STRATEGIC PLANNING COMMITTEE MEETING
OF THE BOARD OF DIRECTORS

MARCH 12, 2013
10:00 A.M.
HHC BOARD ROOM
125 WORTH STREET

AGENDA

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

II. ADOPTION OF JANUARY 15, 2013 STRATEGIC PLANNING COMMITTEE MEETING MINUTES — **JOSEPHINE BOLUS, RN**

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

IV. INFORMATION ITEM:

i. **UPDATE ON ROAD AHEAD OUTSOURCING INITIATIVES**

JOSEPH QUINONES
SENIOR ASSISTANT VICE PRESIDENT OF OPERATIONS

V. OLD BUSINESS

VI. NEW BUSINESS

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

MINUTES

STRATEGIC PLANNING COMMITTEE MEETING OF THE BOARD OF DIRECTORS

JANUARY 15, 2013

The meeting of the Strategic Planning Committee of the Board of Directors was held on January 15, 2013, in HHC's Board Room located at 125 Worth Street with Josephine Bolus, RN presiding as Chairperson.

ATTENDEES

COMMITTEE MEMBERS

Josephine Bolus, RN, Chairperson of the Committee
Alan Aviles
Robert F. Nolan
Anna Kril
Bernard Rosen
Michael A. Stocker, M.D., Chairman of the Board
Ian Hartman-O'Connell, representing Deputy Mayor Linda Gibbs in a voting capacity

OTHER ATTENDEES

J. DeGeorge, Analyst, Office of the State Comptroller
M. Dolan, Senior Assistant Director, DC 37
C. Fiorentini, Analyst, New York City Independent Budget Office
M. Meagher, Budget Analyst, Office of Management and Budget

HHC STAFF

M. Belizaire, Assistant Director of Community Affairs, Intergovernmental Relations
L. Brown, Senior Vice President, Corporate Planning, Community Health and Intergovernmental Relations
D. Cates, Chief of Staff, Office of the Chairman
L. Chang, Data Center Administrator, World Trade Center Environmental Health Center
B. DeIorio, Senior Director, Office of Special Projects
L. Guttman, Assistant Vice President, Office of Intergovernmental Relations
T. Hamilton, Director, HIV Services, Corporate Planning Services
V. Henry, Senior Associate Director, Queens Healthcare Network

J. Jurenko, Senior Assistant Vice President, Office of Intergovernmental Relations
Z. Liu, Senior Management Consultant, Corporate Planning Services
P. Lockhart, Secretary to the Corporation, Office of the Chairman
T. Mammo, Chief of Staff, President's Office
A. Marengo, Senior Vice President, Communications, and Marketing
A. Martin, Executive Vice President and Chief Operating Officer, President's Office
H. Mason, Deputy Executive Director, Kings County Hospital Center
J. Omi, Senior Vice President, Organizational Innovation, and Effectiveness
K. Park, Associate Executive Director, Finance, Queens Health Network
S. Penn, Deputy Director, WTC Environmental Health Center
S. Russo, Senior Vice President and General Counsel, Office of Legal Affairs
A. Saperstein, M.D., Executive Director, MetroPlus Health Plan
W. Saunders, Assistant Vice President, Office of Intergovernmental Relations
D. Thornhill, Associate Executive Director, Harlem Hospital Center
J. Wale, Senior Assistant Vice President, Behavioral Health
K. Whyte, Senior Director, Corporate Planning, Community Health and Intergovernmental Relations

CALL TO ORDER

The meeting of the Strategic Planning Committee was called to order at 10:20 a.m. by the Strategic Planning Committee Chairperson, Josephine Bolus, RN. The minutes of the December 11, 2012, meeting of the Strategic Planning Committee were adopted.

SENIOR VICE PRESIDENT REMARKS

Ms. Brown greeted and informed the Committee that her remarks would include brief updates on federal, state and city issues.

FEDERAL UPATE

Hurricane Sandy Supplemental Funding

Ms. Brown reported that, on December 28, 2012, the Senate had passed a $60.4 billion Hurricane Sandy emergency supplemental relief bill. The House, however, failed to take a vote, which resulted in the demise of that legislation in the 112th Congress. The New York Congressional Delegation, on a bipartisan basis, vociferously objected to this inaction. As the 113th Congress was gaveled into existence on January 3, 2013, the House leadership promised votes on Hurricane Sandy supplemental funding, which would take place in several stages. To date, a $9.7 billion flood insurance extension has passed.

Ms. Brown reported that, after more than 90 amendments had been filed, and as of January 11, 2013, Republicans had cleared the way for House action on Hurricane Sandy disaster aid. She explained that the leadership had stepped in to pare back those amendments that could have been problematic to passage. A key amendment is one seeking a 1.63% across the board cut for all 2013 appropriations. This is essentially a "pay for," which would impact defense and domestic programs. This 1.63% across the board cut was proposed by House Representative Mulvaney. The goal is to fully pay for the first $17 billion tranche of the Sandy aid. Ms. Brown reminded the Committee of the $9.7 billion in Sandy disaster aid that had already passed. She explained that, what remained was approximately $51 billion to make up the $70 billion. Ms. Brown noted that this amendment would be considered. She added that, House Representative Mulvaney from South Carolina had also stated that he would likely face significant resistance from his own party. This is because the defense reduction would be on top of the automatic spending cuts that were already threatening the military.

Ms. Brown explained that the core of today's debate would be a two-step process. The $17 billion is just a starting point. The package, which is sponsored by the House Appropriations Committee Chairman, Hal Rogers (R-KY), will prevail. Another underlying bill, which was introduced by Congressman Rodney Frelinghuysen from New Jersey, for $33.67 billion, would also be debated on the floor. If these proposals are adopted, the Senate would then have to vote again to approve these funds. The objective is to get something out before the end of this month.

Ms. Brown informed the Committee that, over the last month, HHC had hosted several Congressional and FEMA tours of both Bellevue and Coney Hospitals to illustrate the damages that had been caused by Hurricane Sandy. She commented that HHC had been receiving a lot of attention. HHC President, Alan Aviles and the leadership of Coney Island Hospital hosted a visit from Senator Charles Schumer on January 8, 2013, which included press coverage. House Representative Michael Grimm toured Coney Island Hospital on January 9, 2013. This was an important visit because it was the first time that the

only New York City Republican representative had ever visited Coney Island Hospital, which is part of his district. Ms. Brown informed the Committee that it was a positive visit. Representative Grimm was outspoken about joining forces with the New York Delegation in an effort to acquire more aid for the City of New York. He was very specific in terms of aid for Coney Island Hospital's repairs and for long term reparation.

Ms. Brown reported that, on January 11, 2013, staff from the Senate Appropriations Committee, and the Subcommittee of Homeland Security had also toured both Coney Island and Bellevue Hospitals. Ms. Brown announced that, on January 24, 2013, House Appropriations Homeland Security Subcommittee Chairperson, John Carter, a Republican from Texas, and Representative David Price, a Democrat from North Carolina, along with some of their staff would also be touring Bellevue Hospital. She reminded the Committee that HHC had visits from FEMA, including the FEMA administrator, Mr. Craig Fugate. One of HHC's very first visits was from House Energy and Commerce Committee, Health Subcommittee Vice Chair, Michael Burgess, who is a Republican from Texas.

Ms. Brown stated that it had been very helpful for those representatives to visually see the impact of Hurricane Sandy at the affected HHC facilities. Most of the visits with Legislators included the participation of FEMA staff and/or subcommittee staffers. During those visits, the amount of work that HHC hospitals had conducted to prepare to restore services did not go unnoticed. Ms. Brown noted that the most recent visitors didn't see as much as they would have seen at the end of November. Notwithstanding, they were able to still see water lines and a bevy of workers in the basement of Bellevue Hospital and also on the first floor and basement of Coney Island Hospital. They were also impressed by the magnitude of the effort that was being undertaken by the City of New York and HHC to restore services to the communities served by those two important hospitals.

Fiscal Cliff and Sequester

Ms. Brown acknowledged her staff, Leonard Guttman and Judy Chesser of the Office of Intergovernmental Relations, who had been spending a great deal of their time meeting with staffers of key Representatives. Specifically, they worked to ensure that those staffers were apprised of all the work that is being undertaken to restore services. They reinforced HHC's needs in terms of its submission to FEMA and for restoration of lost revenue. Ms. Brown commented that the first thing that Senator Schumer had said without provocation at the press conference at Coney Island Hospital was that HHC needed $183 million in lost revenue and he explained why that was important.

Ms. Brown reported that the recently enacted fiscal cliff legislation, named H.R. 8 or The American Taxpayer Relief Act, included two provisions that would reduce payments to hospitals and negatively impact HHC. In this Act, there are reductions totaling $14.7 billion to help pay for the perennial one year doctor fix. This will assure that Medicare physician payment rates would not decline by 26% for this year. The Legislation imposed the "documentation and coding (DCI)" adjustment, which will phase-in the recoupment of past "overpayments" to hospitals. These overpayments were made as a result of the transition to Medicare Severity Diagnosis Related Groups (MS-DRGs). At the national level, this change was offered as a $10.5 billion Medicare funding cut to hospitals. According to HANYS, this would result in a loss of $34 million for HHC between federal fiscal years 2014 and 2017.

Ms. Brown stated that the second provision of The American Taxpayer Relief Act would rebase Medicaid Disproportionate Share Hospital (DSH) payments by extending the Affordable Care Act's (ACA) Medicaid DSH reductions by an additional year. This would result in a $4.2 billion national cut and an estimated loss to HHC of $471 million (federal and local shares) in FFY 2022.

Ms. Brown explained that, although the fiscal cliff had been avoided, the situation in Washington was not favorable. While the Sequester has been delayed for two months, the debt ceiling must be also raised in two months. Republicans are expected to use both of these levers to demand that no new revenue be included in any bill to address the deficit.

Ms. Brown informed the Committee of several Medicare and Medicaid proposals that were important to HHC that would likely be considered this year. She emphasized that they were important not because they are positive but because they were significant cuts. Among these proposals are:

- Another extension of the Medicaid DSH cut to FFY 2023;
- Reductions in payments for Hospital Outpatient Evaluation and Management services to align reimbursements to visits occurring in physician offices, which would result in a cut to HHC of $187 million in FFY 2013 - 2022;
- A reduction in the Indirect Medical Education (IME) adjustment from 5.5% to 2.2%, which would result in a cut to HHC of $626 million in FFY 2013 - 2022;
- A cap on Graduate Medical Education (GME) payments, which would reduce HHC payments by $215 million in FFY 2013 - 2022; and
- A cut in Medicare bad debt support that would cut HHC funding by $26 million in FFY 2013 - 2022.

STATE UPDATE

Governor Cuomo Delivers State of the State Address

Ms. Brown reported that last week, Governor Cuomo had kicked off the 2013 State Legislative Session when he delivered his annual State of the State address. While his verbal remarks did not include any specific healthcare related initiatives, the accompanying 312 page report, NY Rising, included several initiatives of interest to HHC.

Ms. Brown stated that, citing the death of Rory Staunton, Governor Cuomo had also announced that the State Department of Health (SDOH) would issue new regulations requiring hospitals to adopt SDOH-approved sepsis recognition and treatment protocols. The protocols must incorporate best practices for the early identification and treatment of sepsis, and will vary for adults and children. They will include use of a patient screening process, a "countdown" clock for possible sepsis patients and clear, time-based treatment guidelines. Hospitals will also be required to submit data to SDOH, which will then be publicly reported.

The Governor's report also indicates the State's plan for a major overhaul of Article 6 of the Public Health Law (the means by which localities fund public health initiatives) and the revision of the Certificate of Need (CON) process to require facilities to address the risks resulting from being in a vulnerable location in order to ensure resiliency.

Ms. Brown stated that Governor Cuomo had also announced that he would undertake the "largest housing program in at least 15 years." While very few details will be made available before the release of his Executive Budget on January 22, 2013, the Governor indicated that this initiative would make better use of existing resources and would re-direct $1 billion to preserve and create more than 14,000 quality affordable housing units, including the rehabilitation and updating of 8,700 Mitchell-Lama units and an additional 5,600 housing units. He also revealed that at least a portion of those units will be created through new affordable housing programs.

New Mental Health Provisions in Gun Control Legislation

Ms. Brown reported that, on January 14, 013, Governor Cuomo and legislative leaders had reached agreement on reforming the State's Gun Control laws. She added that the Senate had passed the legislation (sponsored by Senator Klein) late last night and that the Assembly was expected to pass on January 15, 2013.

Ms. Brown explained that there were several provisions of interest to HHC. First, the bill would extend "Kendra's Law" until 2017. It also makes changes to allow the initial order for assisted outpatient treatment (AOT) to remain in place for up to one year (previously six months), to require the Director of an AOT program to evaluate the continued need for an order prior to its expiration, and to petition the courts for an extension of the order if the patient refuses to cooperate.

Ms. Brown informed the Committee that the legislation also included a new requirement for physicians, psychologists, registered nurses, and licensed clinical social workers to report to the Office of Mental Health when they determine that a patient is likely to engage in conduct that would result in serious harm to themselves or others. An exception can be made if the mental health professional determines that making the report would create a risk to them or increase the danger to potential victims. They would not be subject to criminal or civil liability as long as their decision whether to report is reasonable and made in good faith.

CITY UPDATE

City Council to Hold Hearings on Storm Preparedness and Disaster Management

Ms. Brown reported that, beginning on January 16, 2013, the City Council would be holding a series of hearings on the many different aspects of the City's overall preparedness for storms and disaster management during Hurricane Sandy. HHC was asked to have a representative in attendance in case questions come up at the hearing. She also reported that, on January 24, 2013, the Council would hold a specific hearing on the emergency preparedness and disaster management activities of health care facilities in New York City. Mr. Aviles will be providing testimony at that hearing. In addition, the Council will hold a hearing during the month of February on management and operations of the storm shelters. She reminded the Committee that emergency shelters were set up around the City and that HHC had also played a significant role in providing services at those shelters for persons with special medical needs. HHC will be invited to this hearing to discuss its role at these shelters.

INFORMATION ITEM

MetroPlus Health Plan's Focus and Direction for 2013

Arnold Saperstein, M.D., Executive Director, MetroPlus Health Plan

Ms. Brown introduced Arnold Saperstein, M.D., Executive Director, MetroPlus Health Plan. She informed the Committee that Dr. Saperstein would be reporting on MetroPlus Health Plan's work to launch its Managed Long Term Care (MLTC) program. She reminded the Committee that the Governor's Medicaid Reform Taskforce (MRT) had made recommendations that all individuals requiring long term care services including those individuals in institutional long term care settings would need to be enrolled in an MLTC plan, over the next two years. Dr. Saperstein began his presentation by stating that his presentation would focus principally on managed long term care but would also include other

business opportunities that MetroPlus Health Plan would be pursuing over the next year. He provided the Committee with an overview of MetroPlus Health Plan, its mission, vision, values, product lines, focus, and direction for 2013.

MetroPlus Health Plan Overview

Dr. Saperstein reported that MetroPlus Health Plan (MetroPlus) had become licensed in New York State as a Managed Care Organization (MCO) in 1985. In 2001, MetroPlus was converted from a Health Maintenance Organization (HMO) to a Prepaid Health Services Plan (PHSP). MetroPlus is a wholly owned subsidiary corporation of the New York City Health and Hospitals Corporation (HHC). Its lines of business include: Medicaid Managed Care, Family Health Plus, Child Health Plus, Medicare plans, two Special Needs Plans (SNP) for the care of HIV+ members in Medicaid and Medicare, Managed Long Term Care and MetroPlus Gold.

MetroPlus' mission is to provide its members with access to the highest quality, cost-effective health care including a comprehensive program of care management, health education, and customer service. This is accomplished by partnering with HHC and its dedicated providers.

MetroPlus' vision is to provide access to the highest quality, cost-effective health care for its members, to achieve superior provider, member, and employee satisfaction, and to be a fiscally responsible, ongoing financial asset to HHC. MetroPlus will strive to be the only managed health care partner that HHC will ever need. This will be accomplished by a fully engaged, highly motivated MetroPlus staff.

Dr. Saperstein informed the Committee that New York City rates the quality of health plans by both quality and consumer satisfaction measures. This information is reported each year and used in the New York City Managed Care Guide. MetroPlus has been the #1 or top managed care plan for seven out of the last eight years. He noted that MetroPlus had been rated #1 again this year in that guide. He stated that New York State's rating criteria for health plans included a much more comprehensive group of quality, compliance, satisfaction, readmission and other types of measures. MetroPlus was rated #1 across the entire state last year and received an additional $34 million in incentive revenue as a result. He explained that the good news is that MetroPlus received 100% for its quality measures. MetroPlus is one of two managed care plans in the state to score the highest in that category. He noted that MetroPlus would have scored significantly above every other health plan, but MetroPlus needed to improve its performance on some of its access and consumer satisfaction measures. Dr. Saperstein commented that, right now, MetroPlus is at the top level, but its aim is to become uncatchable.

Ms. Bolus, Committee Chairwoman, inquired about the name of the other top rated managed care plan. Dr. Saperstein responded that it was HIP. He added that, last year, HIP had actually come in a little bit above MetroPlus, but on quality MetroPlus had scored 100 percent. MetroPlus needs to improve its consumer satisfaction survey results, specifically by improving in the area of getting needed care, which is a measure of access to care. He explained that, if the next available appointment is not within an appropriate time frame, MetroPlus loses compliance points.

Dr. Saperstein described MetroPlus' values as the pursuit of:

- **Performance excellence** - hold ourselves and our providers to the highest standards to ensure that our members receive quality care
- **Fiscal responsibility** - assure that the revenues we receive are used effectively
- **Regulatory compliance** - with all City, State and Federal laws, regulations and contracts

- **Team work** - everyone at MetroPlus will work together internally and with our providers to deliver the highest quality care and service to our members
- **Accountability** - to each other, our members and providers
- **Respectfulness** - in the way that we treat everyone we encounter

Dr. Saperstein described MetroPlus' relationship with HHC. He informed the Committee that MetroPlus had a close collaboration with HHC at all levels of the clinical and administrative spectrum. Both HHC and MetroPlus serve a mutual inner city, low-income population with many racial minorities and with higher health risk profiles.

Dr. Saperstein informed the Committee that the largest transfer of members out of MetroPlus had been to HealthFirst. When an analysis was conducted to look at 7,000 members who transferred from MetroPlus to HealthFirst, it was found that 80 percent of those members also left HHC because they wanted to seek care with a provider outside of HHC. He stated that MetroPlus' ultimate goal is to try to keep patients at HHC. He added that MetroPlus had done a very good retention job. MetroPlus has a very positive risk arrangement with HHC. This arrangement has produced significant surplus dollars that MetroPlus has been able to give back to HHC every year. He added that the continued growth of MetroPlus and its expansion into new lines of business would allow for the capture of new populations and would assist HHC in maintaining its patient and revenue base.

Dr. Saperstein reported that, as of December 31, 2012, MetroPlus' membership across all product lines had been 438,398 members. He added that MetroPlus had gained 15,700 members in the past year, which reflected a 4% growth rate. The distribution of MetroPlus' membership by product line is the following:

- Medicaid: 372,942
- Family Health Plus: 35,938
- Child Health Plus: 14,486
- Medicaid HIV SNP: 5,741
- Medicare: 6,194
- MetroPlus Gold: 3,097

Dr. Saperstein informed the Committee that he was disappointed with this rate of growth and that MetroPlus could have done much better. Dr. Saperstein explained that, until July 1, 2012, MetroPlus had been the only health plan in New York City that didn't offer managed dental care. As such, MetroPlus covered all other services except dental care. Members were allowed to go anywhere they wanted for dental services. As of July 1, 2012, and as part of Medicaid reform in New York State, every health plan was mandated to provide dental coverage. Through an RFP process, MetroPlus selected HealthPlex as its dental care provider. Over the course of a few months, MetroPlus lost between 2,000 and 4,000 members on a monthly basis. Dr. Saperstein added that this loss rate had decreased significantly. As of January 2013, this rate of loss dropped to under 2,000 members per month. He stated that, if this loss hadn't occurred, MetroPlus could have doubled its growth. Dr. Saperstein commented that, it was not known that dental coverage would have had such a large impact on members' choice. Dr. Saperstein noted that, in a survey of members who had disenrolled from the plan, more than 50% of members reported that they had disenrolled because they didn't like MetroPlus' dental plan, or they wanted to go to a different plan that had different dental coverage.

Dr. Stocker, HHC's Board Chairman, asked what the estimated savings were for a capitated versus a fee-for-service dental program. Dr. Saperstein responded that MetroPlus is expected to save approximately $6 million a year over the other vendor. He explained that HealthPlex' rates were capitated and lower than what the use would be. Notwithstanding, losing a potential 20,000 members is a much greater loss overall. He added that MetroPlus is working with HealthPlex to retain dentists

and to negotiate a fee-for-service program. With HealthPlex, MetroPlus' cost will rise but MetroPlus has to satisfy its membership.

Ms. Bolus commented that both Harlem and Kings County Hospitals had been seeking to expand their dental programs. She asked Dr. Saperstein if it would be beneficial to do that with the current contract that is in place with HealthPlex. Dr. Saperstein responded that this is more of a buy or build question. From MetroPlus' perspective, if HHC is part of the HealthPlex contract and/or if the hospitals build it, MetroPlus would use it. He added that it is more of a matter of whether it is desirable for the member to come to the hospital rather than using the community dentist that they are using. This is out of MetroPlus' realm. From MetroPlus' perspective, members would be referred to the HHC facility if it is available. If it is not available, MetroPlus would have to buy it outside.

Dr. Saperstein informed the Committee that MetroPlus had been very involved with primary care doctors in the community. Of MetroPlus' membership of more than 438,000 members, 54% receive primary care services at HHC facilities, and the remaining 46% use community providers.

MetroPlus' Managed Long Term Care (MLTC) Plan

Dr. Saperstein reported that MetroPlus had been granted a license to operate a Managed Long Term Care (MLTC) Plan in fall 2012. MetroPlus will offer full services for enrolled members in January 2013. He reminded the Committee that the MLTC program offered assistance to people who are chronically ill or have disabilities and who need health and long term care services, such as home care or adult day care. The goal is to allow these individuals to stay in their homes and communities as long as possible. The MetroPlus MLTC plan arranges and pays for a large selection of health and social services, and provides choice and flexibility in obtaining needed services from one place. To be eligible for the MLTC program, an individual must be:

- At least 21 years of age;
- Eligible for Medicaid;
- Capable of remaining in their home and community without jeopardy to their health and safety; and
- In need of community-based long-term services for at least 120 days from the effective date of enrollment.

Dr. Saperstein reported that the MLTC program covered services include:

- Care Management
    - Home delivered or Congregate Meals
    - Social Day Care
    - Social & Environment Supports
- Nursing Home Care
- Home Care
    - Nursing
    - Home Health Aide
    - Physical Therapy (PT)
    - Occupational Therapy (OT)
    - Speech Pathology (SP)
    - Medical Social Services
- Adult Day Health Care
- Personal Care
- DME
- Medical/Surgical Supplies
- Enteral and Parenteral Formula

- Hearing Aid Batteries
- Prosthetics, Orthotics & Orthopedic Footwear
- Personal Emergency Response System
- Non-emergent Transportation
- Podiatry
- Dentistry
- Optometry / Eyeglasses
- PT, OT, SP or other therapies provided in a setting other than a home, limited to 20 visits of each therapy type per calendar year, except the developmentally disabled, MLTC may authorize additional visits
- Audiology / Hearing Aids including batteries
- Respiratory Therapy
- Nutrition
- Private Duty Nursing

Dr. Saperstein informed the Committee that the program does not cover the core services of inpatient and outpatient primary and specialty services. These services are usually covered by another insurer, either fee-for-service or another program. This is why the program is called a partial cap MLTC. The non-covered services include:

- Inpatient hospital services
- Outpatient hospital services
- Physician services including services provided in an office setting, a clinic, a facility or in the home
- Laboratory services
- Radiology & Radioisotope services
- Emergency transportation
- Rural Health Clinic Services
- Chronic Renal Dialysis
- Mental Health Services
- Alcohol & Substance Abuse Services
- OMRDD Services
- Family Planning Services
- Prescription & Non-Prescription Drugs, Compounded Prescriptions
- Assisted Living Program
- Hospice

Dr. Saperstein described the advantages of the MLTC program. He explained that the MLTC program's care management team call and visit the member and family or other individuals who may be assisting the member on a regular basis to assure that the member is satisfied with the care and services. Care managers work with the primary care doctor to obtain the medical orders needed for covered services in the member's plan of care (POC). They authorize covered services for the member based on medical necessity and the POC. They also communicate with the primary care doctor about changes or updates to the member's POC and arrange and coordinate services that are covered by MetroPlus.

Dr. Saperstein described the MLTC enrollment process. He explained that an Enrollment Nurse would arrange to visit the potential member to discuss the MLTC program, to assist the individual with the details of applying for enrollment, and to gather and ask information about their health and long term care needs. During this visit, the Enrollment Nurse will complete a comprehensive clinical assessment using New York State's (NYS) approved forms, and would discuss an initial POC. The Enrollment Nurse reviews the member's Medicaid and Medicare information, if applicable, and discusses and provides information about advance directives, how to access covered and non-covered services, and rights as a

MetroPlus member. The Enrollment Nurse provides a copy of the Member Handbook and Provider Directory and explains the forms required for enrollment which include the enrollment agreement/attestation form; the authorization for release of medical information; and notice of HIPAA privacy practices. Once signed, the enrollment agreement is submitted to the New York City Human Resources Administration (HRA) for review and eligibility verification. If an enrollment agreement is received by Medicaid Choice/Maximus by the 20th day of the month, membership would typically begin on the first day of the next month.

Ms. Brown commented that HHC had two adult medical day care programs. One is located in the Rockaways and the other at Dr. Susan Smith McKinney Skilled Nursing Facility. She asked if these individuals were appropriate to be enrolled in the MLTC program. Dr. Saperstein responded that, if they are living in the community and are in need of adult day home care or additional home care services, those individuals would be the target population for the MLTC program. He added that MetroPlus would arrange for a nurse to visit these sites to conduct an assessment. If they meet the criteria and they voluntarily want to enroll, they can. If they are sent a letter by the state that they have to choose a plan, it is MetroPlus' hope that the providers would inform the plan.

Ms. Brown asked if there would be a benefit to educating HHC's skilled nursing facility staff, particularly staff of the aforementioned facilities. Dr. Saperstein responded affirmatively. He added that MetroPlus has staff that can go out and explain the program to patients. Ms. Bolus asked if the Enrollment Nurse also goes out to present this information in the community. Dr. Saperstein responded that MetroPlus had done some community outreach. He added that this is a much more focused population. MetroPlus does a lot of Medicaid/Medicare marketing by talking to the general community. The individuals being targeted for the MLTC programs have much more intensive needs. MetroPlus has done some advertising in other markets, but the marketing will be different for this population. MetroPlus will be working with community-based support agencies to capture the appropriate population.

Dr. Saperstein also reported that MetroPlus would soon submit an application for participation in a program called MAP Plus. This is a fully capitated, dual eligible program for Medicare Advantage, also called Medicare Advantage Plus. He explained that the target population in New York City for this product line is very small. Notwithstanding, it makes sense for MetroPlus to participate because MetroPlus has members that might float between business lines; and MetroPlus is also participating in the long term care program.

<u>Behavioral Health Special Needs Plan (SNP)</u>

Dr. Saperstein described New York State's strategies concerning behavioral health services as the following:

- Phase I: In January 2012, New York State contracted with behavioral health organizations (BHOs) to monitor and manage fee-for-service mental health and substance abuse services with the goal of improving its fragmented and uncoordinated behavioral healthcare system
    - OptumHealth in New York City
- Phase II: The State anticipates this initiative will pave the way to fully-managed behavioral health entities
- Phase II will complete the transition to fully-managed behavioral healthcare.
- The State envisions that risk bearing Medicaid managed care entities will manage, coordinate, and pay for both behavioral and physical health services for enrollees with serious mental health issues or substance use disorders.
- The statute requires the State to launch Phase II by April 1, 2013, though this is expected to be delayed until late 2013.

- The State Behavioral Health Work Group developed a list of principles intended to apply to Phase II BHOs, which may vary in form across the different regions of the State and include:
    - Special Needs Plans (SNPs). Specialty managed care networks that manage physical and behavioral health services for a defined behavioral health population
    - Integrated Delivery Systems (IDS). Provider-operated risk-bearing entities that manage the physical and behavioral health services for a defined behavioral health population
    - Carve-out BHOs. Risk-bearing managed care entities with a specialization in behavioral health that would only manage behavioral health services.
- The state has yet to decide on a final methodology for this initiative.

Dr. Saperstein informed the Committee that the trade organization of health plans is lobbying extremely hard for the mainstream plan to be able to manage everything under one roof. He explained that MetroPlus had nearly 40,000 members who were enrolled in SSI. For those members, MetroPlus provides coverage for medical but not for behavioral health services. With many SNP options, MetroPlus would risk losing those members. He added that every health plan had large numbers of members enrolled in SSI, and would rather keep the population in a unified program within its current plan. Dr. Saperstein noted that, it appeared that the state might go down that path to allow plans to meet certain criteria of care for those individuals.

Ms. Bolus asked if the plans would be able to monitor the medications of the behavioral health patients. Dr. Saperstein responded affirmatively. He stated that the plans would have to do everything that the state required, which would not only include medication management but intensive case management and having an appropriate network of community-based and support services. Right now, the health plans don't have experience with intensive behavioral health care needs. Every plan will have to develop a network, the care management capability, and the integration to allow these individuals to be cared for appropriately.

Dr. Stocker commented that he did not fully understand the role of the behavioral health organizations (BHOs). Dr. Saperstein responded that BHOs request a lot of information but they don't have any impact on utilization. Ms. Brown added that their output is to provide data to the state to better inform the state's decisions in terms of utilization patterns, ultimately to make the phase two decision. That is essentially why they were put in place. Dr. Stocker asked if they were like organized markets. Ms. Brown responded affirmatively. Dr. Stocker asked how could there be negatives in having OptumHealth operate in New York City if they were not doing anything. Dr. Saperstein explained that the negative is the tremendous administrative burden on providers. They do not assist with care management or help to expedite services. Ms. Brown commented that there is no value added.

Dr. Stocker asked if there was a distinction between managed care organizations that contract with providers and major organizations like HHC that is a provider. He noted that HHC had a big investment in behavioral health services. Dr. Saperstein explained that HHC would either become a special needs plan (SNP) or an individual delivery system. Those are choices that were included in the MRT Report. The problem is that all of the other health plans are fighting these recommendations because of their SSI population, and the risk of losing 10 percent of their membership. Dr. Stocker asked if it was known when this would be decided. Dr. Saperstein responded that the Commissioner of the Office of Mental Health will be retiring, and a successor had not yet been named. That individual would play a very key role in making the decision concerning the state's direction. Additionally, a decision concerning the status of the Office of Mental Health had not yet been made, whether it would become a part of State Department of Health or remain a separate entity.

Ms. Bolus asked if MetroPlus had enough psychiatric nurses. Dr. Saperstein responded that MetroPlus had a psychiatrist consultant who comes in because MetroPlus covers mental health for everybody

else. It is not a big population. He explained that MetroPlus had a model but would have to build a much greater model to care for its population. He stated that MetroPlus' staffing level would definitely have to increase. He noted that MetroPlus had done well in terms of care management for that population.

New York Health Benefit Exchange

Dr. Saperstein provided the Committee with an update on New York's Health Benefit Exchange. He stated that the bottom line is that this is a commercial business that MetroPlus had never ventured into before; and MetroPlus will have a steep learning curve. He reported that the New York Health Benefit Exchange will go live in fall 2013. Insurers seeking to offer qualified health plans (QHPs) will be asked to submit plan designs in March 2013. QHPs will be classified into four types of product levels: Platinum, Gold, Silver, and Bronze with progressively increased co-payments and deductibles. MetroPlus will develop a minimum of eight products to be offered in the Exchange (Platinum, Gold, Silver, Bronze, Catastrophic, and three additional Silver plans with actuarial bands based on a member's income as compared to the federal poverty level). He added that the three actuarial levels associated with Silver would allow MetroPlus to take a population that is low income and still provide at least something that would dramatically decrease out-of-pocket costs.

Dr. Saperstein reported that the Family Health Plus (FHP) program would probably be discontinued when the New York Health Benefit Exchange goes live. He highlighted that FHP represented roughly 8% of MetroPlus' current membership. Dr. Saperstein described the challenges that would be faced by individuals who were currently enrolled in the Family Health Plus (FHP) program. He stated that the FHP population would get some federal subsidies to minor health plans, but still would be expected to pay very significant out-of-pocket costs. He emphasized that, what is basically happening is that a large insured population would be pushed out to become uninsured because they won't be able to afford health care. It is not yet known how this will work out. The health plans are developing their programs and designing benefit packages. He noted that, at the monthly health plan meetings with the state, this issue is consistently raised about the need to make it affordable.

Dr. Saperstein informed the Committee that Medicaid and Child Health Plus would not be offered by the New York Health Benefit Exchange until late 2013/early 2014. He added there had been some discussions that, as early as 2014, Medicaid marketing by health plans may be eliminated and transitioned to the Exchange. This is the reason why MetroPlus has to participate in the Exchange now, in order to maintain its Medicaid population. Eligibility into government programs and for federal subsidies to individuals will be determined based on the Modified Adjusted Gross Income (MAGI). MetroPlus' biggest opportunity/risk is that as individuals lose their eligibility, MetroPlus must offer products that they can afford and will enroll in, to minimize membership loss.

Dr. Stocker commented that, the big commercial insurers would have an advantage in terms of those individuals who are at the high end income of Medicaid, who move back and forth between being eligible for individual/small group products and being eligible for Medicaid. The fact that those insurers are in all of those markets, they will be able to retain their members. He asked if MetroPlus loses a member because that member is no longer income eligible, would that member be re-assigned to MetroPlus if he/she regained Medicaid eligibility at some point in the future. Dr. Saperstein responded that the state had eliminated retroactive re-enrollment nearly two years ago. In the past, an individual who lost Medicaid eligibility and regained it at some point would bounce back to the same plan. Now, those individuals have to actively enroll back in the plan. Dr. Saperstein noted that consumer satisfaction, knowledge of MetroPlus, and the fact that MetroPlus had been their plan would become key factors that would impact their plan decision. Dr. Saperstein further explained that, if MetroPlus

covered those individuals through the Exchange, the hope is that, if they lose that eligibility, those individuals would still remain MetroPlus' member once they are re-determined eligible for Medicaid. Dr. Stocker asked if MetroPlus is at a disadvantage in terms of enrollment compared to the commercial insurers that are in both the Medicaid and commercial markets. Dr. Stocker further commented that, if an individual is covered by United's small group/ individual coverage plan and loses their job and is now eligible for Medicaid that individual could still remain with United. It is just a different version of the same thing. Dr. Saperstein responded that, this is what MetroPlus is setting up now. This is the reason for MetroPlus' participation in all the different levels of the Exchange program, which would allow MetroPlus to have a Medicaid and a commercial program. Dr. Stocker inquired if MetroPlus would have to obtain a commercial license. Dr. Saperstein responded no. He explained that, as long as MetroPlus had less than 10% of its population in the Exchange (i.e. 43,000 or lesser amount of membership), a commercial license would not be required. MetroPlus' government program license will allow MetroPlus to enroll up to 10% of its membership in the Exchange.

Dr. Saperstein concluded his presentation by stating that MetroPlus has many growth opportunities in 2013, all of which are essential to MetroPlus' continued success. MetroPlus looks forward to working with HHC and to share its progress.

ADJOURNMENT

There being no further business, the meeting was adjourned at 11:15a.m.

NYC Health and Hospitals Corporation

Strategic Planning Committee Meeting

March 12, 2013

Presenter:

Joseph Quinones

Senior Assistant Vice President of Operations

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

Dietary Operations Briefing

GNYHA Ventures

sodexo Dietary

US. FOODS
KEEPING KITCHENS COOKING.™

HHC NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

The Objectives of the Dietary Initiative

- HHC Executed a Contract in 2005 with Sodexo Dietary Division, US Foods, and GNYHA Ventures (the Consortium)
- The Contract was fully Implemented in early 2006; the Contract Term is for 10 Years and 3 Five Year Renewals
- The Initial Objectives:
  - Improve patient care, quality of food and standardize menus (within first year of the contract)
  - Increase Patient Satisfaction (to be monitored by independent survey every year after full implementation)
  - Reduce Corporate-wide meal cost (year one of the contract)
  - Re-tool the Cook Chill Plant by replacing non-working equipment and using plant to its full capacity (by December 2005)
  - Standardize food policy and procedures throughout the Corporation (by year one of the contract)
  - Increase staff productivity (implement training program for staff within six months)
  - Target Savings (first year after full implementation): $5M per year
  - No Union Layoffs

Objectives Achieved

- The following objectives were achieved:
  - No Union workers were laid off
  - Reduced staffing levels from 1,400 FTE's to current level of 963 FTE's (437 FTEs Attrited)
  - Instituted Corporate wide Formulary in 2008 for Nutritional Supplements that resulted in improved patient care and lowered costs
  - Implemented a 21 day menu cycle for all Acute Care and Long Term Care facilities in early 2006
  - Improved Patient Satisfaction scores and sustained improvement every year
  - Staffing assessment identified workflows that improved direct and indirect patient care and resulted in maximizing efficiencies since early 2006
  - Standardized policies and procedures for food delivery, floor stock, supplements, nourishments, and catering in 2005
  - Standardized reporting systems for costs controls and financial analysis resulting in real time information that allows for rapid management corrective action plans since 2006
  - Completed renovation of Cook Chill Plant in late 2005, producing 19K meals/day, 7M meals/yr, and adding capacity for generating potential revenue
  - Achieved cost savings of $5.7M per year

Cost Savings

- Did the Corporation meet its Savings objective?
  - Exceeded savings target of $5M a year after full implementation
  - Savings of $5.7M on average per year

	Total Sodexo Contract Dietary Expense (in Millions)	HHC Cost if we did Nothing adjusted for Actual Price Index	Cost Savings
FY 2007	$ 88,837,120	$ 90,159,953	$ 1,322,833
FY 2008	$ 89,624,714	$ 92,323,792	$ 2,699,078
FY 2009	$ 89,848,001	$ 94,539,563	$ 4,691,562
FY 2010	$ 90,960.609	$ 96,808,513	$ 5,847,904
FY 2011	$ 90,745,903	$ 99,131,917	$ 8,386,014
FY 2012	$ 90,397,370	**$** 101,511,083	$ 11,113,713
		Total:	**$ 34,061,104**

Vendor Performance

- How is the Vendor performance monitored?
  - Each facility has assigned a Contract Liaison that the vendor reports to
  - The Vendor produces reports on a monthly basis to the facility and HHC's Office of Operations that tracks the Vendor's contractual obligation such as staffing, contract expectations and survey readiness.
  - The Vendor and Facility staff do quality assurance audits to assure compliance with Centers for Medicare & Medicaid Services (CMS), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and Department of Health (DOH) guidelines as directed by each Facility
  - Mock Surveys are done by Vendor, and Central Office. The results are sent to Senior Staff of the facility.
  - Mock Surveys are also done by an independent consultant at least one year prior to an anticipated Survey. All results are shared with the Senior Staff of the Facility.

Measuring Patient Satisfaction

- Who conducted the survey and how has HHC assured its reliability?
  - The Corporation entered into an agreement with International Point of Contact (IPC), an independent company specializing in conducting surveys
  - HHC and IPC developed a survey tool made up of 17 questions consistent with survey standards in order to measure the patient experience in a comprehensive way
  - The sample size was statistically validated by the vendor and totals approximately 800 patients surveyed face-to-face
  - A baseline face-to-face patient survey was conducted prior to the Sodexo conversion to the Cook Chill Model in 2006
  - The survey has been conducted each year since 2007 and is compared year over year and to the baseline year

Results of the Patient Satisfaction Survey for FY2012

- What were the results of the Patient Satisfaction Survey?

	Wave I (Baseline 2005)	Wave II (2006-2007)	Wave III (2007-2008)	Wave IV (2008-2009)	Wave V (2009-2010)	Wave VI (2010-2011)	Wave VII (2011-2012)
ACUTE							
Overall Satisfaction Dining & Nutrition	3.5	3.6	3.5	3.5	3.7	3.5	3.7
Food Quality	3.4	3.8	3.7	4.2	3.6	3.7	3.7
Food Service	3.7	4.2	4.1	3.7	4.0	4.2	3.9
Mean	**3.5**	**3.9**	**3.8**	**3.8**	**3.8**	**3.8**	**3.8**
LONG TERM CARE (LTC)							
Overall Satisfaction Dining & Nutrition	3.1	3.2	3.1	3.0	2.9	3.0	3.2
Food Quality	3.1	3.2	3.3	2.9	3.2	3.2	3.1
Food Service	3.7	3.9	3.7	4.0	4.0	4.0	4.2
Mean	**3.3**	**3.4**	**3.4**	**3.3**	**3.4**	**3.4**	**3.5**
Overall Mean LTC & Acute	**3.4**	**3.7**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**

Score Legend:
5 = Excellent (extremely satisfied), 4 = Above Satisfactory 3 = Satisfactory, 2 = Below Satisfactory, 1 = Poor (not satisfied)

Environmental Services Operations Briefing

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

The Objectives of Environmental Services Initiative

- HHC executed a contract November 2011 with Crothall, Inc.
- The contract was fully implemented in early December 2011; the contract term is nine years
- The Initial Objectives:
  - Assure Regulatory Survey Readiness of Facilities 24/7
  - Increase Worker Productivity (by year one of the contract)
  - Increase Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS) Scores for all Facilities
  - Standardize Workflow (within six months)
  - Lower Overtime Costs (within six months)
  - Obtain Capital Equipment from vendor at no cost to Corporation
  - Training Program for Union staff
  - No Union Layoffs
  - Target Cost Savings: $2.4M by November 2012, year 1 of the contract
  - Total Cost Savings over 9 years: $180M

Objectives Achieved

- The following objectives were achieved:
  - No Union workers were laid off
  - Environmental Services Operations retrained and absorbed 156 workers from the Brooklyn Central laundry and Facility Laundry distribution workers throughout first year of contract
  - Attrition objectives have been achieved: prior to the contract 1,955 FTE, 156 Laundry workers were transferred to EVS. Current staff is 1887. Total staff attrited 202, backfilled to other jobs 22. Target attrition of 63 FTE was achieved by first year of contract.
  - Capital equipment totaling $1.3M has been delivered to EVS HHC facilities at no cost to the corporation completed (September 2012)
  - All workflows at all facilities have been standardized and worker productivity has increased completed January 2012
  - Overtime costs have been lowered by $600K completed December 2012
  - Target savings of $2.4M have been exceeded, Total savings for the first year $6,774,511

Cost Savings

- Did the Corporation meet its Savings objective?
  - Exceeded budget to contract cost savings target by $2.3M
  - Total Savings of $6.7M

Contract Year 1 (November 2011 – December 2012)		
Total Crothall Contract Budget	$150,328,489	
Total Crothall Actual Contract Cost	$145,952,209	
Actual Spend Below Budget		$4,376,260
Targeted Budgeted Saving - (*Outsourced vs. In-House Operations)*		$2,399,231
Total Contract Savings		**$ 6,775,491**

Vendor Performance

- How is the Vendor performance monitored?
  - Each facility has assigned a Contract Liaison that the vendor reports to
  - The Vendor produces reports on a monthly basis to the facility and HHC's Office of Operations that tracks the Vendor's contractual obligation such as staffing, contract expectations and survey readiness.
  - The Vendor and Facility Staff do "floor rounding" inspecting the areas of the Hospital to assure compliance with Centers for Medicare & Medicaid Services (CMS), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and Department of Health (DOH) guidelines as required by each facility with Administrators of the facility
  - Mock Surveys are done by Vendor, and Central Office. The results are sent to Senior Staff of the facility.
  - Mock Surveys are also done by an independent consultant at least one year prior to an anticipated Survey. All results are shared with the Senior Staff of the Facility.

Measuring Patient Satisfaction

- Who conducts the survey?

- In 2011 HHC entered into a contract with Press Ganey, Inc. to conduct a survey consistent with Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS)

- The survey is the first national, standardized, publicly reported survey of patients' perspectives of hospital care. The environment of the hospital is measured as part of this survey.

- Press Ganey, Inc. conducts the survey in accordance with Federal guidelines and uses a standard Centers for Medicare & Medicaid Services (CMS) approved survey instrument and data collection methodology for measuring patients' perceptions of their hospital experience

- January 1, 2012 – HHC converted the patient satisfaction surveying tool from Health Stream to Press Ganey, the #1 national organization on surveying methodologies. The use of Press Ganey, Inc. allows HHC to be Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS) compliant as recommended by the Centers for Medicare and Medicaid Services and subject to public reporting

- When converting from Healthstream (phone survey) to Press Ganey(mail survey), the average adjustment in percentages is approximately -5.5%

- The first survey was conducted by Press Ganey on January 2012 to May 2012

Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS)

	BASELINE** 1ST QUARTER 2012	CONTRACT YEAR TO DATE	Year 1 TARGET*
OVERALL SYSTEM Cleanliness of the Hospital Environment	62%	63%	65%
LINCOLN MEDICAL CENTER	58%	63%	61%
KINGS COUNTY HOSPITAL	64%	68%	67%
QUEENS HOSPITAL CENTER	64%	67%	67%
HARLEM HOSPITAL CENTER	59%	61%	61%
JACOBI MEDICAL CENTER	64%	66%	67%
METROPOLITAN HOSPITAL	61%	63%	64%
WOODHULL MEDICAL CENTER	67%	68%	70%
ELMHURST HOSPITAL CENTER	56%	55%	58%
NORTH CENTRAL BRONX HOSPITAL	66%	59%	68%
BELLEVUE HOSPITAL CENTER	58%	60%	60%
CONEY ISLAND HOSPITAL	72%	67%	74%

- The baseline period began when HHC first used Press Ganey , Inc. (Jan 12'-Mar 12')
- Year 1 survey data will be evaluated July 1, 2013. There is a 2-3 month lag in data when using discharge date to generate reports. (Surveys are distributed 48 hrs – 6 wks after discharge, patients have up to an additional 6 wks to return survey)

Laundry Operations Briefing

The Objectives of the Laundry Initiative

- HHC Executed a Contract with Sodexo Laundry Division and Nexera Inc. (the Consortium) in July 2011
- The Contract was fully Implemented by November 2011; the term of the contract is 9 years
- The Initial Objectives:
  - Close Brooklyn Central Laundry and Redeploy Staff by October 2011
  - Lower Cost for Supplies and Linen Processing; meet or exceed first year budget savings
  - Lower Personnel Services Cost for Laundry Distribution
  - Standardize HHC Laundry Operations Policies & Procedures
  - No Union layoffs
  - Target Savings Year 1: $ 5.1M

Objectives Achieved

- The following objectives were achieved:
  - Completed 90 day transition of linen distribution & processing on schedule by the end of October 2011
  - Transitioned 156 full-time HHC employees out of Linen & Laundry Operations to Environmental Services and 10 to other Departments
  - Closed Brooklyn Central Laundry (BCL) on schedule in October 2011
  - Standardized policies and procedures for linen and laundry operations by the end of October 2011
  - Implemented Linen Management web based tool to track linen utilization in December 2011
  - Achieved and exceeded Year 1 cost savings target of $5.1M per year (achieved $6.5M)

Cost Savings

- Did the Corporation meet its Savings objective?
  - Exceeded budget to contract cost savings target by $1,402,287M
  - Total Savings of $6,509,377

Contract Year 1 (July 2011-June 2012)		
Total Sodexo Contract Budget	$13,464,862	
Total Sodexo Actual Contract Cost	$12,062,575	
Actual Spend Below Budget		$1,402,287
Targeted Budgeted Saving - (*Outsourced vs. In-House Operations)*		$5,107,090
Total Contract Savings		**$6,509,377**

Measuring Vendor Performance

- How is the Vendor performance monitored?
  - Each facility has assigned a Contract Liaison that the vendor reports to
  - The Vendor produces reports on a monthly basis to the facility and HHC's Office of Operations that tracks the Vendor's contractual obligation such as staffing, contract expectations and survey readiness.
  - The Vendor does Facility "floor rounding" inspecting the areas of the Hospital to assure compliance with Centers for Medicare & Medicaid Services (CMS), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and Department of Health (DOH) requirements as required by each facility with Administrators of the facility
  - Mock Surveys are done by Vendor, and Central Office. The results are sent to Senior Staff of the facility.
  - Mock Surveys are also done by an independent consultant at least one year prior to an anticipated Survey. All results are shared with the Senior Staff of the Facility.

Measuring Patient Satisfaction

- Who conducted the survey and how has HHC assured its reliability?
  - The Corporation entered into an agreement with International Point of Contact (IPC), an independent company specializing in conducting surveys
  - HHC and IPC developed a survey tool made up of 13 questions in order to measure the patient experience in a comprehensive way
  - The sample size was statistically validated by the vendor and totals approximately 800 patients
  - A baseline face-to-face patient survey was conducted prior to the Sodexo conversion July through August 2011
  - The survey was then conducted post transition in the first contract year 2012

Results of the Patient Satisfaction Survey for FY2012

- What were the results of the Patient Satisfaction Survey?

	Wave I (July - August 2011)	Wave II (FY 2012)
ACUTE		
Overall Quality	3.9	4.1
Whiteness / Brightness	4.1	4.1
Softness	3.9	4.1
Mean	**4.0**	**4.1**
LONG TERM CARE (LTC)		
Overall Quality	3.9	3.9
Whiteness / Brightness	4.0	4.1
Softness	3.9	4.0
Mean	**3.9**	**4.0**
Overall Mean LTC & Acute	**4.0**	**4.1**

Score Legend:
5 = Excellent (extremely satisfied), 4 = Above Satisfactory 3 = Satisfactory, 2 = Below Satisfactory, 1 = Poor (not satisfied)

Additional Savings Identified

- HHC has identified additional savings opportunities in the following areas:

- To increase efficiency and achieve additional cost savings the Corporation transitioned six facility internal laundries to Sodexo
  - Total pounds processed by the internal laundries was 1.3 million additional pounds of linen
  - 24 additional FTE's were transferred out of Laundry operation
  - The result was an HHC net savings of $2,045,816 vs. contract cost of $248,400

- Residential Clothing Processing has been transitioned to Sodexo at Coler, Goldwater, Gouverneur and McKinney; planned transition of Seaview scheduled for FY13
  - Due to the move from Goldwater to Henry Carter and the new design at Gouverneur; these facilities could no longer accommodate the processing of Resident Clothing on-site
  - A total of 640,000 lbs of Residential Clothing being processed; 26.8 FTE's identified to be transferred to other HHC departments
  - The result is a net savings of $1,279,106 vs. contract cost of $777,155

- Linen Losses are substantially higher then the projected $605,000 annually
  - Current trend indicated an additional annual cost of $2.2M
  - Sodexo has implemented a loss prevention program to address these costs and we are currently trending down in losses

- Currently piloting transition to reusable linen items (underpads, gowns, and towels) to replace disposable items for further cost savings

Plant Maintenance Operations Outsource Briefing

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

The Objectives of the Plant Maintenance Implementation

- HHC executed a contract with Johnson Controls, Inc. in July 2012; the term of the contract is nine years
- The contract was implemented in October 2012
- The objectives of the implementation plan achieved:
  - Total attrited as of December 31, 2012 - 28 FTE (target year one 55 FTEs)
  - Hire HHC management staff completed in October 2012
  - Implemented training program for managers July 2012
  - Transitioned HHC facility contracts to JCI contracts completed by October 2012
  - Transitioned facility work order system from various HHC work order systems to JCI systems completed by February 2013

The Objectives of the Plant Maintenance Implementation (continued)

- The objectives of the implementation plan achieved (continued):
  - Control overtime at all facilities (in the first year of the contract)
  - Standardized workflow at all facilities (in the first year of the contract)
  - Issued policy and procedure for how the work gets done and how much time it takes to do the work (in the first year of the contract)
  - Maintains or replaces exhausted assets
  - Provide necessary repair and maintenance tools
  - Meet total target savings of $1.3M after first year of the contract
  - All financials will be released 60 days after the first twelve months of the contract

Measuring Vendor Performance

- How is the Vendor performance monitored?
  - Each facility has assigned a Contract Liaison that the vendor reports to
  - The Vendor produces reports on a monthly basis to the facility and HHC's Office of Operations that tracks the Vendor's contractual obligation such as staffing, contract expectations and survey readiness.
  - The Vendor does Facility "floor rounding" inspecting the areas of the Hospital to assure compliance with Centers for Medicare & Medicaid Services (CMS), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and Department of Health (DOH) requirements as required by each facility with Administrators of the facility
  - Mock Surveys are done by Vendor, and Central Office. The results are sent to Senior Staff of the facility.
  - Mock Surveys are also done by an independent consultant at least one year prior to an anticipated Survey. All results are shared with the Senior Staff of the Facility.

Dialysis Transition Briefing

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

Status of Dialysis Initiative

- Executed February 2013 with Atlantic Dialysis Management Services

- Implementation Plan:
  - Woodhull Medical and Mental Health Center — March 2013
  - Queens Hospital Center — March 2013
  - Coney Island Hospital — May 2013
  - Jacobi Medical Center — July 2013
  - North Central Bronx Hospital — July 2013
  - Chronic Facilities: Harlem Hospital Center, Kings County Hospital Center, Lincoln Medical and Mental Health Center and Metropolitan Hospital Center will transition after the state has granted the license – targeted to start in 3rd Quarter of 2013 and complete in early 2014. These facilities will open in their current units.
  - Harlem Hospital's new unit will be outfitted by the vendor and will open in 2014, Lincoln's new unit will be built by the vendor, date yet to be determined.
  - New unit will be constructed by the vendor at North Central Bronx Hospital – estimated start of construction is 2015.
  - Once all construction is complete more than 50 stations will have been added.


Thank You
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