STRATEGIC PLANNING COMMITTEE
OF THE BOARD OF DIRECTORS

November 3, 2016
12 Noon
Boardroom
125 Worth Street, Room 532

AGENDA

I. Call to Order
   Gordon J. Campbell

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

III. Information Item
    a. Update on Transformation
       Ross Wilson, MD, Senior Vice President, Chief Transformation Officer
    b. NYC Health + Hospitals’ System Scorecard FY’16 Third Quarter Report
       Ross Wilson, MD, Senior Vice President, Chief Transformation Officer

IV. Old Business

V. New Business

VI. Adjournment
    Gordon J. Campbell
MINUTES

STRATEGIC PLANNING COMMITTEE MEETING
OF THE BOARD OF DIRECTORS

SEPTEMBER 8, 2016

The meeting of the Strategic Planning Committee of the Board of Directors was held on September 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
Josephine Bolus
Robert F. Nolan
Bernard Rosen

OTHER ATTENDEES

A. Shermansong, Civic Consulting
J. Milloz, Civic Consulting
J. Watson, Analyst, OSDC
J. Wessler, Community Advocate

NYC HEALTH + HOSPITALS' STAFF

P. Albertson, VP, Operations
M. Allen, Interim Chief Medical Officer
C. Barrow, Senior Associate Director, H+H/Lincoln
M. Belizaire, Assistant Director of Community Affairs, Office of Intergovernmental Relations and Planning
M. Beverly, Assistant Vice President, Finance
T. Carlisle, Associate Executive Director, Corporate Planning Services
R. Carter, Director, Patient Experience
E. Casey, Director, Corporate Planning, HIV Services
A. Divittis, Senior Associate Director, NYC Health + Hospitals/Woodhull
R. Dixon, Associate Director, NYC Health + Hospitals/Harlem
T. Hamilton, Assistant Vice President, Corporate Planning and HIV Services
C. Hercules, Chief of Staff, Office of the Chairman of the Board of Directors
L. Johnston, Vice President, Chief Nursing Officer
S. Kleinbart, Director of Planning, NYC Health + Hospitals/Coney Island
Z. Liu, Senior Management Consultant, Corporate Planning Services
P. Lockhart, Secretary to the Corporation, Office of the Chairman of the Board of Directors
L. Lombardi, Chief Strategy Officer, NYC Health + Hospitals/Bellevue
R. Mark, Chief of Staff Office of the President
A. Marengo, Senior Vice President Communications and Marketing
M. McClusky, Senior Vice President, Post Acute Care
S. Newmark, Senior Corporate Health Project Advisor, Office of the President
K. Park, AED Grants, H+H/Elmhurst
C. Philippou, Assistant Director, Corporate Planning Services
S. Ritzel, Associate Director, NYC Health + Hospitals/Kings County
S. Russo, Senior Vice President, Office of Legal Affairs
U. Tambar, Assistant Vice President, Office of Transformation
D. Thompson, AED, Strategic Planning
K. Whyte, Senior Director, Intergovernmental Relations and Planning
R. Wilson M.D., Senior Vice President, Chief Transformation Officer
V. Yogeshwar, Senior Director, Office of Transformation
A. Young, Director of Community Affairs, Office of Intergovernmental Relations and Planning
M. Zaccagnino, Chief Administrative Officer
CALL TO ORDER

Mr. Gordon Campbell Chairman of the Strategic Planning Committee, called the September 8th meeting of the Strategic Planning Committee (SPC) to order. The minutes of the June 8th, 2016 SPC meeting were adopted.

ACTION ITEM

FY’16 Community Health Needs Assessment Implementation Strategies
Sharon Abbott, PhD, Assistant Director, Corporate Planning Services
Steven Fass, Assistant Vice President, Corporate Planning Services

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.

Mr. Fass said that 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 implementation strategies that address the high priority needs identified in the CHNA.

An Implementation Strategy (IS) identifies the actions, programs, or initiatives that will be undertaken that addresses each of the identified significant community health needs identified in the CHNA. 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 4 months and 15 days after the end of the fiscal year, or November 15.

Below is a summary table of the 12 hospitals’ significant community health needs and some of the larger or more common implementation strategies employed. The leftmost column are the consolidated significant health needs of all 12 hospitals. The center column shows the DSRIP projects that directly addresses the significant health needs, and two projects that address multiple needs. The right column includes examples of some of the more common or larger projects employed at hospitals. The individual CHNA IS reports include a more complete inventory of projects. The table below shows that NYC Health + Hospitals is addressing all significant community health needs identified in the CHNA report with large scale projects and evidence based interventions with carefully planned evaluations and outcome metrics.
Mr. Fass said that the next steps would be to: disseminate the 12 reports to public before Nov. 15, 2016; collect public input which must be included in the subsequent CHNA report; keep the information current, including population and patient demographics, population health, available resources, and better understand the gap between community need and community resources.

Mr. Campbell brought this proposal to vote and it was passed unanimously.
Dr. Raju addressed the members: Healthcare around us is changing very fast and this change got exacerbated by the implementation of Affordable Care Act across the country. It produced some pressure points to all public hospitals across the country. With that in mind, we came up with the Transformation Strategic Plan that is called 2020 Vision. This Plan is all about the efficiency and growth. Patient experience and access to care are two important aspects; together with the employee engagement, it will really drive us to better market share and better market share will eventually give us financial sustainability. Subsequently, City Hall worked with the NYC Health + Hospitals and came up with 12 strategies: revenue strategies, expense strategies, and other strategies on how to reduce expenses and increase revenue. One of the 12 strategies require us to create the Office of Transformation. The Office of Transformation will lead us into 2020 Vision and beyond that and also, will implement 12 strategies that were identified by City Hall. Dr. Ross Wilson was chosen and appointed to lead the Office of Transformation.

Dr. Wilson addressed the members: Discussion of appropriate ways to keep the Board of Directors informed about the aforementioned activities. It has been decided to have the Office of Transformation report as a standing item on the agenda.

- One New York Report - Data comparison overview
  - NYC Health + Hospitals and other NYC Hospital Systems
  - Hospitals within NYC H+H
- 3 key missions: quality, access to care, and financial performance
- Provision of sustainable coverage and access to the uninsured
  - Managing the uninsured
  - Establishing maximum revenue from other sources
  - Maximizing how many of uninsured could be eligible for coverage and help that to occur
- Move to Value-Based systems in a Managed Care environment
  - Incentive to manage patients in the community or at home and to minimize unnecessary encounters with the health system
- Expansion of the Community-based services
- Transformation of our system to a high-performing healthcare system
  - Focus on operational efficiency
- Maximization of Metro Plus revenue
- Establishment of workgroups and executive leadership

Dr. Wilson informed the members that City Hall sees it as the whole city transformation process. City Hall is developing an oversight process for this project. It is a very complicated process and needs to be carefully planned. It is an opportunity to leverage resources. We have to work constructively with other city agencies. We are still in early development stage.
Dr. Raju concurred and commented that this is a major project and needs to be properly coordinated with City Hall.

- Summarized Progress Report as of September 2, 2016 - Overview
  - Outline of 12 Strategies from the Mayors Report, Work groups, Progress made, Critical issues & Risks, and Actions

Mr. Campbell addressed the members with the following recommendations: Committee will be meeting 6 times a year instead of 11 for a 2-hour block of time and with the idea that in each of the meetings, it will be drilling-down one or two major recommendations and the reports out. Part of the discussion will be high level and part will be granular. The Office of Transformation report to be part of every Board meeting. Members in agreement to accept the recommendations.

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
Dr. Raju explained that CEOs will evaluate the performance of their respective facilities and meet quarterly with Mr. Antonio Martin to report out. If they are not meeting target scores, the explanation and action plan will have to be provided.

NYC Health + Hospitals’ Facility Level Scorecard Template
Antonio Martin, Executive Vice President and Chief Operating Officer  

Mr. Antonio Martin addressed the members: Over the last 6 months, we have appointed 3 Service Line Leaders and 9 new CEOs at our facilities. It was clearly communicated that they will be held accountable for their facility’s performance.

- 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

- Training/ Educational opportunities for the employees - Discussion
# MINUTES OF THE SEPTEMBER 8, 2016 STRATEGIC PLANNING COMMITTEE

### 2016 June

<table>
<thead>
<tr>
<th>Patient experience</th>
<th>Target</th>
<th>Actual System</th>
<th>Actual Hospital</th>
<th>Prior Period</th>
<th>Prior Year</th>
<th>Target 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 In-patient satisfaction (rate-the-hospital 9 or 10)</td>
<td>62%</td>
<td>60%</td>
<td>65% G</td>
<td>67%</td>
<td>64%</td>
<td>80%</td>
</tr>
<tr>
<td>2 Emergency Dept satisfaction (overall)</td>
<td>80%</td>
<td>73%</td>
<td>78% X</td>
<td>76%</td>
<td>81%</td>
<td>85%</td>
</tr>
<tr>
<td>3 Out-patient satisfaction (overall)</td>
<td>80%</td>
<td>76%</td>
<td>74% X</td>
<td>72%</td>
<td>75%</td>
<td>93%</td>
</tr>
</tbody>
</table>

### 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         |
| 5a % eligible supervisors & managers trained           | 19%    | 16%           | 10% R          | 11%          | NA         | TBD         |
| 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 try care)  | 70%    | NA            | 66% Y          | 66%          | 66%        | 70%         |
| 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%         |

This space is left intentionally
# Metrics definitions

<table>
<thead>
<tr>
<th>Metrics</th>
<th>SOURCE</th>
<th>DEFINITION</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient experience</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. In-patient satisfaction (rate &lt;= hospital 5 or 10)</td>
<td>Press Ganey.com - Dir Patient Experience</td>
<td>% in-patients surveyed who rank hospital 5 or 10 out of 10 (random sample), 3-month average. Data pull performed on 8.11.16. By received date</td>
<td>Monthly</td>
</tr>
<tr>
<td>2. Emergency Dept satisfaction (overall)</td>
<td>Press Ganey.com - Dir Patient Experience</td>
<td>Standard overall satisfaction score (%), 3-month average. Data pull performed on 8.11.16. By provided data</td>
<td>Monthly</td>
</tr>
<tr>
<td>3. Out-patient satisfaction (overall)</td>
<td>Press Ganey.com - Dir Patient Experience</td>
<td>Roll-up average of all outpatient scores from each outpatient survey (random sample), 3-month average. Data pull performed on 8.11.16. By received date</td>
<td>Monthly</td>
</tr>
</tbody>
</table>

| People | | | |
| 4. Recommend this org as a place to work (out of 5) | Press Ganey.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. % of eligible supervisors & managers | HR - Dir Workforce Development | 12 month number of employees completing Central Office supervisor and manager leadership and fellowship one-month training. | Monthly |
| 5a. % of eligible supervisors & managers | HR - Dir Workforce Development | # as a percentage of total eligible employees (supervisors defined as managing 3+ people, manager defined as managing 5+ people) | Monthly |

| Quality / Patient safety | | | |
| 6. Quality Index based on NYSPFP | NYSPFPorg - Wing Lee | Complete index tracking NYSPFP dashboard metrics. Based on NYSPFP targets, each metric on target contributes 1/ Denominator Denominator is equal to the number of metrics available for the period. Scale 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 | Monthly |
| 8. & | ED Dashboard | % of patients who left before being seen by a provider | Monthly |
| 9. Access to appos (new adult patient TINAA days) | Access database - SAM 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/ Hgb < 8 (outpatient try 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 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 buasublood AB1C 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 lower | Monthly |
| 12. Occupancy rate (staffed beds excluding psych & rehab) | Finance - ASVP | Inpatient occupancy rate as a function of staffed beds, excluding psych & rehab. Numerator: Total number of inpatient days for 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 hours worked | Monthly |
| 13a. % clinical FTEs | Finance - ASVP | Numerator: Clinical FTEs employees (Registered Nurses, LPN, Physicians, Residents, Nurse specialists) | Monthly |
| | Denominator: Total FTEs employees | | |
| | | | |
| 6. Quality Index based on NYSPFP | | | |
| 6a. CLABSI rate | NYSPFPorg | Central Line Associated Blood Stream Infections (CLABSI) Rate per 1,000 central line days - ICU & Non-ICU | Monthly |
| 6b. CAUTI rate | NYSPFPorg | Catheter Associated Urinary Tract Infections (CAUTI) Rate per 1,000 Urinary Catheter Days - ICU & Non-ICU | Monthly |
| 6c. SSI rate (Surgical Site Infections) | NYSPFPorg | SSI rates per 100 operative procedures (hip, CABG, colon, hysterectomy, knee) | Monthly |
| 6d. VAE (Ventilation-Associated Events) | NYSPFPorg | VAE rate per 1,000 ventilator days | Monthly |
| 6e. VTE (Venous Thromboembolism) | NYSPFPorg | VTE rate per 100 adult inpatient discharges | Monthly |
| 6f. Clostridium difficile | NYSPFPorg | CDI healthcare facility-onset incidence per 10,000 patient days | Monthly |
| 6g. Injuries From Falls and Immobility | NYSPFPorg | Falls with moderate or greater harm per 1,000 patient days | Monthly |
| 6h. Pressure ulcer rate | NYSPFPorg | Prevalence rate of patients with facility-acquired pressure ulcers of Stage 2 or higher (rate per 100 patients) | Quarterly |
| 6i. 30-days preventable readmission | NYSPFPorg | 30 day potentially preventable readmission rate (PPR) - Observed | Quarterly |
MetroPlus Updates

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

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

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>384,521</td>
</tr>
<tr>
<td>QHP</td>
<td>19,216</td>
</tr>
<tr>
<td>EP</td>
<td>58,436</td>
</tr>
<tr>
<td>Other LOBs</td>
<td>38,594</td>
</tr>
<tr>
<td>Total</td>
<td>500,767</td>
</tr>
</tbody>
</table>

- Growth Trajectory

![Growth Trajectory Chart]

- Actual membership
MINUTES OF THE SEPTEMBER 8, 2016 STRATEGIC PLANNING COMMITTEE

- **Market Share – 2016**

<table>
<thead>
<tr>
<th>Percentage of Total (NYC)</th>
<th>QH</th>
<th>EP</th>
</tr>
</thead>
<tbody>
<tr>
<td>MetroPlus</td>
<td>23.4%</td>
<td>16.52%</td>
</tr>
<tr>
<td>Healthfirst</td>
<td>17.54%</td>
<td>28.86%</td>
</tr>
<tr>
<td>Fidelis Care</td>
<td>14.41%</td>
<td>19.22%</td>
</tr>
<tr>
<td>Empire BCBS</td>
<td>10.02%</td>
<td>11.50%</td>
</tr>
<tr>
<td>United</td>
<td>5.18%</td>
<td>9.93%</td>
</tr>
<tr>
<td>Affinity</td>
<td>4.72%</td>
<td>5.29%</td>
</tr>
</tbody>
</table>

- **New Enrollment – 2015 vs. 2016**

- **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 Enrollment**
  - 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
ADJOURNMENT
There being no further business, the meeting was adjourned.
Transformation Update

Strategic Planning Committee of the Board

Dr. Ross Wilson
Senior Vice President and Chief Transformation Officer
November 3, 2016
One New York
Health Care For Our Neighborhoods
Transforming Health + Hospitals

The City of New York
Mayor Bill de Blasio

Prosperity Shorrock
Health Commissioner

Kimika Trimmell
Deputy Mayor for Health and Human Services

NYC
Transformation Areas from the “12 Strategies” in Mayoral Report

- Efficiency & Organizational Effectiveness
- Structure to meet community needs
- Services to meet community needs
- Maximize eligible revenue
- Effective partnerships across continuum of care
- Enhance capacities for population healthcare management & VBP
Key Implications of Current State Findings

- Busy emergency departments with low admission rates indicate patient needs could be better addressed in lower-cost, lower-acuity settings.

- New York City has an excess of inpatient bed capacity as more care is provided in ambulatory setting.

- Community needs indicate opportunities for outpatient and post-acute investment and integrated social services.

- Significant investments needed in physical plants to maintain accreditation over next 15-20 years.

  **Larger-scale structural change is necessary to set Health+ Hospitals up for sustainability and success.**

  Investment is needed in repurposing existing facilities, creating of new ambulatory and post-acute services.

*New York State trauma registry 2010-2013. 2013-2016 registry statistics not yet available but additional analysis is currently being conducted. Elmhurst, Bellevue, Jacobi and Kings historically among the most utilized trauma centers in the City.*
What Does the Community Need?

*Community Needs Assessments indicate that our patients have chronic illness and preventive care needs. These needs are often best addressed outside the hospital*

- Greater access to primary care, preventative, and urgent care services outside of costly emergency settings, including after hours
- Greater capacity for mental health and substance abuse services, including continued access to inpatient psychiatric services and alternative settings for care
- Improved care coordination and care management to connect individuals to community supports, link care across settings, and manage chronic conditions (hypertension, diabetes, heart disease, obesity, and mental illness prevalent in most recent community needs assessments)
- “One stop shopping” for health care services to reduce burden and inconvenience on individuals
- Timely access to emergency and trauma care in the community
- Linkages and access to high quality tertiary care, other high acuity care and post acute care for the very sickest patients
- Increased attention to addressing the social determinants of health, and integrated access and linkages to social and community supports, including day care and housing (at least 6% of current occupancy is from patients who are clinically able to be discharged but need transitional care, also known as ALOC)
The Tasks

1. Design the healthcare delivery system that is appropriate for 2020
   • That is consistent with our mission
   • That meets the health care needs of those we serve
   • That has strong partnerships to ensure we cover the continuum of care
   • That is financially sustainable
   • That succeeds (with MetroPlus) in a managed care, population health, value based purchasing environment

2. Maximize revenue from external sources
   • Delay DSH reductions and change NYS distribution
   • NYS Safety Net Legislation
   • Development of a new waiver for additional funding for uninsured care

3. Maximize internal operating efficiency
   • Transition from network structure to “service lines” for inpatient, ambulatory and post-acute care
   • Transition to a centralized share services model for finance, HR, emergency management etc
   • Maximize organizational effectiveness
   • Specific attention to revenue cycle, supply chain and real estate opportunities

4. Maximize patient engagement and clinical quality
We are seeking advice……..
What are others doing?

- **Regional Community Acute Care Campuses**
  - Full service emergency and acute care
  - Broader diversity of specialty services
  - Referral centers, focus on quality and sufficient volume of higher acuity procedures

- **Community Access Campuses**
  - Emergency services with modest inpatient footprint (plus strong referral relationships)
  - Sophisticated outpatient services including clinics, procedures and outpatient specialty programs

- **Health & Wellness Ambulatory Campuses**
  - Multi-disciplinary outpatient medical centers with significant ambulatory care services and extended-hour access (possibly 24-7)

- **Community Clinics and Access Points**
  - Access points in communities that provide integrated behavioral/physical health care, enhanced primary care, and sometimes urgent care or other targeted specialty or social services
  - Diagnostic & Treatment Centers
  - Satellite and School-Based Clinics
  - Community Health & Social Service Partnerships
  - Post-Acute and Long Term Care

- **Regional Community Clinics and Access Points**
  - Supported by patient-oriented integrated delivery system and robust care management infrastructure
How H+H Benefits from Partnerships

- Increased likelihood of receiving new federal funds for uninsured care and commitment to caring for this population from partners
- Improved care coordination, especially for patients bouncing between different systems
- Ability to thoughtfully rationalize clinical services by downsizing inpatient and growing ambulatory care assets
- Opportunity for joint deployment of population health infrastructure
- Opportunity for joint development of ambulatory care capacity
- Enhanced ability to get VBP contracts from payors and manage the total cost of care under those contracts
The Institute for Community Living (ICL) is proceeding with plans for a 44,600-square-foot center, where the nonprofit Community Healthcare Network will provide primary care in 5,100 square feet of the space.

The Hub will offer nine different programs, including mental health services, social services and care coordination. The nonprofit's goal is to provide needed health care services in one of the most underserved areas of the city.

Scheduled for completion in 2018, the new site will double the Institute for Community Living's capacity for services to about 9,700 patients annually and will create 150 full-time jobs and 50-construction-related temporary jobs.

ICL is using Dattner Architects and Mega Contracting Corp as its general contractor.

ICL accessed $26.5M in New Market Tax Credits, a $18.4M loan from Deutsche Bank’s Community Development Finance Group, and $750K from NYC.
Example Health & Wellness Campus Models:
CHOP South Philadelphia Community Health and Literacy Center

- The Children’s Hospital of Philadelphia (CHOP) launched a $42.5 million, Community Health and Literacy Center in South Philadelphia in May 2016
- The 96,000 square foot facility will house just over 50,000 square feet of clinical services through:
  - The CHOP Pediatric Health Clinic will include six new exam rooms and a roomy waiting area with a dedicated station for reading and computer use by patients and their families
  - Philadelphia Dept of Public Health’s “Health Center 2” will offer both adult and pediatric care in 29k sq ft of space, including dental care and women’s health services
- The DiSilvestro Playground and Recreation Center, with a state-of-the-art renovated playground and green space will also be on site, providing youth programs, a basketball court and new outdoor community events in partnership with the library
- The South Philadelphia Neighborhood Library will add a full day of operation in 12,000 square feet, including a new Consumer Health Resource Center, a new computer lab, new literacy training, and a site for career development and guidance
Example Health & Wellness Campus Models: St Barnabas Community Wellness Project, The Bronx

- **Medical Facility**
  - 8,000 SF Urgent Care
  - 22,000 SF Mind Body Center and Population Health Space
  - 13,000 SF Women and Children’s Centers
  - 6,000 SF Nutrition/WIC Programs

- **Affordable Housing**
  - 50 MRT Units
  - 45 Working Homeless Units
  - 219 Affordable Units

- **Commercial Space**
  - Extended Hour Daycare
  - Local Pharmacy
  - Healthy Food Café

- **Financing**
  - $147M total financing; $26M in construction cost
  - $1M in financing from Bronx Borough
Public Systems Across County Investing in Ambulatory, Urgent Care & Behavioral Health

(San Francisco, California) In 2014, San Francisco Department of Health developed a network of providers, including San Francisco General Hospital, and centralized administrative functions (e.g. HR, contracting etc.)

(Chicago, IL) As part of their 2015 outpatient expansion strategy, Cook County Health and Hospital Systems proposed to open two new regional clinics, bulk up outpatient surgery and imaging services, and extend clinic hours.

(Miami-Dade, FL) By 2020, as part of a larger expansion plan, Jackson Memorial will open up 6 urgent care centers, one stand alone emergency department, and one pediatric outpatient center.

(Phoenix, Arizona) In partnership with the health plan, Mercy Maricopa, social service provider Jewish Family and Children’s Service (JFCS) launched an integrated behavioral and physical health care treatment and service center in 2016.

(Houston, Texas) Since 2014, Harris Health System has opened 6 same day clinics and 3 ambulatory centers. Harris Health is also tightly aligned with the UT Health System.

System Scorecard

Strategic Planning Committee of the Board

Dr. Ross Wilson
Senior Vice President and Chief Transformation Officer
November 3, 2016
## System Scorecard 2016 Q3

<table>
<thead>
<tr>
<th>Anticipate &amp; meet patient needs</th>
<th>LEAD</th>
<th>TARGET Q3</th>
<th>ACTUAL Q3</th>
<th>VARIANCE TO TARGET</th>
<th>PRIOR QUARTER</th>
<th>PRIOR YEAR</th>
<th>TARGET 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Out-patient satisfaction (overall mean)</td>
<td>COO</td>
<td>85%</td>
<td>79%</td>
<td>-7%</td>
<td>Y</td>
<td>78%</td>
<td>78%</td>
</tr>
<tr>
<td>2 In-patient satisfaction (rate-the-hospital top box score)</td>
<td>COO</td>
<td>65%</td>
<td>61%</td>
<td>-6%</td>
<td>R</td>
<td>62%</td>
<td>62%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Engage our workforce where each of us is supported &amp; personally accountable</th>
<th>LEAD</th>
<th>TARGET Q3</th>
<th>ACTUAL Q3</th>
<th>VARIANCE TO TARGET</th>
<th>PRIOR QUARTER</th>
<th>PRIOR YEAR</th>
<th>TARGET 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Staff completing leadership programs</td>
<td>COO</td>
<td>504</td>
<td>627</td>
<td>+24%</td>
<td>G</td>
<td>521</td>
<td>462</td>
</tr>
<tr>
<td>4 Employee engagement (5 point scale)</td>
<td>COO</td>
<td>4.1</td>
<td>3.6</td>
<td>-13%</td>
<td>Y</td>
<td>3.6</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provide high quality safe care in a culturally sensitive, coordinated way</th>
<th>LEAD</th>
<th>TARGET Q3</th>
<th>ACTUAL Q3</th>
<th>VARIANCE TO TARGET</th>
<th>PRIOR QUARTER</th>
<th>PRIOR YEAR</th>
<th>TARGET 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 Hospital-acquired infections (CLABSI SIR)</td>
<td>CMO</td>
<td>0.90</td>
<td>0.79</td>
<td>-12%</td>
<td>G</td>
<td>0.79</td>
<td>0.85</td>
</tr>
<tr>
<td>6 DSRIP on track</td>
<td>OneCity CEO</td>
<td>90%</td>
<td>98%</td>
<td>+9%</td>
<td>G</td>
<td>98%</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expand access to serve more patients (market share)</th>
<th>LEAD</th>
<th>TARGET Q3</th>
<th>ACTUAL Q3</th>
<th>VARIANCE TO TARGET</th>
<th>PRIOR QUARTER</th>
<th>PRIOR YEAR</th>
<th>TARGET 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 Access to appts (new adult patient TNAA days)</td>
<td>CMO</td>
<td>14</td>
<td>22</td>
<td>+54%</td>
<td>Y</td>
<td>23</td>
<td>21</td>
</tr>
<tr>
<td>8 Unique patients (thousand)</td>
<td>COO</td>
<td>1,218</td>
<td>1,153</td>
<td>-5%</td>
<td>R</td>
<td>1,171</td>
<td>1,168</td>
</tr>
<tr>
<td>9 MetroPlus members (thousand)</td>
<td>M+ CEO</td>
<td>510</td>
<td>505</td>
<td>-1%</td>
<td>Y</td>
<td>501</td>
<td>472</td>
</tr>
<tr>
<td>10 Patient revenue (proportion of expense)</td>
<td>COO</td>
<td>63%</td>
<td>56%</td>
<td>-11%</td>
<td>Y</td>
<td>56%</td>
<td>56%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Increase efficiency by investing in technology &amp; capital (organizational reform)</th>
<th>LEAD</th>
<th>TARGET Q3</th>
<th>ACTUAL Q3</th>
<th>VARIANCE TO TARGET</th>
<th>PRIOR QUARTER</th>
<th>PRIOR YEAR</th>
<th>TARGET 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 EMR budget variance</td>
<td>CIO</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>G</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>12 EMR implementation on track (milestones)</td>
<td>CIO</td>
<td>100%</td>
<td>90%</td>
<td>-10%</td>
<td>Y</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>13 Contractors performance at service level</td>
<td>COO</td>
<td>100%</td>
<td>94%</td>
<td>-6%</td>
<td>Y</td>
<td>92%</td>
<td>91%</td>
</tr>
<tr>
<td>14 FEMA projects on track</td>
<td>COO</td>
<td>100%</td>
<td>96%</td>
<td>-4%</td>
<td>Y</td>
<td>91%</td>
<td>100%</td>
</tr>
</tbody>
</table>

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).
Indicators 4, 5 & 10 reflect Q2. Q3 not yet available.
GLOSSARY

### Anticipate & meet patient needs

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>1</td>
<td>Out-patient satisfaction (overall mean) Roll-up average of all outpatient scores from each outpatient survey (random sample); by visit date. Based on data received as of 10.19.2016. QTD totals and subject to update</td>
</tr>
<tr>
<td>2</td>
<td>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. Based on data received as of 10.19.2016. QTD totals and subject to update</td>
</tr>
</tbody>
</table>

### Engage our workforce where each of us is supported & personally accountable

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<tr>
<td>3</td>
<td>Staff completing leadership programs Cumulative YTD employees completing supervisor, manager, leadership, and fellowship training; ~5,000 employees are eligible</td>
</tr>
<tr>
<td>4</td>
<td>Employee engagement (5 point scale) Survey of employees &quot;I would recommend this organization as a good place to work&quot;; actual Q2 2016; target national safety net average</td>
</tr>
</tbody>
</table>

### Provide high quality safe care in a culturally sensitive, coordinated way

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<tr>
<td>5</td>
<td>Hospital-acquired infections (CLABSI SIR) Observed / expected Central Line Associated Blood Stream Infection - Standardized Infection Rate; data finalized 5 months after the reporting; most accurate after CMS reporting deadline for the Total PPS $ awarded / total potential (up to $1.2 B over five years); cumulative since April 2015; reported Jan &amp; Jul. Projected percentage and subject to update</td>
</tr>
<tr>
<td>6</td>
<td>DSRIP on track</td>
</tr>
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### Expand access to serve more patients (market share)

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<tr>
<td>7</td>
<td>Access to appts (new adult patient TNAA days) Average days to third next available appointment for new adult patients (primary care only).</td>
</tr>
<tr>
<td>8</td>
<td>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</td>
</tr>
<tr>
<td>9</td>
<td>MetroPlus members (thousand) Active MetroPlus members across all categories at the end of the quarter</td>
</tr>
<tr>
<td>10</td>
<td>Patient revenue (proportion of expense) Patient-generated revenue / operating expense excluding City payments (cash receipts &amp; disbursements YTD)</td>
</tr>
</tbody>
</table>

### Increase efficiency by investing in technology & capital (organizational reform)

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<tr>
<td>11</td>
<td>EMR budget variance EMR implementation over or under budget</td>
</tr>
<tr>
<td>12</td>
<td>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</td>
</tr>
<tr>
<td>13</td>
<td>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) for top 10 contracts by spend</td>
</tr>
<tr>
<td>14</td>
<td>FEMA projects on track % milestones from monthly FEMA Program Dashboard on track (green or yellow)</td>
</tr>
</tbody>
</table>

---

**Legend:**
- **G** on target
- **Y** trending toward target
- **R** off target