2007 Year in Review

Report to the HHC Board of Directors

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

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Alan D. Aviles
President and Chief Executive Officer
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2007 Year in Review

Earlier this month, one of the presidential contenders, quoting Martin Luther King, referred to "the fierce urgency of now," which is an apt phrase as we look at the fast emerging challenges and opportunities across the healthcare landscape.

Dramatic change in healthcare appears certain over the next few years, fueling both hope and anxiety. There is hope, engendered by the Presidential primary campaign focus on the crisis of the uninsured, that progress will be made toward universal healthcare coverage in the coming years. And it appears that government at the federal and state level may finally begin to re-think whether it makes sense to continue paying for healthcare in ways that perpetuate a predominately passive approach of caring for the sick, rather than investing in more proactive efforts that keep patients and communities as healthy as possible.

At the same time, there is deep anxiety that the pursuit of simplistic approaches to the very complex problems in healthcare may take us backward, potentially restricting access even further and deepening the inequities in an already inequitable system. Indeed, President Bush recently proposed slashing Medicaid, Medicare and other healthcare spending by $200 billion over the next five years, and has issued or proposed federal regulations that would cut billions more in Medicaid funding that supports public hospitals specifically.

Although it is unlikely that all of these proposed reductions will occur, the sheer magnitude of the cuts proposed is chilling, and would disproportionately affect the already underserved. Moreover, the obsession with healthcare spending cuts reflects the legitimate concern that the projected growth of spending in healthcare is unsustainable and requires radical intervention. New executive leadership at the federal level may deal with the growing crisis of spiraling healthcare costs differently (and more compassionately), but there is a growing consensus across party lines that the status quo is untenable and fundamental change inevitable.

Alan D. Aviles, HHC President and CEO

At the state level, our governor is proposing both cuts and far-reaching budget reforms in the State's approach to reimbursement of Medicaid services. On balance, we support most of these reforms, which seek over the course of the next three or four years to make Medicaid reimbursement more rational and equitable. However, the state also is proposing to use its purchasing power to channel volume for certain high cost Medicaid services – initially bariatric surgery and breast cancer surgery – to a handful of hospitals on the theory that this will lower cost while improving quality. While such selective contracting may help to develop cost-effective centers of excellence in the future, we are deeply concerned about the extent to which access to essential services may be limited, especially for patients traditionally served by our public hospitals.

However these specific budget proposals play out, over the long run the relentless drumbeat of change in healthcare will be increasingly heard. Cost-containment pressures will intensify, and greater efficiencies will be demanded. Hospitals and providers will be compelled to report comparative quality and patient safety data and such data will be made available to the public. With hospitals soon to be ranked publicly on the basis of patient satisfaction, patients will become less accepting of poor service. Competition for patients, including newly insured patients, will undoubtedly increase and not all hospitals are assured of long-term survival, as we have seen.

This unfolding turbulent future will be challenging. We will fight proposed change that unfairly targets safety net providers in ways that threaten our mission. But wherever possible we will anticipate the trajectory of the forces of reform and prepare and position our system to adapt successfully. And we will seize the opportunity to embrace and drive impending change that makes sense for our patients and furthers our mission.

Remaining Steadfast in Our Mission

While we cannot predict the future with certainty, some things of importance will remain constant. HHC will remain steadfast in its core mission of affording broad access without regard to ability to pay or immigration status. And, as in the past, our intensely mission-driven agenda will continue to attract and help us to retain deeply committed and talented personnel at every level of our organization.

Unfortunately, we recently have had one advantage that is less enduring. Our success over the last few years has been enabled greatly by the unwavering support of Mayor Michael Bloomberg who has less than two years remaining in his term. Once again this past year, the Mayor has stepped up the City's support for our system in several ways. None of these is more important that his support for the expansion of our WTC Environmental Health Center, a program that began at Bellevue and in the past year has been expanded to include sites at Elmhurst and Gouverneur.

By the middle of this year, we will have significantly increased our capacity to treat patients – including area residents and day laborers involved in the clean-up – who suffer from illness related to the immediate aftermath of the 9/11 attack. Later this year we will work closely with community-based organizations to conduct an extensive outreach to ensure that affected residents and workers are aware that these specialized healthcare resources are available to them at no charge.

Our WTC Environmental Health Center provides expanded access of a highly targeted kind. But we continue to work to ensure that we can provide broad access to those who most need our services.

Increasing Access in Staten Island

In Staten Island, for example, last year we continued to support the expansion of primary care capacity for low-income and uninsured Staten Island residents in several ways. We extended the temporary Staten Island Health Access program (SIHA) through June 2008 to permit low-income, uninsured Staten Islanders to continue receiving primary and select specialty care from private community physicians, while we worked to create more permanent solutions. We also have funded a local community-based organization to help enroll eligible low-income Staten Islanders into government insurance programs for which they are eligible. Overall, we have provided better access or facilitated more affordable care for more than 4,500 Staten Island residents.

Our efforts to expand primary care capacity permanently include our continuing financial support of the Community Health Center of Richmond, where we have financed a physical expansion that should be completed this summer. We also have purchased a state-of-the-art mobile medical clinic that should hit the streets this summer, bringing a new source of affordable primary care to communities across the borough. In addition, we have purchased a site at 155 Vanderbilt Avenue that will be the home of a future HHC ambulatory care center and we are searching for our next site.

HHC Options Program

This past year we revised our HHC Options Program to make care even more affordable for very low-income New Yorkers, even as we maintained heavily discounted fees to families with incomes up to four times the federal poverty level. We eliminated all outpatient fees for pregnant women and children of families with incomes below 250% of the federal poverty level. For patients at the lowest income levels, we have reduced our already modest prescription drug fees – to a mere $2 – to further lower barriers to medication compliance. And we are promoting our HHC Options Program broadly with marketing material that has been translated into the twelve languages most commonly spoken by our patients.

Making Capital Investments for the Future

At the same time, to ensure that HHC is positioned to meet the needs of the next generation of New Yorkers, we continue to move forward with an ambitious capital program that is systematically rebuilding large portions of our aging infrastructure. It is the most extensive hospital capital construction program in New York City's history, and is producing therapeutic environments that better support the practice of modern medicine and enable the use of technology to realize better outcomes for our patients.

Over the past three years, we have completed construction on major modernization projects totaling more than $700 million on the campuses of six facilities. Over the next five years, we will complete major projects on the campuses of five facilities constituting nearly $750 million in additional construction. And this year we also will complete the last of our labor and delivery suite renovations, allowing us to say that each of the more than 21,000 babies born annually at HHC will arrive in state-of-the-art facilities.

Replacing Major Information Technology Systems

To continue driving clinical performance improvements at an accelerating pace and to simultaneously meet the financial challenges that lie ahead, the replacement of our outdated information systems will be critical. A new financial system was selected this past year that, among other things, will ensure that we optimize our collection of revenue due us from third-party payors for all services provided to our patients. Collaborative teams of local experts shortly will begin the complex and time-consuming work of preparing for a system-wide implementation that will span the next several years.

Later this year, we will commence a competitive procurement process for a new electronic medical record (EMR) system that will be easier to use and allow us to more readily access a patient's clinical data from anywhere within our system while offering much more robust functionality… functionality that will not just permit more intuitive and efficient documentation, but also guide and support more comprehensive and consistent evidence-based care.

It is a tribute to the creativity and talent of our staff involved with our current finance and clinical systems that they have accomplished so much – including three national awards in the past five years for clinical IT excellence – with technology that is now more than two decades old. Imagine what they will be able to do once we equip them with state-of-the-art systems.

Going forward, we'll have to shift resources to undertake these mammoth and immensely complicated transitions and that will mean a new challenge: we will need to freeze all further development of our current finance and clinical IT systems as we proceed to transition to the new ones.

As a system that provides nearly 40% of the hospital-based outpatient and inpatient behavioral health services in our City, we must ensure that any new EMR extends its functionality to that important realm of our work… something that we have not been able to accomplish successfully with our current EMR. As we proceed with a competitive procurement for a new enterprise-wide core EMR that meets all of our complex needs, a team of our behavioral health leaders simultaneously will seek to identify a specialized electronic medical record for behavioral health settings that could be interfaced to a new core system, if the core system selected does not include that functionality.

Continuing to Enhance Quality and Patient Safety

We are pursuing enhanced quality and patient safety across many fronts. Last year we restructured and strengthened our central office division responsible for supporting and facilitating system-wide quality and patient safety efforts. We have brought on a dedicated senior manager to focus on our continuing work around accommodating the needs of patients with limited English proficiency. We view such accommodation, especially as it relates to clear communication and cultural sensitivity, as being an important dimension of quality and patient safety.

We continue to perform above national and local averages on federal quality performance indicators that measure our adherence to evidence-based medicine in the treatment of heart attack, heart failure and pneumonia, as well as in the prevention of surgical infection. Beyond that, we are improving patient outcomes in significant ways through a broad array of initiatives that reflect our proactive approach to prevention as well as to screening and the early detection of disease.

Smoking Cessation, Colon Cancer Screening, and Expanded HIV Testing

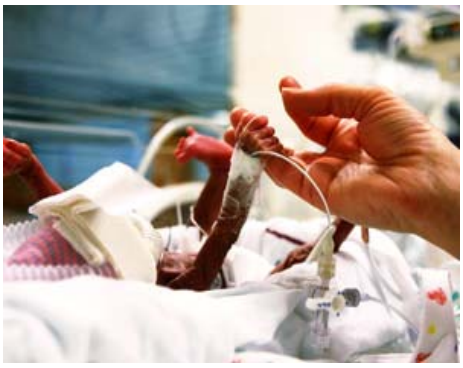
Over the past three years, our efforts around smoking cessation, colon cancer screening and expanded HIV testing have advanced meaningfully, with significant measurable benefits to our patients. Last year, we increased participation in our smoking cessation program for the third year in a row, enrolling roughly 23,000 patients. Over the past three years, we have helped more than 25,000 patients to quit smoking successfully. Research suggests that at least one-third of these patients, or about 8,000 former smokers, will avoid smoking-related disease and premature death as a result. We expect to enroll about 23,000 smokers in cessation programs again this year.

We also continue to focus heavily on cancer screening, performing more than 90,000 mammograms and 165,000 cervical cancer screenings last year. Last year, for the third year in a row, we also performed more than 20,000 colonoscopies, considerably more than twice the number performed just four years ago. As a result, we are more often detecting colon cancer at an earlier stage when the prognosis is better. Equally important, we have removed pre-cancerous polyps from nearly 14,000 patients over the past five years and we know many of these patients would have gone on to develop colon cancer.

Last year was our second year of a major push to make HIV testing a more routine part of care across our emergency departments, inpatient units, and many outpatient clinics. Two years ago, we increased HIV testing by 50% and tested more than 95,000 patients. During 2007, we achieved another 50% increase and tested roughly 140,000 patients. As a result, over the past two years we have identified and linked to care more than 3,000 patients who were HIV positive and did not know it.

That means a better long-term prognosis for those patients as well as a reduction in the likelihood of further transmission of the HIV virus to others. We expect to test more than 160,000 patients for HIV this year.

Developmental Care, Breastfeeding, and Palliative Care



Let me highlight three other, more recent, system-wide initiatives with equal promise that we have ramped up during the last year. Two of these initiatives focus on the health of infants.

In neonatal intensive care units, we are re-engineering the environment as well as the delivery of care to minimize stress factors and maximize comfort and developmental support. These evidence-based measures have been demonstrated to improve survivability and outcomes for fragile infants born very prematurely. In 2007, all NICU staff – about 600 people – were trained in these nurturing developmental care protocols. By the end of this year, we will complete the final phase of implementation, which entails capital improvements to modify the NICU physical environment to reduce noise levels and lighting intensity.

This past year we also committed ourselves to improving the health of the babies born in our facilities by doing everything possible to promote and support breastfeeding. With dedicated grant funding from DOHMH, we have deployed breastfeeding coordinators at each of our hospitals. We are educating expectant mothers about the health benefits of breastfeeding during prenatal care and actively supporting successful breastfeeding post-delivery.

We have discontinued the routine practice of distributing free formula samples and formula marketing materials to all mothers, although we, of course, make formula available to mothers who cannot or who choose not to breastfeed. (And we pay for that formula now through our own operating funds, rather than receive it free in exchange for acting as a marketing agent for formula distributors.)

The percentage of new mothers who are discharged exclusively breastfeeding their well infants increased to 34% during this past calendar year, and it is our goal to reach 50% by the end of this calendar year.

Even as we address how to better meet the needs of our patients and families as a new life begins, we are also grappling with doing a better job toward life's end. Over the course of the last year, we have allocated dedicated funding to support the deployment or strengthening of palliative care services at every one of our hospitals. At Metropolitan Hospital, for example, a newly recruited physician leader trained in pain management and palliative care has established a Center of Pain Management and Palliative Care. Most facilities have opted to add palliative care as a consultative service at this point, rather than establish a discrete palliative care center or unit. Under this model, patients across our system will have access to a specially trained palliative care team.

Now that our patients and providers have increasing access to expert palliative care as an option for end of life (and chronic pain) situations, fewer patients are spending their last days in an ICU – with all of the high tech, invasive indignity that entails – and are opting instead for closure with family and friends in greater comfort and with less trauma.

This past year, about 1,500 patients received palliative care services across HHC. This coming year we expect that number to increase as our palliative care services, supplemented by contracted home hospice services, mature further.

Stepping Up the Fight Against Chronic Disease

Another very important dimension of quality relates to the effective management of chronic disease. Chronic disease drives much of the cost in our nation's healthcare system and disproportionately impacts the low-income communities served primarily by HHC. For this reason, we have spent the past three years working collaboratively to develop and implement best practices to help our patients manage their chronic disease more effectively, with an emphasis on asthma, diabetes, congestive heart failure and depression. During last year, we funded dedicated chronic disease coordinator positions in every network and have deployed clinical IT solutions, including our electronic chronic disease registries, to help support this work.

The incidence of diabetes in our City has doubled over the past ten years and the trend lines still point upward. We have nearly 50,000 patients with diabetes receiving primary care at HHC facilities and the implications of poorly controlled diabetes for these patients and their families are enormous. Diabetes is the leading cause of end-stage renal failure, adult blindness, as well as amputation of extremities. It also is a major contributor to heart disease and stroke.

With the stakes so high, this year we will be targeting additional resources to support the more effective management of diabetes.

Among other things, we will be expanding a successful telehealth pilot that has helped 70% of the patients remotely monitored to reduce their blood sugar levels with coaching and, if necessary, intervention from a nurse care manager who tracks the daily telehealth data downloads. Going forward, the number of patients supported in the pilot will be tripled and their blood pressure in addition to their blood sugar levels will be monitored through telehealth technology.

Our recent significant reduction in prescription medication fees for very low-income patients should help to reduce an obvious barrier to medication compliance for patients with diabetes who generally take several prescription medications each month.

We also have begun the process of building a model care management center in one of our networks in partnership with our two major Medicaid managed care plans. Once fully staffed, these care managers will provide intensive support to patients with diabetes who are under the care of teams in the primary care clinics and health centers within that network. If such care management support yields significant improvements in health status, we will scale the operation up so that it can supplement care for diabetic patients in an increasing number of HHC facilities.

This past year, we also began to make depression screening a routine part of our primary care services and we screened 72,000 patients across our system. We will look to increase that number by 50% this year and to screen virtually all of our patients in primary care who have diabetes. We know that untreated depression can be a significant impediment to our engaging patients in the management of their diabetes and other chronic disease.

Behavioral Health Disparities

On a related note, as we continue to search for better ways to address the health toll taken by poorly controlled chronic disease, we need to focus our efforts on our patients with mental illness. HHC facilities provide a very significant portion of the hospital-based inpatient and outpatient mental health services in this city. Because we run the majority of our City's psychiatric emergency departments, we also care for a large percentage of New Yorkers with serious and persistent mental illness.

Across the nation, the average life expectancy for patients with severe and persistent mental illness is 20 years less than the general population. This disparity is shocking and much of it is attributable to our collective failure to treat more effectively chronic medical conditions in patients with severe mental illness. Indeed, too often the psychotropic medications used to treat mental illness can exacerbate underlying chronic medical conditions like diabetes and hypertension. This year we will explore ways to better coordinate care to address chronic diseases like diabetes, hypertension and congestive heart failure in our mentally ill patients.

The combination of mental illness (and sometimes substance abuse) together with other chronic illness often typifies many patients who have a disproportionate number of emergency room encounters and hospital admissions. During the course of a year, these so-called "high-utilizers" consume extraordinary levels of healthcare resources, often without improving their health status.

One of our facilities has been analyzing the profiles of "high-utilizer" patients. This year it will partner with several other HHC facilities and certain community-based organizations to attempt to devise interventions that will address the complex needs of these patients and inform our efforts to produce better outcomes in a more cost-effective manner.

Patient Safety

Patient safety is an extremely important dimension of quality, one with the power to change the public's perception of overall quality at HHC's hospitals. In 2007, we deepened the dialogue with staff around patient safety at widely attended leadership forums and through an effective employee awareness campaign; we ramped up our training for Patient Safety Officers and began to see the effect of patient safety in the culture of HHC; and we pressed forward with a wide range of patient safety initiatives. This broad array included preventing hospital-acquired infections, reducing out-of-ICU cardiac arrest with rapid response teams, reducing the incidence of pressure ulcers, reducing suicide risks, implementing electronic medication administration reconciliation, screening and treating patients at heightened risk for deep vein thrombosis, improving management of severe sepsis, preventing patient falls, and increasing employee influenza vaccination rates, among others.

Our system-wide efforts to reduce the incidence of ventilator-associated pneumonia (VAP) and central line-associated blood stream infections among ICU patients have been dramatically effective. During 2006 we recorded a 30% drop in central line infections and a 65% drop in VAP. Preliminary results for 2007, which will be reported officially next month, reflect very significant additional declines in both types of hospital-acquired infections. We also have achieved a remarkable 50% decrease in the incidence of pressure ulcers over the past year. Although the final results of this year's employee flu vaccine campaign are not in, we already have increased the rate of employee vaccination by more than 50% over last year.

Our patient safety initiatives in the aggregate have contributed to a steady reduction in patient harm and preventable deaths. Even as the acuity of our patients – as measured by each hospital's case mix index – has increased over the past four years, our system-wide mortality rate has dropped for each of those years. As a result, about 880 fewer patients died across our system this past year as compared to four years ago, despite the fact that we had more inpatient admissions and patients on average were more acutely ill. This is an extraordinary accomplishment for which our facility leadership and staff can rightly feel proud.

Advanced Learning Institute

As we make our care and processes more patient-safe in a variety of ways, we also must look to ensure that we build capabilities among our physicians, nurses and other clinical staff for effective team work, especially in coping with high risk situations that suddenly unfold in the very complex arenas of obstetrics, intensive care and emergency medicine.

Beginning later this year, we will start to put in place the infrastructure for an Advanced Learning Institute comprised principally of faculty from among our own clinicians and equipped with the latest in computerized simulation technology. The Advanced Learning Institute will create a learning environment where our clinical personnel can test and hone their ability to respond quickly as a high performance team to the most challenging emergent situations in obstetrics, intensive care and emergency medicine.

Transparency

Our many ongoing efforts to continuously improve our performance around quality and patient safety have begun to garner attention. This past year HHC was honored with a national award from *Modern Healthcare* magazine and the Health Information and Management Systems Society for our use of clinical information to drive improvements in care.

One of our long-term care facilities, Sea View, won the prestigious Ernest Amory Codman Award from the Joint Commission for excellence in improving care through outcomes measurement.

We also were featured in the widely distributed 2008 Progress Report of the Institute for Healthcare Improvement as a national leader in using transparency to drive performance improvement.

This last recognition is a reference to our bold step last year of posting to our public website a range of important quality and patient safety data, much of which is not otherwise publicly available for other hospitals in this state. Under a new section of our web site entitled "HHC in Focus," we included our system-wide and hospital-specific data reflecting mortality rates and hospital-acquired infection rates for recent years, among other data. We believe that the sharing of this data will engender greater confidence in our communities that we are committed to making ongoing improvements in quality and safety that are important to our patients. Such public disclosure also helps to further galvanize and concentrate our own efforts to deliver on our promises of continuous improvement.

Next month, we will update the current data in "HHC in Focus" to reflect our performance during 2007 and we will add new data reflecting the status of our work to help our patients better manage their chronic disease. For example, a series of performance indicators reflecting the health status of our adult patients with diabetes will be posted on a system-wide and facility-specific basis, allowing the public to monitor whether we are being successful in bringing more diabetic patients into good control over the coming years.

Increasing Efficiency and Shoring Up Our Financial Health

Many of these clinical initiatives, which so clearly reflect better, more effective care from a patient-centered perspective, also amount to more efficient and cost-effective care as well.

For example, offering compassionate and supportive palliative care as an option does reduce the expensive and futile consumption of intensive care resources for those patients who opt to accept palliative care.

Although we often stress our clinical initiatives to enhance our quality of care, we are equally concerned with efficiency and cost-effectiveness. As the Board knows, among other approaches, we increasingly have sought to leverage HHC's size to reduce costs where that makes sense.

Leveraging Our Size To Reduce Costs

This year we will complete the last facility installations of an e-commerce system that helps us to more closely track our procurement of goods and supplies. We recently have changed our operating procedures to both more readily comply with new campaign finance reform laws restricting political contributions from vendors that do business with the City, and to more readily channel our procurement through centralized contracts that ensure that we can use our vast purchasing volume to obtain the lowest possible price.

As part of this effort, we will continue to work with our physicians to forge consensus around standardizing our use of certain medical and surgical supplies and devices to leverage volume and lower cost. This year we will contract with a prime distributor for medical and surgical supplies, as we have done successfully in the past with pharmaceuticals, to lower our inventories and ensure just-in-time delivery of an array of products from a single distribution source.

Ensuring Equitable Staffing

Because personnel costs are the single largest component of our expense budget, we need to restrain further increases in staffing so we do not outpace projected increases in revenue.

Over the past two years, our workforce has grown roughly in proportion to the increase in our workload and we have held our administrative and managerial positions relatively flat while adding appreciably more direct care staff, especially nurses. We do need to maintain appropriate staffing levels to ensure that we can render effective and safe patient care. However, we also need to ensure that we are allocating staffing budget dollars equitably across facilities and that staffing patterns are fair when comparing one facility to another.

To better monitor and assess the adequacy of staffing at each of our facilities, we will develop a staffing model and algorithm this year that should better allow us to make certain that we are deploying limited staffing resources as fairly and effectively as possible in light of facility-specific patient volume and acuity, service mix, and other factors.

Reducing Reliance on Agency Nursing

Much of our increased staffing over the last year has been in nursing, with more than 480 nurses added to our ranks. In some instances, this hiring reflects more competitive salaries under a recently negotiated union contract that is allowing us to more readily fill vacancies and reduce our reliance on expensive contracted agency nurses. As we focus on the nurse staffing that we need now and in the future, we are taking action to address alarming projections pointing toward an overall nursing shortage in healthcare over the next decade.

With the help of the Mayor's Center of Economic Opportunity (CEO) and in partnership with the New York City Department of Education, we have established an LPN training program at Coler-Goldwater that will graduate its first class of LPNs this year. At the same time, and also with the help of CEO, Kings County Hospital has joined with Long Island University to build classrooms and establish a training program for registered nurses on that hospital's campus. This program – which restores a rich tradition of HHC training its own nurses – will offer 240 academic scholarships leading to a four-year RN and BS degree, and guaranteed jobs with HHC for the graduates. The first class of RN students will commence classes in September 2009.

As we work to recruit enough front-line nurses, we also need to prepare for the loss of senior nursing leaders who are reaching retirement age. To strengthen our bench of tomorrow's nursing leaders, we have created HHC's Nursing Leadership Academy, which is funded in part by the Jonas Center for Nursing Excellence. Last year, 102 nurse leaders completed leadership training, and this year 150 nurses have been selected to participate.

Aligning Our Managed Care Strategy with Our Mission

A fundamental irrationality of our nation's healthcare system is its failure to reimburse services to promote healthier patients and communities. The Medicaid and Medicare programs generally reimburse hospitals at rates that approximate the cost of treating the acutely ill who need hospital admission. However, they often do not come close to covering the actual cost of ambulatory care; primary care services, in particular, are woefully under-reimbursed at present. This creates a dangerous headwind to our mission-driven investment in a vast ambulatory care network that stresses comprehensive primary and preventive care for our patients.

Because government payers – and most managed care plans – take this "fee-for-service" approach to reimbursement, they reap the sole benefit of any avoided emergency room encounters and hospital admissions. As a result, HHC's considerable investments at the "front-end" of healthcare, i.e., in more effective primary care, screening and early disease detection and more effective management of chronic disease, cause us to lose a great deal of money. For example, as we invest in more education to involve patients and families in the self-management of asthma in children, and we are successful in driving down asthma-related pediatric emergency room visits and inpatient admissions, we lose all the revenue associated with those avoided emergency room visits and hospital admissions. The same negative financial consequences befall us as we do a better job of helping our diabetic and congestive heart failure patients stay out of our emergency rooms and hospital beds.

To address this fundamental systemic dysfunction, *our* managed care plan, MetroPlus, is set up to pay us a monthly amount to keep each of our MetroPlus patients as healthy as possible. This approach is called "global capitation" and is based upon the assumption that if hospitals are paid a fixed amount on a monthly basis to manage the health of large numbers of patients, they will have an incentive to invest toward promoting the health of those patients, rather than simply passively waiting for them to need a hospital's emergency room services or hospital bed.

This past year, we made the difficult decision to cancel most of our Medicaid managed care contracts with plans that pay us on a "fee-for-service" basis, rather than a "global capitation" basis. Although this decision necessarily involved some disruption in services for many of our patients enrolled in those plans, we believe that most of those patients will ultimately opt to join MetroPlus or another plan with which we still contract.

We project that, over the long run, we will derive more revenue from roughly the same number of patients, spend less money on administrative costs associated with contracting with so many different plans, and have more freedom to spend the revenue generated on health promotion, screening and early detection of disease, and supporting more effective management of chronic disease.

MetroPlus Health Plan

MetroPlus's enrollment increased by almost 15% in 2007, and is expected to exceed 300,000 within the next month or two.

As the federal government continues to encourage the enrollment of Medicare patients into managed care plans, we also are looking to MetroPlus to help us serve more of our Medicare patients in a globally capitated reimbursement model. It is especially important for us to offer this managed care option to our low-income elderly patients who are increasingly aging into the Medicare program as "dual-eligibles," that is, patients who are eligible for both Medicaid and Medicare. To that end, this past year MetroPlus successfully became licensed to enroll dual eligible Medicare patients across our system and is poised to grow its Medicare enrollment this year.

Building Community Physician Networks

HHC connectx nyc.gov/hhcconnectx

Just as we have revised our past thinking that we should contract with as many managed care plans as possible, we have begun to rethink our historically limited relationship to community physicians. As the need to use community health resources more efficiently increases and our ability to tackle care coordination across settings slowly evolves, we need to build bridges to community physicians.
This year we will dedicate budget funding to help each of our networks establish and nurture referral and care coordination relationships with private physician practices in their communities. In addition, we will roll out across all networks our HHC Connectx software application that enables the secure transfer of patient information between our hospitals and community physician offices.

Meanwhile, several of our hospitals and one of our long term care facilities will continue developing a promising clinical data exchange pilot that uses internet-based technology to enable the sharing of portions of a patient's medical record among our facilities and other community-based settings, including private physician offices, community health centers, and nursing homes. Ultimately, the great promise of enhanced information sharing, where confidentiality law allows, will be to give practitioners – whether they be in the community, in our facilities, or in other institutions – access to a more comprehensive understanding of their patient's needs.

Increasing Competitiveness Through Patient Satisfaction

Patient satisfaction goes hand-in-hand with patient-centered care, another important dimension of quality in healthcare. However, because it is an aspect of quality that is readily discernable by patients as consumers of healthcare, patient satisfaction also impacts heavily on competitiveness.

Beginning this year, the federal government will start releasing to the public the results of standardized patient satisfaction surveys that measure the degree to which inpatient hospital services are perceived by patients to meet their needs. In anticipation of this development, we engaged a consultant last year to conduct such surveys at each of our hospitals – using the same survey tool that the federal government will mandate going forward. The results were fed back to our hospitals to pinpoint for them areas of weakness from the standpoint of "customer service" that warranted their attention.

The survey results reflected that one of our hospitals – Queens Hospital Center – achieved outstanding results on each of its trial surveys, a reflection of its innovative work around customer service training under its "Charm Star" program. Although many of our facilities are devising their own approaches to addressing customer service weaknesses identified by their survey findings, we will be looking at harvesting best practices from Queens Hospital Center for possible implementation at other HHC hospitals.

Managing and Leading Adaptive Change

As imperatives around cost-containment, value purchasing and other powerful forces converge to alter fundamentally the framework of healthcare, we must continue to build our large organization's capacity to adapt to such potentially rapid and large-scale change. This means we must change the way that we manage and lead our organization and its facilities.

Our need to improve our competitiveness and increase patient satisfaction in our ambulatory care settings led us several years ago to launch our Ambulatory Care Restructuring Initiative (ACRI). The first phase of ACRI was intended to restructure patient flow through our primary care clinics and health centers to reduce the average time to complete a visit from more than two hours to one hour or less, and to do it without adding significant additional resources.

To meet this challenge we employed a radically different management approach. Managers were trained to delegate this task of restructuring patient flow to front-line staff. These teams – drawing on their first-hand experience with the bottlenecks in the system – were then empowered to make changes quickly that might reduce waste and inefficiency while increasing convenience for patients. If the changes achieved the desired effect, they were incorporated into the workflow. This approach – encouraging and supporting team-based rapid improvement cycles aimed at reducing wasted effort and time – yielded surprising results, with the average primary care visit across our system now at the target of one hour, and many clinics and centers achieving even better results.

This year our primary care clinics and centers will continue tackling the second phase of ACRI – restructuring our appointment system to make appointments more readily available when patients need them and to reduce no-show rates – using the same redesign methodology driven by front-line teams.

As the Board knows, this past year we have retained the services of a consulting company, with deep experience in training managers and teams, to approach continuous performance improvement in a very similar way. Using techniques first designed for the manufacturing environment and modified in recent years for healthcare, the approach – known as LEAN, but renamed by HHC as Breakthrough – puts performance improvement and streamlining for efficiency largely in the hands of teams composed of front-line staff. Several hospitals across the country, including the Denver public hospital system, have successfully used this workforce-led redesign methodology to achieve significant measurable savings while improving service delivery and patient satisfaction.

This approach to leadership is fundamentally different from the conventional one, which treats managers as experts who largely dictate any changes in the way that work is performed, with the expectation that front-line staff will simply carry out the manager's directive. The Breakthrough approach proceeds from the proposition that the true experts are the staff who work at delivering care and serving our patients every day, and that they are best equipped to redesign their work processes in ways that eliminate waste and increase both patient and staff satisfaction.

Under this fundamentally different approach, our managers must learn to support, coach and facilitate this work, rather than direct it.

Five of our hospitals and two divisions within our central office will undergo intensive training and will roll out Breakthrough initiatives to redesign work processes for efficiency this year. We have made an inviolate pledge to our labor unions that no unionized employee will lose his or her job as a result of these redesign efforts and that any efficiencies gained will result in a re-investment to enable us to provide more services with our current resources.

HHC is fortunate in that it largely attracts personnel at all levels with a deep commitment to our patients, communities and mission. Time and again, when supported and encouraged, our staff have shown an ability to solve seemingly intractable problems and to improve our performance through innovation. I regard Breakthrough as the introduction of a style of management that capitalizes on this great asset, and I am confident that it will spur continuous organizational learning, innovation and timely adaptation to change.

Momentum

To invoke another election season term, our public hospital system moves into 2008 with great momentum. We are a better organization than we were a year ago in providing access to the people who need us; better at rendering evidence-based care to patients in comfortable, technologically advanced settings; better at keeping patients free from harm in our facilities; better at informing the public about the quality of our care and the areas where we need improvement; better at providing linguistically and culturally competent care; better at helping patients become better partners in the maintenance of their own health; better at preparing to face our challenges next year, and in the years to come.

We owe those proud accomplishments to the strong support of the Board, the dedication of talented leaders here in central office and across our facilities, and to the commitment of the thousands of people who work within our system to make our mission a reality every day.

Bellevue Hospital Ambulatory Care Pavilion

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