to the next Glossary slide comprised of the definition of all the indicators.

Mr. Bernard Rosen, Board Member, asked Mr. Tambar to expand on the patient revenue (proportion of expenditure) metric. Mr. Tambar answered that it is a ratio of revenues over expenses.

Dr. Raju explained further that, as we are approaching the status in this country of supplemental income going down, we need to access whether we are able to pay our expenses through patients' internal income. Therefore, where we stand on that ratio is important. Dr. Raju noted that in the past that ratio used to be 60%. Dr. Raju also noted that 40% or our $7.8 billion comes from UPL/DSH money. Therefore, there is a need to move more and more towards less than that. It is projected that in 2020 70% of our total expenses will come from patient generated revenue.

Mr. Tambar added that it is a ratio that is fixed on a target which does not exactly mirror where our revenues and expenses go which is a little more up and down. Since it is a work in progress, there is a need to figure out the right way to measure this metric. That is the reason that it is in red this time even though it was green before as it reflects just the nature of how money comes in and out.

Mr. Tambar stated that the goal of the scorecard is to give a system view of what is going on. He highlighted that the employee engagement which was red last time is yellow this time. Also, the CLABSI score which was green on the last report is red, because, as explained in the footnote, CLABSI data are not finalized for 5 months after the reporting period; they are considered to be most accurate after CMS reporting deadline for the quarter. He highlighted that FEMA projects went from yellow to green and are now on target.

Mr. Campbell thanked Mr. Tambar for adding the glossary listed on the next slide. He commented that it is very helpful to show for each of the metrics what the variance is in terms of when they will become a target as each one of them is calibrated and calculated differently.

GLOSSARY

Anticipate & meet patient needs	
1 Out-patient satisfaction (overall mean)	roll-up average of all outpatient scores from each outpatient survey (random sample); by visit date
2 In-patient satisfaction (rate-the-hospital top box score)	% in-patients surveyed who rank hospital 9 or 10 out of 10 (random sample); by discharge date
Engage our workforce where each of us is supported & personally accountable	
3 Staff completing leadership programs	cumulative YTD employees completing supervisor, manager, leadership, and fellowship training; ~5,000 employees are eligible
4 Employee engagement (5 point scale)	survey of employees "I would recommend this organization as a good place to work"; baseline Q3 2015; actual Q1 2016; target national safety net average
Provide high quality safe care in a culturally sensitive, coordinated way	
5 Hospital-acquired infections (CLABSI SIR)	observed / expected Central Line Associated Blood Stream Infection - Standardized Infection Rate; data not finalized for 5 months after the reporting period; considered
6 DSRIP on track	total PPS $ awarded / total potential (up to $1.2 B over five years); cumulative since April 2015; reported Jan & Jul
Expand access to serve more patients (market share)	
7 Access to appts (new adult patient TNAA days)	average days to third next available appointment for new adult patients (primary care only)
8 Unique patients (thousand)	12-month cumulative of unique patients across entire system (not double counting patients who visit multiple sites); high estimate; actuals = 3 month cumulate
9 MetroPlus members (thousand)	active MetroPlus members across all categories at the end of the quarter
10 Patient revenue (proportion of expense)	patient-generated revenue / operating expense excluding City payments (cash receipts & disbursements YTD)
Increase efficiency by investing in technology & capital (organizational reform)	
11 EMR budget variance	EMR implementation over or under budget
12 EMR implementation on track (milestones)	estimate of milestones completed on time: Green = 100%; Yellow = missed milestones have no impact on go-live dates; Red = delays expected for go-live
13 Contractors performance at service level	% vendors compliant with Key Peformance Indicators (for 11 biggest spend contracts ~45% of spend); KPIs vary by contract
14 FEMA projects on track	% milestones from monthly FEMA Program Dashboard on track (green or yellow)

G	on target
Y	trending toward target
R	off target

Mr. Tambar added that the scorecard is not just an exercise that is done for the Board, but rather data that is used to manage the organization. Therefore it is not only a governance tool, but a management tool as well. In addition to the System scorecard, there is also a facility-level scorecard at the Chief Operating Officer level showing how the different facilities compared to each other that Mr. Martin's Operations and Logistics team can use in his conversation with leadership. Mr. Tambar informed the Committee that the Transformation Office has been working with a few facilities to pilot the facility scorecard and had received some positive feedback. The idea is, within the facility level, to get to a unit or department level that will subsequently cascade on the front line staff, so that it is all aligned with the direction we wish to go. See chart below.

Creating a result-oriented culture
Scorecards provide levers for change and tools to collect upward feedback

Creating a result-oriented culture
Scorecards provide levers for change and tools to collect upward feedback
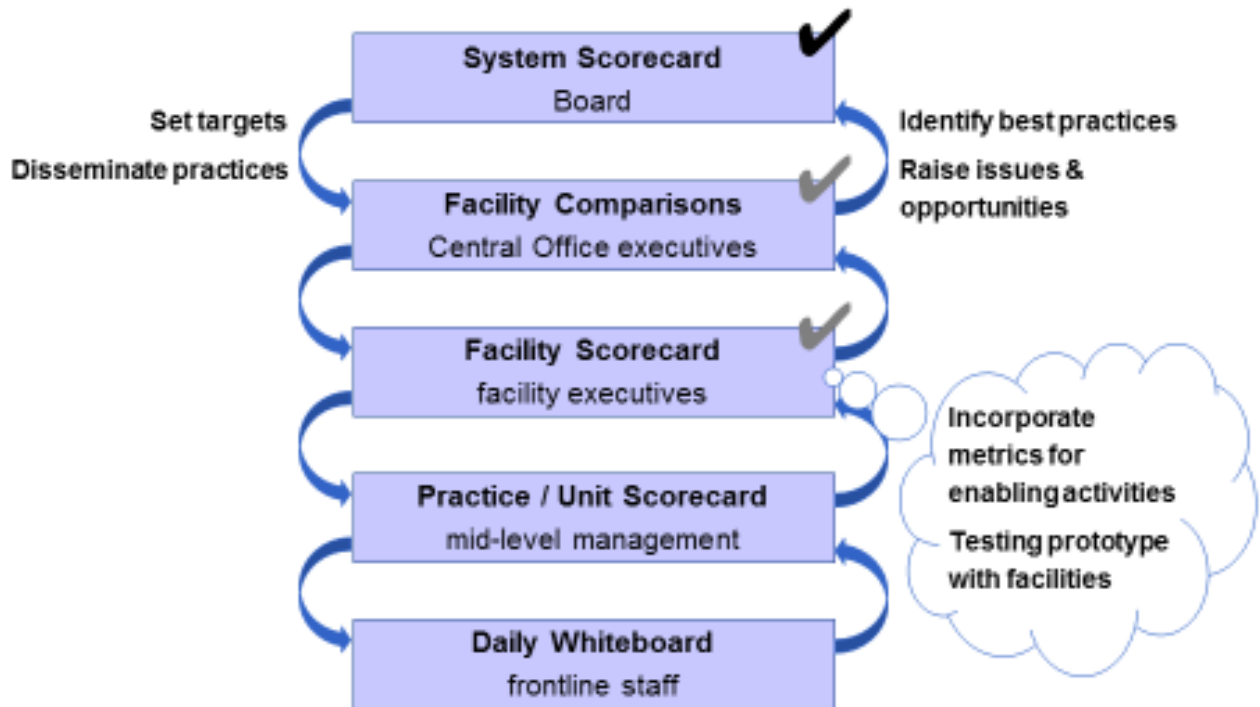
Mr. Tambar reported on testing prototype Facility Scorecard with Hospital Executives. The findings are listed below:

Benefits
- "True North" - Takes everything a CEO is supposed to look and gives a snapshot
- Enables everyone to "speak the same language"
- Will be useful in creating a disciplined focus on the System's priorities
- Supporting metrics begin to give a sense of how to "get ahead of the game"

Examples of current practices to monitor and drive results
- Facility CNO runs a weekly report on "Communication with Nurses" report and discusses the results with the relevant units
    - Result: Surveys scores are trending up
- Facility CMO holds a weekly huddle to review Hospital-Acquired Infections and revise policies and procedures
    - Result: CLABSI is better than target
- Facility COO facilitated Rapid-Assessment Event on "respect" which led to daily discussions of it, among other actions
    - Result: Surveys show positive trends, which should be reflected on the next Employee Pulse Check Survey

Mr. Tambar reported on the Scorecard's Next Steps as the following:

July – September 2016	October-December 2016	January 2017
Determine Facility-level Metrics	*Deploy Facility Dashboards*	*Determine department and frontline metrics*
Expand metrics & Align w/ System Scorecard	Refresh dashboards Frequently	Develop training
Develop review Protocol	Share best practices	

Mr. Tambar reiterated that the scorecard is a supporting tool, and that the data provided are helpful to make informed decision to improve the quality of services NYC Health + Hospitals provide. Mr. Tambar stated that there have been discussion of a timeline. There is a system-wide scorecard and for the next quarter, a kind of protocol or draft for the multiple facilities will be developed so that the facility-level scorecard will be finalized by the end of the year.

Mr. Campbell commented that the scorecard is creating a culture where it is metric-driven and inculcated in that culture, sharing the best practices and lessons learned. He reiterated that it is still a work in progress leading to the desired direction.

Mr. Tambar added that the scorecard is creating that common language, being objective and then framing it as not a punitive exercise.

Mr. Tambar concluded his presentation stating that a draft template of the facility-level scorecard will be available on his next report. Mr. Campbell also reminded the Committee that each report will address one or two of the 14 metrics. He announced that Press Ganey will also present today and that MetroPlus Health Plan will be presenting on the following report.

Mr. Tambar turned the meeting over to Ms. Carter to present the Patient Experience Review.

Patient Experience Review
Raven Carter, MBA/FACHE, Director, Patient & Family Experience

Ms. Carter introduced Ms. Gwen Faust, Advisor, Press Ganey Associates, and invited her to join her at the table. She started her presentation with an overview of the Survey Methodology as shown on the following slide:

Data is available for ad hoc and standard reporting

Names, addresses, and other demographics are uploaded to Press Ganey

We verify addresses, print, and mail surveys

We receive and scan surveys, post images, data, and comments for review and use

Your patients complete surveys and return them to Press Ganey
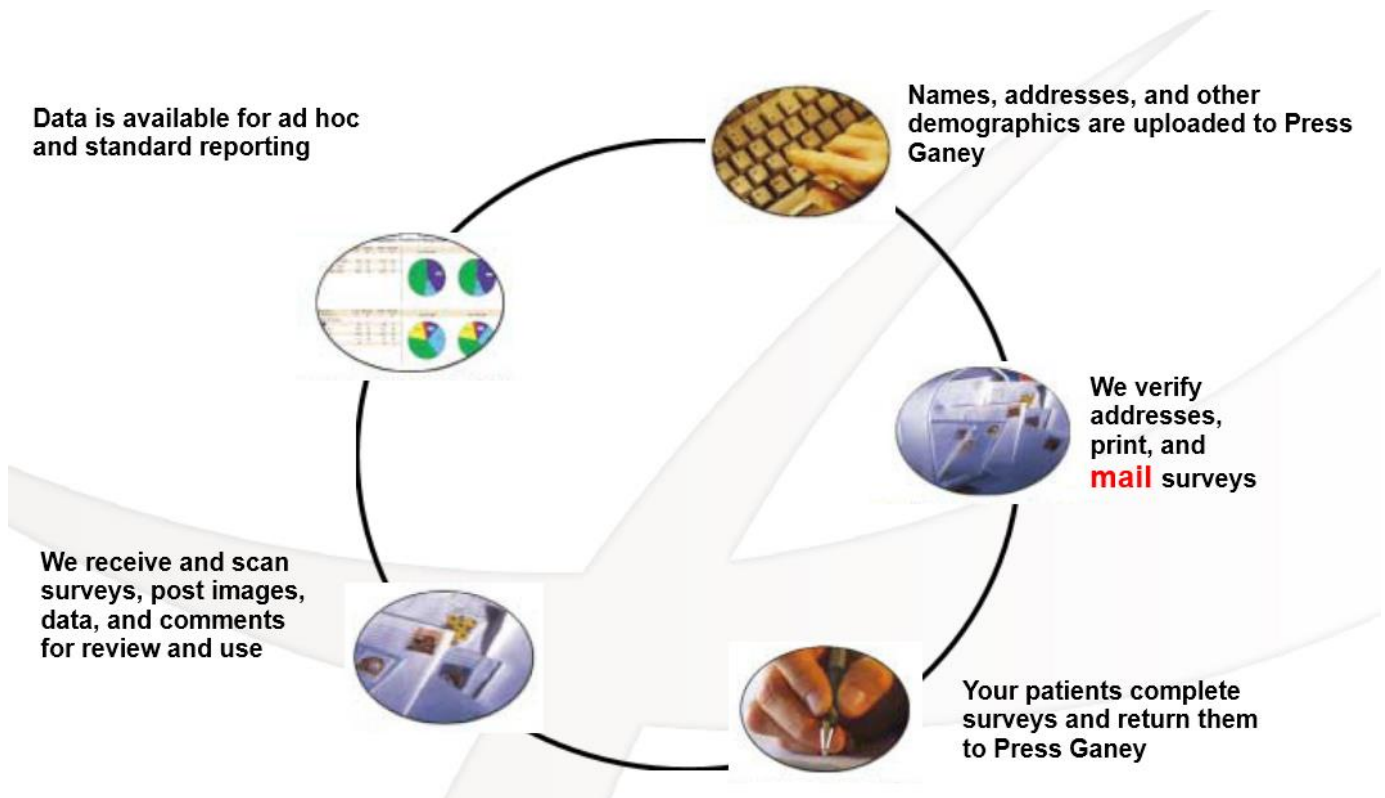
Ms. Carter informed the Committee that most of the patients take at least four to six weeks to return the survey to Press Ganey's processing plant in South Bend, IN. Mr. Campbell asked about the rate of return for inpatient and outpatient surveys. Ms. Carter answered that each survey has its own response rate as the survey questions are a little bit different from inpatient to outpatient. Looking at inpatient facilities, just on the HCHAPS surveys, Ms. Carter stated that our response rate ranges from 12 – 17% while on the National level average is 29%. On the outpatient's side, however, our response rate ranges from 4% - 8% as opposed to 20% on the national level. Ms. Carter explained that our lesser response rate range is based on patients' population. She explained that a lot of the patients have transient addresses. She added that, based on her experience of working with other public hospitals, some of the patients do not have a stable home address to send the survey to. Ms. Carter explained that the roadblocks encountered for getting patients to complete a survey are the same when employees are requested to complete a survey. The key is to: 1) communicate with them stating that "we need your feedback and we value it", and 2) Using their feedback to make changes. That is really where the patient is going to connect to. He will not hesitate to share his feedback as he knows that it will be used.

Mr. Rosen asked if it is possible to give the patient a small gift just to encourage him to do the survey. Dr. Raju answered by reminding the Committee that healthcare reimbursement has moved to value-based purchasing; therefore, it is no longer about the quality of care but the patient's perception of the care he/she received. As such, the Federal Government (CMS) prohibits this practice as it is considered as bribing to get better scores. Dr. Raju commented that New York City does not have an evaluation culture. In addition, people tend to feel surveys only if they feel very good about it or very bad about it. Should they be neutral, they really are not interested. Therefore, the issues are not process issues, but the psyche of the population issues coupled with language issues.

Ms. Carter reiterated that we cannot give gifts to patients for filling out the surveys because CMS is very specific about how the survey is to be conducted including the language to be used in the survey. She stressed that communication is the best way to engage the patients in the survey process. She

informed the Committee that there are other modes of surveys other than the paper survey, which is the most approved way by CMS. She stated that people feel that e-surveys are a little easier and could have generated more robust responses. However, e-surveys are not an approved methodology from CMS. He informed the Committee that we survey a lot of areas not just the inpatient CAPS survey which is mandated by CMS either via a paper or a phone survey. She shared with the Committee that from her experience with both methodologies, the phone survey does not increase the response rate as you would think it would because people do not answer their phone nowadays.

Dr. Raju asked while we are not allowed to give the patient an incentive to feel the survey, he would like to know if on a routine basis the discharged patient is advised that he/she will be receiving a survey at home that will serve to improve services at that facility. Ms. Carter answered that discharge phone calls is part of NYC Health + Hospitals' discharge process for the patients to receive a call from their caregiver, most likely the person that discharged them as they already have a relationship with that person who will ask them about not only the survey but also about their patient experience at the facility and any questions that need to be answered since they have been home. Ms. Carter noted that a lot of information are exchanged on the day of discharge, 75% of which goes out of the window. She reminded the Committee that one of the initiatives of Dr. Raju's 2020 vision is for the discharge procedures to include an after-visit communication in order to bridge the people that are being discharged from the hospital to the next level of care. A transformation plan is in the work to standardize that process.

Ms. Faust added that discharge information should not be given at the point of discharge but talking about it all through, and so should it be for the survey. She added that it is customary that during rounding, a nurse leader or a nurse manager may receive a compliment for his staff from a patient. The nurse leader should take the opportunity to tell the patient that he/she might be receiving a survey at home and that the hospital staff would be delighted if he would feel it out. In addition, the patient should be briefed on how this information will be used without asking for a score.   Dr. Page added that it is not a "might be", but "you are going to". Ms. Carter added that it is a "might be" because it is a random sample as not 100% of the patients receive the survey in the mail.

Dr. Raju asked about the method used to follow-up on the survey after sending it to the patient. Ms. Carter answered that the inpatient survey is sent to the patient within the discharge week. After 21 days, a follow-up letter is sent to them with another survey asking them to complete the survey. Ms. Carter informed the Committee that 70% of the patients receive that follow-up letter. She noted that surveys conducted for other areas do not receive that secondary follow-up letter.

Dr. Page asked if we are allowed to send the patients home with the survey. Ms. Carter answered that the first time that the patients will be able to see the questions on the survey is when they received the official document in the mail. Dr. Raju explained that, according to CMS, a gap is needed for the patients to be removed from the system so as to reflect back on and be thoughtful and objective about the services provided. If the patients were to receive the survey while in the hospital, it would be perceived as if a gun is put to their head and all the hospitals would fall in the 99% percentile.

Ms. Carter added that hand-out methodology is used in a lot of different areas such as inpatient behavioral health and nursing home residents. She explained that because of the confidentiality standpoint, that opportunity is given at discharge. In addition, there is a whole different process involved. According to Press Ganey, there are different biases built into the mode of a survey, whether it is a hand out methodology or a paper survey. Also, there is a lot of pressure as one may feel that he/she has to answer positively. In addition, there is a mode adjustment for phone surveys. People feel that when the survey is done over the phone, one tends to rate someone higher because you hear a voice, you put a picture of that voice in your mind and feel bad by saying something bad. Therefore,

a paper survey gives the patients the ability to complete it in their own time, thereby give them a chance to unbiasedly react and record how they really feel about the survey.

Ms. Maureen McClusky, Senior Vice President of Post-Acute/Long Term Care, interjected that her experience with Press Ganey is for the survey questions to be shared with the nurses so that they can use the same terminology when addressing the patients. For example, I am going to talk about your "discharge planning" right now so that they can relate to the question on the survey stating "Did the nurse talk to you about your discharge plan". They will be able to make the connection and answered positively. As such, by informing the hands-on bedside staff about the survey terminology and using that terminology when addressing the patients will not only raise the scores but also improve their response rate. Dr. Raju interjected that it is about connecting the key words.

Mr. Richard Gannotta, Senior Vice President for Hospitals, added that research also indicates that hospitals that have surgical services like open heart surgery, have a different perception. He explained for example, if you save someone's life, even if the experience is poor, you may still get a good score, versus if dealing with chronic conditions that may have taken a toll on the patient through the course of a lifetime. As big influence varies from hospital to hospital, it is just something to think about as well as you may be comparing yourself to programs that have big surgical services such as saving life programs versus other programs.

Ms. Faust added that in the past, nurses were advised not to use the word pain, because it was perceived that by using this word, patients would develop pain. As such, today's younger nurses are cautiously using the word pain and would sometimes substitute it with the word "discomfort" instead. In support to Ms. McClusky's point, Ms. Faust stated that there is a need to use the word "pain" such as, "Mr. Jones, do you have any pain?   How is your pain being managed" because those are the words on the survey. She stressed that using the word pain will not in no way create pain for the patient.

Dr. Page added that while seeing results of the survey is the perfect place to land, however, if the patient is notified about receiving a survey in the mail and is briefed on how important it is to the facility for him to read it, it may ring the bell when the patient actually receives the package in the mail.

Ms. Carter reported on the different types of survey conducted. They are listed below:

- IN – Inpatient Integrated HCAHPS***
- MD – Outpatient Integrated Patient Visit**
- AS – Ambulatory Surgery
- ER – Emergency Department
- PY – Inpatient Behavioral Health
- HH – Home Health CAHPS*
- NH – Annual Nursing Home
- LTACH – Annual Long Term Care
- ACO – Annual Accountable Care CAHPS *
- PCMH – Annual Patient Centered Medical Home CAHPS *

Ms. Carter reported on the various languages used for the survey as listed below:

- CAHPS (Hospital Inpatient & Home Health)
- CMS approved
  - English
  - Spanish
  - Russian

- Chinese

- Non-CAHPS
  - English, Spanish Russian, Chinese
  - Polish
  - French
  - Arabic
  - Korean
  - Haitian-Creole
  - Hindi
  - Urdu
  - Albanian
  - Bengali

Ms. Faust reported on the Inpatient National Trends as noted on the chart below:
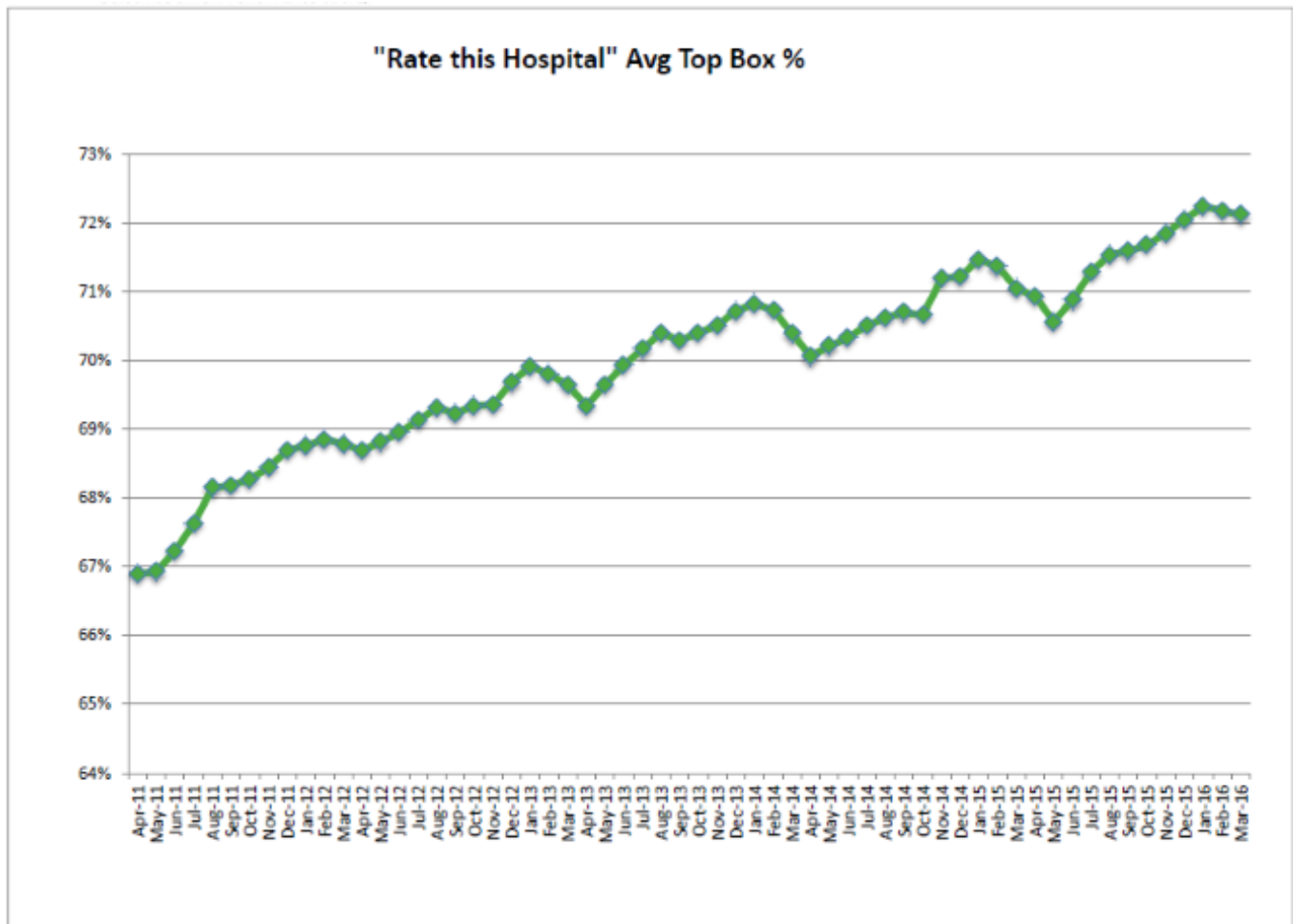
*Represents results from 1961 Press Ganey clients based on received date.

Ms. Faust observed that nationally, the trend is moving up slowly but steadily on a month by month basis. She pointed out that New York State is also moving up slowly and their score is about 65% which is below the national average. As a Board member of the Healthcare Association of New York State (HANYS), Dr. Raju explained that rural hospitals have the top box scores to their advantage because the people they serve know each other. They are either friends, neighbors or relatives. However, in an urban setting, this connection does not exist especially for a four-day length of stay. There is always an urban discrepancy. In addition, Emergency Department patients are more dissatisfied than the persons that come for elective surgeries. The latter are taken directly to a room while the ED patients may have been lying down on a stretcher for nine hours waiting for a room. Because of the aforementioned reasons, the scores of some of the most populous states like California, New York, Texas and Arkansas are low as opposed to the rural states like Utah and Montana whose scores are in the 99% percentile. Dr. Raju reiterated that payments from the Federal Government are no longer based on volume but value-based purchasing a large portion of which is based on patient experience. In other words, if you do not score high, we are going to lower your reimbursement rate.

Ms. Faust agreed not only by states but also in the large cities, from the East to the West, California and New York do not score as well as the middle of the country. She stated that for the past two quarters, NYC Health + Hospitals has been at 59% of the top box. She noted that it is a drop from the third quarter in October of 2015, which was at 62%.

Mr. Campbell emphasized the importance of the facilities' scorecard. As noted by Ms. Faust, the inpatient top box has dropped down; therefore it is important to look at each individual hospital of the system. Therefore, there is a need to disaggregate the data to see which ones are trending the wrong way versus the others that are going up. Ms. Carter interjected that several states are at the State if not already at the national level.

Ms. Judy Wessler, Community Advocate, added that the lack of survey responses is due to the fact that it does not work in a lot of the communities because it is a national survey and that the language used for the survey questions is not something common to their life.

Dr. Raju agreed with Ms. Wessler and confessed that he once was part of the national group that designed these surveys. He informed the Committed that psychologists, not practitioners were consulted to design the questions and agreed that some of them are not understandable. Dr. Raju noted that a large part of the reimbursement will depend on not just how good is the quality of care but also how good the people feel about it. As we are entering a new era in the healthcare industry, this metric is important in the scorecard as it can either make or break the system.

Ms. Carter informed the Committee that other types of surveys are twice as long as the inpatient's survey. Therefore, the use of surveys is not going away but is expanding.

Dr. Page asked if we really believe that hospital care is improving on a trend. Dr. Raju added that it is a perception. It is not hospital care. It is how the patients perceive the care. Dr. Page asked if it has to do with the art of the survey questions or their perception. Dr. Raju answered by explaining what is meant by "perception". He clarified that to some extent, perception is linked to outcome. However, he added that it also depends on other factors such as: ability to navigate the system quickly, length of time for a cat scan in a cold weather; previous experiences, cleanliness of the bathrooms, etc.

Dr. Page asked Dr. Raju if he believes that perception of the patients overall has steadily improved in US hospitals. Dr. Raju answered both positively and negatively. Positively, not because of the quality of care, but because patients' needs are being addressed more than they were ten years ago. For that specific reason, some of the hospitals are adding concierge services to their plan of care just to monitor and ensure that the patients' needs are met.

Mr. Rosen gave the example of a family member who was given a small gift to compensate for the long hours of wait in the Emergency Department. Dr. Raju informed Mr. Rosen that this gesture is called "service recovery." He added that service recovery is given to patients that are not happy with the service provided. Therefore, if unhappy, the patients may receive as service recovery such as: free TV services. Dr. Raju reminded the Committee that hospitals are not only about hospital care but also hotel services.

Ms. Carter reported on the Outpatient National Trends as noted below:
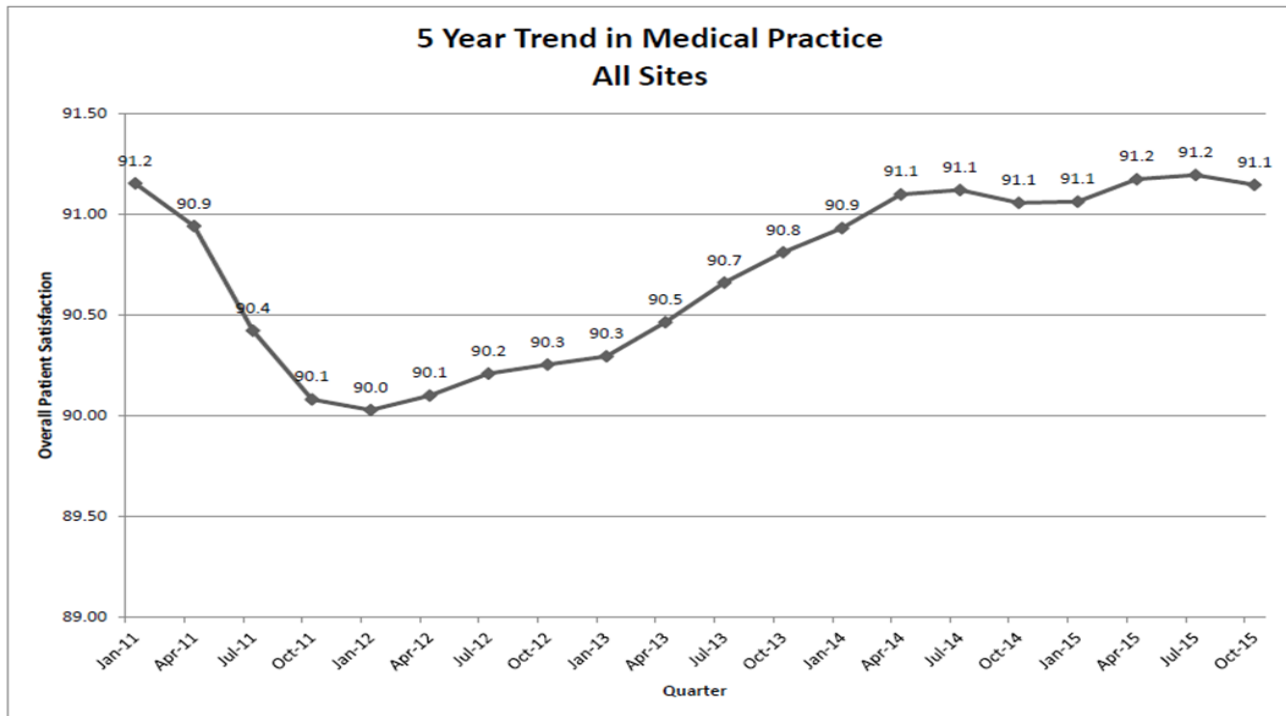
Ms. Carter stated that because hospitals are penalized for their inpatient scores, they all are working hard to try to make things better in any way they can by including concierge services, room service to their plan of care because at the end of the day, they will lose money if the scores are poor.

Mr. Campbell reminded the Committee of Dr. Raju's Vision 2020 goal to reach the 90% percentile of the top box scores.

Mr. Campbell thanked Mr. Tambar and Ms. Carter for their presentations. He requested a copy of the Inpatient Survey that Ms. Carter will forward to him.

ADJOURNMENT

There being no further business, the meeting was adjourned at 11:18 AM.

RESOLUTION

Adopting, in the name of the New York City Health and Hospitals Corporation ("NYC Health + Hospitals") Board of Directors, the twelve Implementation Strategies prepared for each of NYC Health + Hospitals' eleven acute care hospitals and for the Henry J. Carter Specialty Hospital and Rehabilitation Center ("HJC") as supplemental documents to the Community Health Needs Assessments ("CHNA"), which were approved by the Board of Directors in June 2016.

WHEREAS, NYC Health + Hospitals operates eleven acute care hospitals and HJC, a long term acute care hospital; and

WHEREAS, NYC Health + Hospitals has 501(c)(3) tax exempt status under the Internal Revenue Code; and

WHEREAS, The Patient Protection and Affordable Care Act, signed into law in 2010 (the "Affordable Care Act"), added to Internal Revenue Code Section 501(r)(3) which requires that hospitals with 501(c)(3) tax status conduct a CHNA at least once every three years; and

WHEREAS, regulations adopted under the Affordable Care Act specify that a CHNA be prepared for each licensed facility operated by hospital organizations enjoying 501(c)(3) status; and

WHEREAS, regulations further specify that the hospital organization prepare an Implementation Strategy that list and describe the facility's clinical programs intended to meet the health needs identified in the CHNA; and

WHEREAS, on June 30, 2016 the NYC Health + Hospital's Board of Directors approved the CHNAs conducted for the eleven acute care hospitals and HJC; and

WHEREAS, new regulations allow the Implementation Strategies to be adopted and made publicly available within five months and 15 days of the end of the taxable year in which the CNHA is conducted; and

WHEREAS, NYC Health + Hospitals has prepared Implementation Strategies for each of NYC Health + Hospitals' eleven acute care hospitals and for the Henry J. Carter Specialty Hospital and Rehabilitation Center ("HJC"); and

WHEREAS, under the Affordable Care Act, a hospital organization's governing body or a committee authorized by the governing body must adopt the Implementation Strategy.

NOW, THEREFORE, BE IT

RESOLVED, that the New York City Health and Hospitals Corporation's Board of Directors hereby adopts the twelve Implementation Strategies prepared for each of NYC Health + Hospitals' eleven acute care hospitals and for the Henry J. Carter Specialty Hospital and Rehabilitation Center as supplemental documents to the Community Health Needs Assessments, which were approved by the Board of Directors in June 2016.

EXECUTIVE SUMMARY

IMPLEMENTATION STRATEGY, 2016 UPDATE

Purpose of the Community Health Needs Assessment and Implementation Strategy
The Affordable Care Act ("ACA") requires that any tax-exempt, Internal Revenue Service-designated 501(c) (3) hospital complete or update a publicly-available, comprehensive Community Health Needs Assessment ("CHNA") every three years to document its understanding of the unique characteristics and needs of the local communities it serves. In a companion document known as the "Implementation Strategy," each facility is also required subsequently to list and describe the clinical services and programs available to meet the health needs identified in the CHNA.

Required Components of the CHNA

1) Definition of community served
2) A prioritized description of the significant health needs of the community
3) Transparency in the process and methods used to conduct the CHNA, including how it took into account input from the community served and prioritized community health needs
4) A description of the resources potentially available to address the identified significant prioritized community health needs
5) An evaluation of the impact of actions taken to address the significant health needs identified in the previous CHNA report (June 2013).

The 2016 CHNA reports were adopted by the New York City Health + Hospitals Board of Directors in June 2016.

Requirements of the Implementation Strategy

The U.S. Department of the Treasury and the IRS requires a hospital organization to specifically address each of the community health needs identified in the CHNA, and describe the strategies that will be used to address these priority needs. This may entail providing a list of programs and/or clinical services (new or continuing) available to address each need. If the hospital facility does not intend to meet the needs identified in the CHNA, it is required to explain explicitly why it does not intend to meet such health need.
Process and Methods for Conducting the CHNA

A work group composed of representatives from the planning offices from all hospitals in the NYC Health + Hospitals system and Central Office was formed to coordinate and conduct the CHNA. To identify community health needs, the work group reviewed documentation from City, State and Federal public health resources, including but not limited to Take Care New York 2020, New York State Prevention Agenda 2013-2018 and Healthy People 2020, as well as previous need assessments conducted

for the hospital system. From this review, an initial list of over 40 potential community health needs were identified. To refine the list, the work group solicited input from other facility representatives, resulting in the 13 community health needs below (note: this is not in priority order):

- Heart disease, high cholesterol, stroke
- Cancer
- Diabetes
- Asthma and other breathing issues
- Hypertension/ high blood pressure
- Violence
- Mental illness and psychiatric disorders
- Dementia including Alzheimer's
- Obesity
- Premature births, low birth weight
- HIV, Hepatitis, STDs
- Alcohol and/or drug use
- Smoking

Community and Facility Input

Community Advisory Board ("CAB")

The process used to conduct the 2016 CHNA was presented to each CAB individually. A survey was administered anonymously and confidentially to each CAB member asking them to indicate the relative importance of each of the 13 identified community health needs in their community. In an open discussion, CAB members were also asked about community health needs not included in the survey question. These responses were coded for inclusion in the prioritization matrix (see detailed explanation below).

Facility Users
NYC Health + Hospitals engaged approximately 150 adult facility users from each hospital throughout the main facilities and within community-based clinic sites to complete an anonymous and confidential survey. Survey questions included demographics, health insurance status, language preferences, health concerns, primary and preventive health care utilization, barriers in obtaining ambulatory care and reasons for use of emergency care. Respondents were asked to indicate the relative importance of each of the 13 identified community health needs in their community. These responses were coded for inclusion in the prioritization matrix.

Facility Leadership
Hospital leadership were engaged to indicate the relative importance of each of the 13 identified community health needs in their service area; and their responses were included in the prioritization matrix. Leadership was also invited to comment on the final ranking of health needs, and assisted in the identification of facility programs to address these concerns.

Secondary Data

To measure the prevalence of chronic conditions and health concerns, data were extracted from several publically available datasets, including the New York City's Department of Health and Mental Hygiene's Take Care New York 2020, New York State Department of Health's Prevention Agenda 2013-2018, federal agencies, Centers for Disease Control and Prevention and Healthy People 2020. (For a full list of sources, please see the 2016 CHNA.)

Prioritization of Community Health Needs

For the 2016 CHNA, hospitals were required to identify community health needs and to rank them in order of priority. Hospitals developed their facility-specific community health needs prioritization by ranking the community needs as determined by CAB members, facility users, hospital leaders, and the prevalence of the conditions within their respective communities – independently - to create an overall blended rank score of each community health need.

Facility users, CAB members, and hospital leaders completed a survey which asked them to rate each of the 13 community health needs using the criteria: "Very Serious" = 3; "Somewhat Serious" = 2; "Not Serious" = 1. The option, "Don't Know/Not Applicable" was also provided to respondents, but excluded for the scoring.

Condition prevalence within the hospital service area was considered in prioritizing the community health needs. A 'z' score, which represents the distance/variance between the raw score (service area average) and the population mean (citywide average) in units of the standard deviation, was calculated for each condition prevalence. A positive number suggests that the service area experiences a higher prevalence of the condition than the rest of the city, while a negative number suggest a lower prevalence in the area relative to other NYC neighborhoods.

Each of the community health needs were assigned a rank from 1 to 13 by each of the three groups –CAB members, facility users, and hospital leaders – based on their survey results. Community health needs were also assigned a rank from 1 to 13 based on their prevalence, using 'z' scores. Finally, scores from each of the four categories were added together and health issues were ranked based on their overall score.

Community health needs that were considered significant were ranked among the top five of identified needs. The final list, including the identified significant community health needs, were reviewed by hospital leadership.

NYC Health + Hospitals Comprehensive Response to Community Health Needs

NYC Health + Hospitals has developed numerous initiatives to address community health needs and to support and improve patient and population health, with additional programs to be launched soon. Programs include local, or facility-specific, innovations as well as system-wide projects undertaken as part of the New York City Delivery System Reform Incentive Payment Program (DSRIP). The Implementation Strategies include DSRIP projects as well as facility-specific initiatives that address the "significant," or top five, community health needs identified through the CHNA process. Some of the more commonly employed implementation strategies employed at NYC Health + Hospitals are as follows:

Community Health Needs and Commonly Employed Implementation Strategies at NYC Health + Hospitals

Community Health Need	DSRIP Projects	Additional Projects
Hypertension and Heart Disease	Improve Cardiovascular Disease Management: Support primary care excellence and patient self-management	Cardiovascular Risk Registry: Identify and manage patients with hypertension to ensure disease management, adherence to medications and other treatment plans
		Treat to Target: Enroll patients with uncontrolled hypertension in an intensive care management program
Diabetes	n/a	Diabetes Registry: Identify and manage Diabetic patients to ensure disease management, adherence to medications and other treatment plans
		Diabetes Center of Excellence
Obesity	n/a	Farmers Market: Provide patients and staff access to fresh fruit and vegetables and promote healthy eating
		Community Garden: Educate community residents about healthy diet and nutrition, and grow to fresh produce.
Mental Illness / Substance Use	Integrate Primary Care and Behavioral Health Services: Ensure optimal care coordination by providing coordinated, accessible behavioral health and primary care to patients with behavioral health issues	Ambulatory Detox Program: Provide ambulatory access to substance abuse treatment services as an alternative to inpatient care.
Asthma	Home Environmental Asthma Management Program: Reduce avoidable ED use and hospitalizations related to asthma by changing the patient's indoor environment to reduce exposure to asthma triggers	Asthma Educators: Engage patients with Asthma before and after provider visit to provide general information and inhaler techniques to reduce the number of asthma related ED visits
Cancer	Integrate Palliative Care into the PCMH Model: Integrate palliative care into appropriate settings including PCPs and other community resources.	No Cost Colon Cancer Screening Program
Smoking	n/a	Smoking Cessation Program: Provide education and support for tobacco cessation
Multiple Community Health Needs	Care Transitions: For patients discharged from the hospital at high risk of readmission, special teams will bridge the patient to community resources	
	Health Home At Risk: For patients with poor control of chronic disease; social problems; or behavioral health conditions, provide additional resources to address social determinants of health, including increased linkages to community support	

NYC Health + Hospitals' Implementation Strategies for the Community Health Needs Assessments Update 2016

NYC Health + Hospitals

Strategic Planning

September 8, 2016

Background

- The Affordable Care Act (ACA) mandates that each 501(c) (3) tax-exempt hospital must update or conduct a Community Health Needs Assessment (CHNA) every three years.

- The goal of the CHNA is to improve community health by identifying opportunities to improve health care delivery or address other community needs.
  - CHNAs conducted for New York City Health + Hospitals facilities were approved by the Board of Directors on June 30, 2016

- Hospitals are also required to develop and make available to the public an implementation strategy to meet the high priority needs identified in the CHNA.
  - An Implementation Strategy lists the actions the facility intends to take to address each identified health need, including anticipated impact, outcome measures, resources, and potential partners
  - If a facility does not intend to address an identified need, an explanation must be provided

- Implementation strategies must be adopted by an authorized body of the facility no later than November 15

- The ACA imposes an excise tax of $50,000 on any hospital organization that fails to meet these requirements.

Process and Methods to Identify and Prioritize Community Health Needs

- A work group of facility planning directors and other representatives reviewed documentation from city, state and federal public health resources, the NYC Health + Hospitals' 2013 CHNAs, and the DSRIP Community Needs Assessment. A list of over 40 health needs were identified.

- Incorporating input from other facility representatives and tested with hospital users this list was refined to 13 community health needs.

- Each community's *most significant* health needs and their priority order was determined by blending input from:

  1. Facility Users (approximately 150 per facility) completed a survey with questions regarding issues include health concerns, barriers to care, reasons for ED use, and to prioritize their community's health needs. The surveys were translated into NYC Health + Hospitals' top 7 languages.
  2. Community Advisory Boards were asked to prioritize their community's needs.
  3. Facility Leadership were surveyed to identify and prioritize the health needs of their service area.
  4. Prevalence within community (variance to citywide average)

- Final results reviewed by hospital leadership and staff.

Community Health Needs and Commonly Employed Implementation Strategies

Community Health Need	DSRIP Projects	Additional Projects
Hypertension and Heart Disease	Improve Cardiovascular Disease Management: Support primary care excellence and patient self-management	Cardiovascular Risk Registry: Identify and manage patients with hypertension to ensure disease management, adherence to medications and other treatment plans.
		Treat to Target: Enroll patients with uncontrolled hypertension in an intensive care management program.
Diabetes	n/a	Diabetes Registry: Identify and manage Diabetic patients to ensure disease management, adherence to medications and other treatment plans.
		Diabetes Center of Excellence
Obesity	n/a	Farmers Market: Provide patients and staff access to fresh fruit and vegetables and promote healthy eating.
		Community Garden: Educate community residents about healthy diet and nutrition, and grow to fresh produce.
Mental Illness / Substance Use	Integrate Primary Care and Behavioral Health Services: Ensure optimal care coordination by providing coordinated, accessible behavioral health and primary care to patients with behavioral health issues.	Ambulatory Detox Program: Provide ambulatory access to substance abuse treatment services as an alternative to inpatient care.
Asthma	Home Environmental Asthma Management Program: Reduce avoidable ED use and hospitalizations related to asthma by changing the patient's indoor environment to reduce exposure to asthma triggers.	Asthma Educators: Engage patients with Asthma before and after provider visit to provide general information and inhaler techniques to reduce the number of asthma related ED visits.
Cancer	Integrate Palliative Care into the PCMH Model: Integrate palliative care into appropriate settings including PCPs and other community resources.	No Cost Colon Cancer Screening Program
Smoking	n/a	Smoking Cessation Program: Provide education and support for tobacco cessation.
Multiple Community Health Needs	Care Transitions: For patients discharged from the hospital at high risk of readmission, special teams will bridge the patient to community resources.	
	Health Home At Risk: For patients with poor control of chronic disease; social problems; or behavioral health conditions, provide additional resources to address social determinants of health, including increased linkages to community support.	

Next Steps

- Disseminate report to public before Nov. 15, 2016

- Periodically assess community health needs, using

  - Secondary data (internal, City, and State data)
  - Patients, community and CAB input
  - Experts, partners, local agencies

- Compile community health needs and report on 2016-2019 program effectiveness, June, 2019

  - Most programs included in Implementation Strategy have a built-in assessment mechanism

- Complete additional State and Federally required community health needs assessment requirements

  - Gotham community health needs assessment, 1st quarter, 2017 (HRSA)
  - DSRIP community health assessment, 2017 (NYSDOH)

System Scorecard

Dr. Ross Wilson
Chief Transformation Officer

Strategic Planning Committee

September 8, 2016

SYSTEM SCORECARD 2016 Q2

	LEAD	TARGET Q2	ACTUAL Q2	VARIANCE TO TARGET		PRIOR QUARTER	PRIOR YEAR	TARGET 2020
Anticipate & meet patient needs								
1 Out-patient satisfaction (overall mean)	COO	80%	78%	-3%	Y	78%	78%	93%
2 In-patient satisfaction (rate-the-hospital top box score)	COO	62%	62%	-0%	Y	59%	63%	80%
Engage our workforce where each of us is supported & personally accountable								
3 Staff completing leadership programs	COO	362	521	+44%	G	385	381	1,200
4 Employee engagement (5 point scale)	COO	4.1	3.6	-13%	Y	3.5	NA	4.1
Provide high quality safe care in a culturally sensitive, coordinated way								
5 Hospital-acquired infections (CLABSI SIR)	CMO	1.00	0.79	-21%	G	1.07	0.92	0.50
6 DSRIP on track	OneCity CEO	90%	98%	+9%	G	100%	NA	90%
Expand access to serve more patients (market share)								
7 Access to appts (new adult patient TNAA days)	CMO	14	19	+36%	Y	20	27	14
8 Unique patients (thousand)	COO	1,200	1,171	-2%	Y	1,172	1,167	2,000
9 MetroPlus members (thousand)	M+ CEO	500	501	+0%	G	493	474	675
10 Patient revenue (proportion of expense)	COO	63%	56%	-11%	Y	55%	56%	70%
Increase efficiency by investing in technology & capital (organizational reform)								
11 EMR budget variance	CIO	0%	0%	0%	G	0%	0%	0%
12 EMR implementation on track (milestones)	CIO	100%	90%	-10%	Y	90%	90%	100%
13 Contractors performance at service level	COO	100%	92%	-8%	Y	91%	NA	100%
14 FEMA projects on track	COO	100%	91%	-9%	Y	100%	NA	100%
	LEAD	TARGET	ACTUAL	VARIANCE		PRIOR QUARTER	PRIOR YEAR	TARGET 2020

Note: Calendar year.

CLABSI data continually subject to change but considered to be most accurate after the CMS reporting deadline for the quarter (5 months after the close of the reporting period)

G on target
Y trending toward target
R off target

GLOSSARY

	Anticipate & meet patient needs	
1	Out-patient satisfaction (overall mean)	Roll-up average of all outpatient scores from each outpatient survey (random sample); by visit date
2	In-patient satisfaction (rate-the-hospital top box score)	% in-patients surveyed who rank hospital 9 or 10 out of 10 (random sample); by discharge date
	Engage our workforce where each of us is supported & personally accountable	
3	Staff completing leadership programs	Cumulative YTD employees completing supervisor, manager, leadership, and fellowship training; ~5,000 employees are eligible
4	Employee engagement (5 point scale)	Survey of employees "I would recommend this organization as a good place to work"; actual Q2 2016; target national safety net average
	Provide high quality safe care in a culturally sensitive, coordinated way	
5	Hospital-acquired infections (CLABSI SIR)	Observed / expected Central Line Associated Blood Stream Infection - Standardized Infection Rate; data not finalized for 5 months after the reporting period; considered to be most accurate after CMS reporting deadline for the quarter
6	DSRIP on track	Total PPS $ awarded / total potential (up to $1.2 B over five years); cumulative since April 2015; reported Jan & Jul
	Expand access to serve more patients (market share)	
7	Access to appts (new adult patient TNAA days)	Average days to third next available appointment for new adult patients (primary care only)
8	Unique patients (thousand)	12-month cumulative of unique patients across entire system (not double counting patients who visit multiple sites); high estimate; actuals = 3 month cumulate
9	MetroPlus members (thousand)	Active MetroPlus members across all categories at the end of the quarter
10	Patient revenue (proportion of expense)	Patient-generated revenue / operating expense excluding City payments (cash receipts & disbursements YTD)
	Increase efficiency by investing in technology & capital (organizational reform)	
11	EMR budget variance	EMR implementation over or under budget
12	EMR implementation on track (milestones)	Estimate of milestones completed on time: Green = 100%; Yellow = missed milestones have no impact on go-live dates; Red = delays expected for go-live
13	Contractors performance at service level	% of contracts with satisfactory reviews(total number of reviews scored satisfactory or outstanding / total number of reviews at each facility).
14	FEMA projects on track	% milestones from monthly FEMA Program Dashboard on track (green or yellow)

G	on target
Y	trending toward target
R	off target

Presentation to the
H + H Strategic Policy Committee

Arnold Saperstein, MD
Executive Director

Agenda

- Current State

- Growth Trajectory to 2020

- Market Share

- Increasing Enrollment Strategies

- Decreasing Disenrollments Strategies

Current State

- Reached 500,000 members in July
- Over 5% membership growth since January 2016
- On track with five-year growth plan

Membership as 8/1/2016	
Line of Business	**Membership**
Medicaid	384,521
QHP	19,216
EP	58,436
Other LOBs	38,594
Total	**500,767**

Growth Trajectory to 2020

Quarter	Value
Q4 2020	675,000
Q3 2020	669,249
Q2 2020	668,372
Q1 2020	663,597
Q4 2019	658,839
Q3 2019	650,770
Q2 2019	642,764
Q1 2019	634,802
Q4 2018	626,894
Q3 2018	617,108
Q2 2018	607,442
Q1 2018	597,861
Q4 2017	588,364
Q3 2017	574,450
Q2 2017	560,861
Q1 2017	547,621
Q4 2016	530,027
Q3 2016	513,582
Q2 2016	501,307
Q1 2016	489,846
Q4 2015	476,733
Q3 2015	470,695
Q2 2015	472,101

Actual membership (Q2 2015 – Q2 2016)

4

Market Share - 2016

	Percentage of Total (NYC)	
	QHP	EP
MetroPlus	**23.48%**	**16.52%**
Healthfirst	**17.54%**	**28.85%**
Fidelis Care	**14.41%**	**19.22%**
Empire BCBS	**10.02%**	**11.50%**
United	**5.16%**	**9.92%**
Affinity	**4.72%**	**5.28%**

Increasing Enrollment

New Enrollments – 2015 vs. 2016

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2015	26,689	17,484	23,116	18,147	19,654	19,565	18,334	17,441	18,583	19,987	21,278	21,522
2016	57,870	23,551	29,120	29,150	25,974	22,047	24,023	18,876				
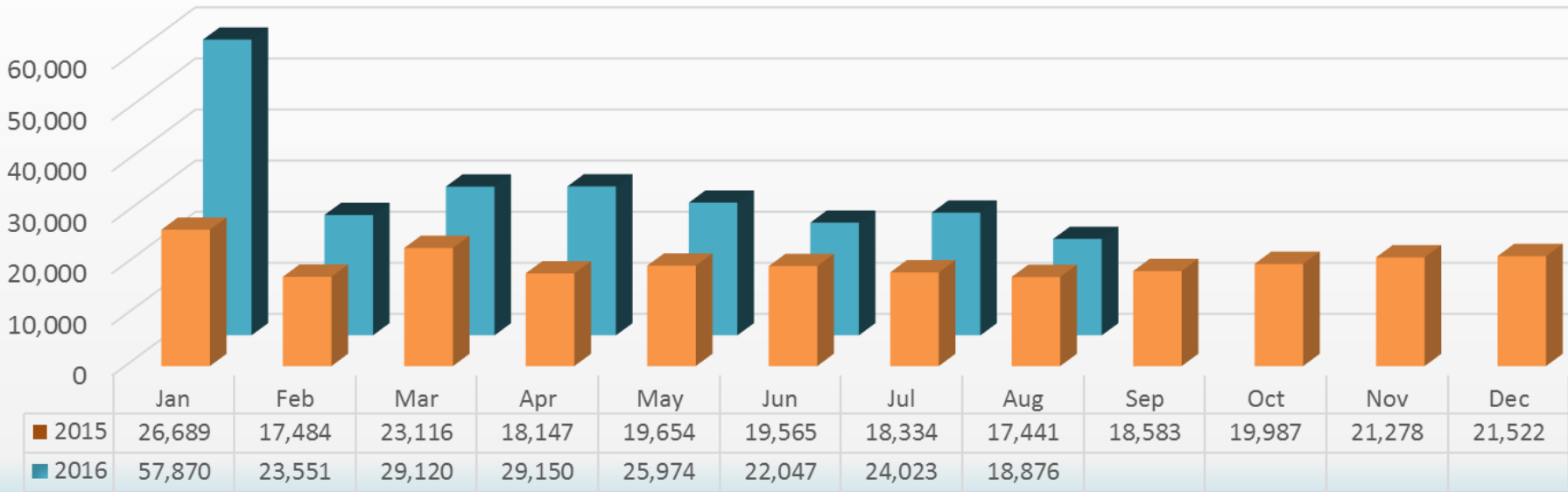
Increasing Enrollment

- Identifying products to target increased enrollment (QHP and EP products

- Creating marketing and distribution campaigns to support enrollment (focused advertising, community offices, etc)

- Enhancing collaboration with H + H (enrollment, quality, access)
- Developing and employing strategies to increase member satisfaction (enhance call center, member outreach, etc)

- Increasing marketing staff engagement (incentive programs)

- Building stronger partnerships with City agencies

Decreasing Disenrollment

- Deploying survey to catalogue drivers of member attrition

- Rewarding members for engagement in care (Finity contract)

- Electronic communications to members (text and email)

- Partnering with ZocDoc

- Enhancing member portal for increased member satisfaction (access to self-service modules)

- Expanding network and developing closer relationships with providers

Questions?

NYC H+H Strategic Planning Committee:
Hospitals Scorecard

Hospitals Scorecard expands on System Scorecard

Overview of the Hospitals Scorecard

- Metrics aligned at hospital level with system-wide measures, in some cases with more granularity
- Developed in collaboration with CMO, Finance, IT, Planning, and Hospital CEOs

Hospitals Scorecard: a utility for the hospital CEOs

- Focuses on H+H key missions around patient experience, people, quality / patient safety, and finance
- Provides a "true north," clear goals and tracks progress of strategic initiatives
- Promotes dialogue, accountability and standardization
- Creates a fact base for performance improvement and helping the CEO group identify opportunities across hospitals
- Supports informed decision-making and to set expectations for the direct reports

Work-in-progress that will be refined and automated

Hospitals Scorecard focuses on key performance metrics and targets

HOSPITAL SCORECARD   **DRAFT**

2016 June

		TARGET	ACTUAL SYSTEM	ACTUAL HOSPITAL		PRIOR PERIOD	PRIOR YEAR	TARGET 2020
Patient experience								
1	In-patient satisfaction (rate-the-hospital 9 or 10)	62%	60%	65%	G	67%	64%	80%
2	Emergency Dept satisfaction (overall)	80%	73%	78%	Y	76%	81%	85%
3	Out-patient satisfaction (overall)	80%	78%	74%	Y	72%	75%	93%
People								
4	Recommend this org as a place to work (out of 5)	4.1	3.6	3.7	Y	3.5	NA	4.1
5	Staff completing leadership programs	NA	502	44		48	NA	TBD
5.a	% eligible supervisors & managers trained	19%	16%	10%	R	11%	NA	TBD
Quality / patient safety								
6	Quality index based on NYSPFP *	1.0	0.1	0.2	Y	0.4	0.22	1.0
7	ALOS (excluding psych & rehab - in days)	5.0	5.2	5.6	Y	5.6	6.37	5.0
8	Emergency Dept - left without being seen	6%	8%	4%	G	4%	NA	3%
9	Access to appts (new adult patient TNAA days)	14	19	18	Y	21	NA	14
10	Diabetic patients w A1c < 8 (outpatient 1ry care)	70%	NA	65%	Y	66%	65%	70%
Finance								
11	Unique patients (last 12 months, thousand)	TBD	1,169	131		132	132	TBD
12	Occupancy (staffed bed excluding psych & rehab)	85%	76%	77%	Y	76%	NA	90%
13	FTEs	TBD	48,406	5,899		5,831	NA	TBD
13.a	% clinical FTEs	45%	39%	39%	R	NA	NA	51%

G	on target
Y	trending toward target
R	off target - trending off target

* CLABSI, CAUTI, Surgical Site Infections, Ventilator-associated events, Clostridium difficile infections, injuries from falls and immobility, pressure ulcer rate, Preventable readmissions, See drill-down in appendix
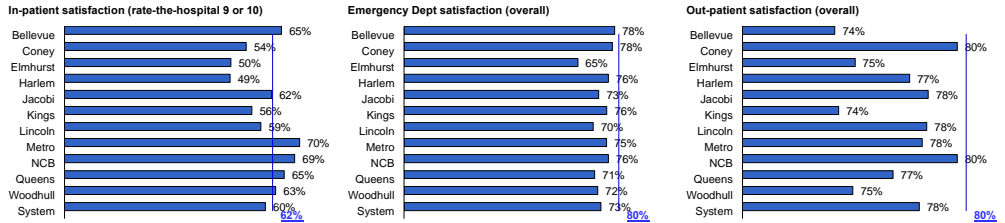
Scorecard enables collaboration across facilities to identify best-practice & support improvement

NYC HEALTH+HOSPITALS

HOSPITAL SCORECARD
Facility Comparisons
2016 June

DRAFT

| Target

Patient experience

In-patient satisfaction (rate-the-hospital 9 or 10)

Facility	Value
Bellevue	65%
Coney	54%
Elmhurst	50%
Harlem	49%
Jacobi	62%
Kings	56%
Lincoln	59%
Metro	70%
NCB	69%
Queens	65%
Woodhull	63%
System	60% (Target 62%)

Emergency Dept satisfaction (overall)

Facility	Value
Bellevue	78%
Coney	78%
Elmhurst	65%
Harlem	76%
Jacobi	73%
Kings	76%
Lincoln	70%
Metro	75%
NCB	76%
Queens	71%
Woodhull	72%
System	73% (Target 80%)

Out-patient satisfaction (overall)

Facility	Value
Bellevue	74%
Coney	80%
Elmhurst	75%
Harlem	77%
Jacobi	78%
Kings	74%
Lincoln	78%
Metro	78%
NCB	80%
Queens	77%
Woodhull	75%
System	78% (Target 80%)

People

Recommend this org as a place to work (out of 5)

Facility	Value
Bellevue	3.7
Coney	3.2
Elmhurst	3.7
Harlem	3.7
Jacobi	4.2
Kings	
Lincoln	
Metro	
NCB	
Queens	
Woodhull	2.9
System	3.6 (Target 4.1)

Staff completing leadership programs

Facility	Value
Bellevue	44
Coney	17
Elmhurst	14
Harlem	35
Jacobi	184
Kings	72
Lincoln	32
Metro	27
NCB	9
Queens	
Woodhull	
System	

% of eligible supervisors & managers

Facility	Value
Bellevue	10%
Coney	9%
Elmhurst	5%
Harlem	16%
Jacobi	54%
Kings	14%
Lincoln	11%
Metro	11%
NCB	8%
Queens	9%
Woodhull	15%
System	16% (Target 19%)

Data to be finalized

Quality / patient safety

Quality index based on NYSPFP

Facility	Value
Bellevue	0.2
Coney	0.3
Elmhurst	0.6
Harlem	0.4
Jacobi	0.2
Kings	0.3
Lincoln	0.7
Metro	0.6
NCB	0.9
Queens	0.4
Woodhull	0.6
System	0.1 (Target 1.0)

ALOS (excluding psych & reh...)

Facility	Value
Bellevue	
Coney	
Elmhurst	6.1
Harlem	4.4
Jacobi	5.3
Kings	6.0
Lincoln	4.1
Metro	4.2
NCB	4.4
Queens	4.8
Woodhull	4.8
System	5.2

Emergency Dept - left without being seen

Facility	Value
Bellevue	4%
Coney	3%
Elmhurst	
Harlem	
Jacobi	
Kings	15%
Lincoln	
Metro	3%
NCB	7%
Queens	-
Woodhull	8%
System	8% (Target 6%)

Access to appts (new adult patient TNAA days)

Facility	Value
Bellevue	18
Coney	21
Elmhurst	-
Harlem	11
Jacobi	13
Kings	27
Lincoln	6
Metro	42
NCB	15
Queens	-
Woodhull	22
System	19 (Target 14)

Diabetic patients w A1c < 8 (outpatient 1ry care)

Facility	Value
Bellevue	65%
Coney	63%
Elmhurst	-
Harlem	64%
Jacobi	59%
Kings	60%
Lincoln	64%
Metro	62%
NCB	58%
Queens	-
Woodhull	58%
System	- (Target 70%)

Finance

Unique patients (last 12 months, thousand)

Facility	Value
Bellevue	131
Coney	82
Elmhurst	146
Harlem	78
Jacobi	109
Kings	146
Lincoln	139
Metro	69
NCB	56
Queens	98
Woodhull	111
System	-

Occupancy (staffed bed excluding psych & rehab)

Facility	Value
Bellevue	77%
Coney	82%
Elmhurst	81%
Harlem	72%
Jacobi	72%
Kings	91%
Lincoln	81%
Metro	61%
NCB	48%
Queens	79%
Woodhull	69%
System	76% (Target 85%)

FTEs

Facility	Value
Bellevue	5,899
Coney	3,229
Elmhurst	4,492
Harlem	3,191
Jacobi	4,189
Kings	5,559
Lincoln	4,197
Metro	2,709
NCB	1,391
Queens	2,918
Woodhull	3,148
System	-

% clinical FTEs

Facility	Value
Bellevue	39%
Coney	40%
Elmhurst	43%
Harlem	36%
Jacobi	40%
Kings	36%
Lincoln	41%
Metro	37%
NCB	38%
Queens	38%
Woodhull	36%
System	39% (Target 45%)

3

Appendix

HOSPITAL SCORECARD

DRAFT

2016 June

		TARGET	ACTUAL SYSTEM	ACTUAL HOSPITAL		PRIOR PERIOD	PRIOR YEAR	TARGET 2020
6	**Quality index based on NYSPFP**	**1.0**	**0.1**	**0.2**	**Y**	**0.4**	**0.2**	**1.0**
6.a	CLABSI rate	0.5	1.4	0.6	Y	1.5	0.8	0.5
6.b	CAUTI rate	0.5	1.7	2.5	Y	4.6	4.1	0.5
6.c	SSI rate (Surgical Site Infections)	1.7	6.7	4.4	Y	0.0	6.5	1.7
6.d	VAE (Ventilator-Associated Events)	2.5	2.6	0.0	G	0.0	2.4	2.5
6.e	VTE (Venous Thromboembolism)	0.1	0.2	0.3	R	0.0	0.19	0.1
6.f	Clostridium difficile	4.4	4.8	8.3	Y	8.3	6.5	4.4
6.g	Injuries From Falls and Immobility	0.1	0.1	1.5	R	0.6	0.6	0.1
6.h	Pressure ulcer rate	2.0	2.7	1.0	G	1.1	1.6	2.0
6.i	30-days preventable readmission	6.5	6.3	6.6	R	6.5	6.5	6.5

Metrics definitions

DRAFT

	Metrics	SOURCE	DEFINITION	Update
Patient experience				
1	In-patient satisfaction (rate-the-hospital 9 or 10)	PressGaney.com - Dir Patient Experience	% in-patients surveyed who rank hospital 9 or 10 out of 10 (random sample). 3-month average. Data pull performed on 8.18.16. Byreceived date	Monthly
2	Emergency Dept satisfaction (overall)	PressGaney.com - Dir Patient Experience	Standard overall statisfaction score (%). 3-month average. Data pull performed on 8.18.16. By received date	Monthly
3	Out-patient satisfaction (overall)	PressGaney.com - Dir Patient Experience	Roll-up average of all outpatient scores from each outpatient survey (random sample). 3-month average. Data pull performed on 8.18.16. By received date	Monthly
People				
4	Recommend this org as a place to work (out of 5)	PressGaney.com - Dir Patient Experience	Survey of employees "I would recommend this organization as a good place to work"; baseline Q3 2015; actual Q2 2016	Quarterly
5	Staff completing leadership programs	HR - Dir Workforce Development	12 month number of employees completing Central Office supervisor and manager, leadership and fellowship one-month training.	Monthly
5.a	% of eligible supervisors & managers	HR - Dir Workforce Development	#5 as a percentage of total eligible employees (supervisors defined as managing 2+ people, Manager defined as managing 5+ people)	Monthly
Quality / patient safety				
6	Quality index based on NYSPFP	NYSPFP.org - Wing Lee	Composite index tracking NYSPFP dashboard metrics. Based on NYSPFP targets, each metrics on target contributes 1 / Denominator Denominator is equal to the number of metrics available for the period. Goal is at 1.0	Monthly and quarterly
7	ALOS (excluding psych & rehab - in days)	Finance - ASVP	Average Length Of inpatient Stay, in days, excluding 1-day stays, psychiatric and rehab patients. Based on discharges only	Monthly
8	Emergency Dept - left without being seen	ED Dashboard	% of patients who left before being seen by a provider	Monthly
9	Access to appts (new adult patient TNAA days)	Access database - SAVP Office of the President	Average length of time in days between the day a new patient makes a request for an appointment with a provider and the third available appointment for a new patient physical, routine exam, or return visit exam. Adult medicine	Monthly
10	Diabetic patients w A1c < 8 (outpatient 1ry care)	Population Health - Dir Clinical Quality Improvement Initiatives	Numerator = Total # of adult diabetic patients 18 to 75 in Patient Registry at the end of the reporting period with latest A1c<8 in past 12 months Denominator = Total # of adult diabetics 18 to 75 in Patient Registry at the end of the reporting period. A1c stands for heamoglobin A1c level, a standard indicator of diabetes risk)	Quarterly
Finance				
11	Unique patients (last 12 months, thousand)	Finance - ASVP	Rolling number of Last Twelve Months (LTM) unique patients (in-patient, Emergency Department and out-patient). Note that NYC H+H considers its billing complete after 3 months, which causes the latest time period to be slightly lowered.	Monthly
12	Occupancy (staffed bed excluding psych & rehab)	Finance - ASVP	Inpatient occupancy rate as a function of staffed beds, excluding psych & rehab. Numerator: Total number of inpatient days for a the month Denominator: Available staffed beds x Number of days in the period	Monthly
13	FTEs	Finance - ASVP	Total FTEs including NYC H+H staff (payroll), affiliate, allowances, overtime, temporary services (nursing), temporary services (general temps), FTE charge backs, and overtime	Monthly
13.a	% clinical FTEs	Finance - ASVP	Numerator: Clinical FTEs employees (Registered Nurses, LPN, Physicians, Residents, Nurse specialists) Denominator: Total FTEs employees	Monthly
6	**Quality index based on NYSPFP**			
6.a	CLABSI rate	NYSPFP.org	Central Line Associated Blood Stream Infections (CLABSI) Rate per 1,000 central line days - ICU & Non-ICU	Monthly
6.b	CAUTI rate	NYSPFP.org	Catheter Associated Urinary Tract Infections (CAUTI) Rate per 1,000 Urinary Catheter Days - ICU & Non-ICU	Monthly
6.c	SSI rate (Surgical Site Infections)	NYSPFP.org	SSI rates per 100 operative procedures (hip, CABG, colon, hysterectomy, knee)	Monthly
6.d	VAE (Ventilator-Associated Events)	NYSPFP.org	VAE rate per 1,000 ventilator days	Monthly
6.e	VTE (Venous Thromboembolism)	NYSPFP.org	VTE rate per 100 adult inpatient discharges	Monthly
6.f	Clostridium difficile	NYSPFP.org	CDI healthcare facility-onset incidence rate per 10,000 patient days	Monthly
6.g	Injuries From Falls and Immobility	NYSPFP.org	Falls with moderate or greater harm per 1,000 patient days	Monthly
6.h	Pressure ulcer rate	NYSPFP.org	Prevalence rate of patients with facility-acquired pressure ulcers of Stage 2 or higher (rate per 100 patients)	Quarterly
6.i	30-days preventable readmission	NYSPFP.org	30 day potentially preventable readmission rate (PPR) - Observed	Quarterly